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

# FY 2013–2014 Site Review Report

*for*

# Denver Health Medicaid Choice and Denver Health Medical Plan

April 2014

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

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## Introduction

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their Medicaid managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with federal health care regulations and contractual requirements. Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires CHP+ managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the BBA requiring that states also conduct a periodic evaluation of their CHP+ MCOs and PIHPs to determine compliance with federal health care regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Medicaid and 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 report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013, for the Medicaid and CHP+ lines of business. Although the two lines of business were reviewed concurrently with results reported in this combined compliance monitoring report, the results for the CHP+ and Medicaid managed care lines of business have been differentiated. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the two standard areas reviewed this year for both lines of business. Section 2 contains graphical representation of results for all standards reviewed over the past three years and trending of required actions. Section 3 describes the background and methodology used for the 2013–2014 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2012–2013 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials record review. Appendices C and D contain details of a provider appointment availability open shopper call project and results of a focus group, both designed to further assess Medicaid member access to services and appointment availability. Appendix E lists HSAG, health plan, and Department personnel who participated in some way in the site review process, as well as the focus group participants. Appendix F describes the corrective action plan process the health plan will be required to complete for FY 2013–2014 and the required template for doing so.

## Summary of Results

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

### *CHP+ Results*

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

**Table 1-1—Summary of CHP+ Scores for the Standards**

| Standard | # of Elements | # of Applicable Elements | # *Met* | # *Partially Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|---|
| I Coverage and Authorization of Services | 34 | 34 | 29 | 5 | 0 | 0 | 85% |
| II Access and Availability | 21 | 21 | 17 | 4 | 0 | 0 | 81% |
| **Totals** | **55** | **55** | **46** | **9** | **0** | **0** | **84%** |

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

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

| Description of Record Review | # of Elements | # of Applicable Elements | # *Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|
| Denials | 33 | 15 | 13 | 2 | 18 | 87% |
| **Totals** | **33** | **15** | **13** | **2** | **18** | **87%** |

### Medicaid Results

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

**Table 1-3—Summary of Medicaid Scores for the Standards**

| Standard | # of Elements | # of Applicable Elements | # *Met* | # *Partially Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|---|
| I Coverage and Authorization of Services | 34 | 34 | 31 | 3 | 0 | 0 | 91% |
| II Access and Availability | 21 | 20 | 16 | 4 | 0 | 1 | 80% |
| **Totals** | **55** | **54** | **47** | **7** | **0** | **1** | **87%** |

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

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

| Description of Record Review | # of Elements | # of Applicable Elements | # *Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|
| Denials | 110 | 60 | 59 | 1 | 50 | 98% |
| **Totals** | **110** | **60** | **59** | **1** | **50** | **98%** |

## Standard I—Coverage and Authorization of Services

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

### Summary of Findings as Evidence of Compliance

DHMC/DHMP policies were comprehensive, generally clear, and described:

- The regulations and standards used to perform utilization review (UR), including processes to ensure interrater reliability (IRR).
- Clinical criteria and UR guidelines used.
- The pharmacy management program.
- Processes for preservice, concurrent, and postservice UR.

- Definitions and processes for obtaining emergency and poststabilization care.

Providers were informed of requirements, definitions, and processes via provider contracts, manuals, and newsletters.

Through on-site review of DHMC/DHMP's electronic authorization system and denials records, HSAG found evidence that DHMC/DHMP consistently used established criteria such as Milliman Care Guidelines (MCG) and a medical necessity standard to make authorization determinations. DHMC/DHMP's authorization system contained documentation when requests for additional medical records or consultation with the requesting provider were needed to make authorization decisions.

Notice of action (NOA) templates included fields for the required information and were easy to understand. Member-specific information inserted in the templates included the required information, except in one CHP+ record, and were easy to understand, except for one CHP+ record.

## Summary of Strengths

DHMC/DHMP had a comprehensive Utilization Management (UM) Program Description that outlined the goals and responsibilities of the program and addressed essential requirements such as structure of the department for making authorization determinations, clinical expertise of individuals who make determinations, and medical management and oversight of the UM Program. Pediatric and adult guidelines delineated which services may be limited at Denver Health and Hospital Authority (DHHA) clinics; therefore, UM staff may approve out-of-network providers for these services.

DHMC/DHMP's UM processes included extensive training and IRR using MCG training and IRR modules, and processes that ensured DHMC/DHMP staff understood that compensation for individuals making UM decisions is not structured to provide incentive for denying or limiting authorizations of services.

## Summary of Findings Resulting in Opportunities for Improvement

For claims denials for which the reason is provider noncompliance with prior authorization, coding, or billing requirements, if the member receives a NOA, DHMC/DHMP may want to consider informing the member via the NOA that the provider may not bill the member for services under these circumstances.

## Summary of Required Actions

DHMC/DHMP staff members acknowledged that the DHHA schedulers must prioritize populations when scheduling due to limited appointment availability. Staff members stated that children and pregnant women who are new Medicaid members are prioritized over new adult Medicaid members when scheduling and that a wait list is used for new adult Medicaid members. Limited appointment availability negatively impacts DHMC's ability to provide a standard of care to Medicaid and

CHP+ members equally. DHMC must evaluate appointment capacity in the DHHA provider system and develop a mechanism to accommodate Medicaid and CHP+ populations equally.

One CHP+ claims denial record reviewed on-site contained an NOA that was not easily understood due to inaccurate and incomplete information regarding the reason for the denial. The intake form in the authorization tracking system indicated that this was a retroactive review of a claim. The NOA to the member indicated that this was a new service request. The letter also stated the denial reason was that this was not a covered benefit. In fact, this was a covered benefit; however, the provider was an out-of-network provider, and prior authorization was required and not obtained. The denial reason was actually that no prior authorization was obtained. DHMC/DHMP must develop a mechanism to review claims denials to ensure ease of understanding and provide clearer information to members as well as ensure accuracy of the information.

One of the CHP+ records reviewed on-site contained an Appeal Rights attachment that included appeal rights based on the Department of Insurance (DOI) requirements rather than the current CHP+ contract requirements. Therefore, the letter did not contain the information required by the CHP+ managed care contract. DHMC/DHMP must ensure that NOAs include each of the required elements.

Although only one of the 20 records reviewed on-site contained a NOA that was sent outside the required time frames, DHMC/DHMP must ensure that all NOAs are sent within the required time frames.

Although DHMC/DHMP's policies described processes that met Medicaid and CHP+ requirements, the Medicaid and CHP+ member handbooks stated that DHMC/DHMP is not responsible for payment if the emergency provider determines that the incident was not an emergency. The CHP+ member handbook stated that DHMP would not pay for an emergency admission if the member did not notify DHMP of the emergency within one day. While the member handbook statements are unclear as to whether the emergency physician would use a medical necessity standard or a prudent layperson standard, DHMC/DHMP must revise member handbook language to clarify that DHMC/DHMP uses a prudent layperson standard to determine payment for emergency services and revise the CHP+ member handbook to clarify that DHMP will not refuse to cover emergency care based on DHMP's notification requirements.

## Standard II—Access and Availability

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

### *Summary of Findings as Evidence of Compliance*

DHHA has a system of primary care clinics in various locations throughout the city and county of Denver. The annual Strategic Access Report stated that 99.8 percent of DHMC members and 99.77 percent of CHP+ members are within 30 miles of a DHHA (the provider network for DHMC and DHMP) clinic. The report analyzed transportation patterns and noted that there are 54 bus stops

within a quarter mile of a DHHA clinic, and some are actually on the DHHA property. Policies were applicable to both Medicaid and CHP+ processes. DHMC/DHMP policies adequately addressed:

- Direct access to specialists for members with special health care needs.
- Direct access to women's health care specialists.
- Access to providers in- or out-of-network for second opinions.
- 24-hour emergency care access in or out of the DHMC/DHMP network.
- Scheduling guidelines.
- Preventive health programs.
- Practices that support service delivery in a culturally competent manner.

The Strategic Access Report provided analysis of Healthcare Effectiveness Data and Information Set (HEDIS®[1-1]) and Consumer Assessment of Healthcare Providers and Systems CAHPS®[1-2] data, and described planned interventions including conducting patient experience, customer experience, and ambulatory care workgroups; conducting provider and clinic-based CAHPS surveys; adding appointment availability questions to open shopper survey calls, and developing member focus groups. Some of these activities started late in 2013, others had implementation dates of early 2014, while a few specific interventions were waiting for staff positions to be filled before implementation could begin. While access to care issues are complex and it has been difficult for DHMC to demonstrate compliance with all requirements, it was clear that valuable studies and interventions are planned that will serve DHMC well in the coming year.

## Summary of Strengths

Once members become established patients with the DHHA clinic system, a variety of programs were available. DHMC/DHMP's Behavioral Health and Wellness Services Program Description delineated preventive health services available and a continuum of care for members with alcohol and tobacco use disorders, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure, diabetes, weight management issues, and depression and anxiety related to these disorders using health coaches, disease management processes, and complex case management. The program description described creative and community-based programs such as interactive education and exercise classes; distribution of written materials and/or DVDs; shopping and cooking classes; and individualized telephonic follow-up coaching, counseling, or case management.

The Cultural and Linguistic Appropriate Services Annual Evaluation reported numerous committees, workgroups, staff trainings, and evaluation of metrics regarding provision of interpreters and understanding of culture with respect to health care. DHMC/DHMP provided reports delineating interpreter use (in-house and language line services) and reports of ethnicity and race, which are reviewed by DHHA and DHMC management.

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

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

### Summary of Findings Resulting in Opportunities for Improvement

The Strategic Access Report showed member-to-provider ratios within the required parameters; however, it should be noted that ratios were calculated separately for each population (CHP+ and Medicaid). Denver Health should consider calculating ratios based on the total number of individuals (across all lines of business) its primary care and specialty physicians are expected to care for.

In preparation for the on-site review, HSAG conducted a focus group discussion with DHMC, DHHA, and community organizations dependent on DHMC for providing medical care to members they also serve. HSAG also conducted an open shopper call survey to evaluate wait times for obtaining appointments within the DHHA clinic system. These activities demonstrated that, while DHMC policies and procedures were in compliance, the process of obtaining appointments is cumbersome. While DHMC/DHMP policies and the Strategic Access Report reported DHHA provider panels as open, these pre-on-site activities found that wait lists were used for newly enrolled Medicaid members passively enrolled into the DHMC managed care organization (MCO), that new members seeking appointments were not offered the option to continue seeing out-of-network providers for 60 days (as required) to ensure continuity of care, and that members who do see out-of-network providers do not have access to diagnostic tests or further care within the DHHA system. DHMC staff members indicated willingness to meet individually with some of the focus group organizations to have follow-up discussions and pursue solutions to unique problems with timely access. DHMC is encouraged to initiate those discussions and follow up with action plans to improve timely access to care. Simultaneously, DHMC is encouraged to pursue more effective mechanisms for identifying and assisting members who desire disenrollment from DHMC to alleviate the backlog as members are passively enrolled into a staff model health maintenance organization (HMO) whose provider leadership admits is consistently at capacity (see Appendices C and D).

The requirements for specific scheduling wait times were scored as *Met* based on policies and procedures and communication to members and providers that indicated DHMC/DHMP strived to meet scheduling guidelines. Anecdotally, through the focus group and open shopper calls, information strongly indicated that these scheduling guidelines were not consistently met. In addition, review of DHMC's grievance reports showed that the access and availability category had the highest percentage of grievances. These grievances related to appointment delay and wait time to obtain appointments. Further, Denver Health's member satisfaction survey data (CAHPS) showed that for Medicaid and CHP+, level of satisfaction on the *Getting Care Quickly* and the *Getting Needed Care* measures fell below the 25th percentile for FY 2012—2013. However, without clear documentation of actual wait times and because CAHPS and satisfaction information was used for scoring other requirements, HSAG must score requirements for specific wait times as *Met*. HSAG strongly encourages DHMC to develop a more targeted strategy to investigate access issues, wait lists, conduct causal barrier analyses on grievances related to access, and create an action plan that specifically addresses DHMC's capacity issues.

While the Strategic Access Report made numerous references to the Access Committee, during the on-site interview DHMC/DHMP staff members reported that an actual Access Committee did not exist but that various ad hoc committees periodically review access issues. Staff members reported that the Access Committee was under development. DHMC/DHMP should consider the

development of this committee to be a priority and assign the evaluation and investigation of complaints and anecdotal information regarding access and capacity issues to this committee for in-depth review and recommending action.

During the on-site interview, DHMC staff members reported that DHHA had recently hired a number of primary care providers, and later admitted that these were replacement hires. Staff reported additional provider positions were being recruited during 2014. DHMC should apply caution and ensure that the numbers of new passively enrolled members are considered and that network adequacy is regularly evaluated. While DHMC staff members reported that DHMC is considering contracting with providers outside of the DHHA clinic system, staff also described several barriers to being able to do this and stated that DHMC did not have that ability at the time of the site review. HSAG encourages DHMC to seriously evaluate barriers to contracting with non-DHHA providers.

### *Summary of Required Actions*

Related to the use of the wait list for newly enrolled adult Medicaid members, and the significant number of grievances related to appointment delay and wait time to get appointments, as well as Denver Health's low member satisfaction survey results (CAHPS) (with scores below the 25th percentile for FY 2012–2013), DHMC must develop a mechanism to more fully explore wait list processes. DHMC must develop a process to specifically track, by individual, the length of time members remain on the wait list. DHMC must also work with the Department to problem solve solutions to barriers that create the need for the wait list and develop mechanisms to ensure that new adult Medicaid members are not wait-listed beyond the required access to care standards.

DHMC/DHMP reports that all providers have an "open panel," which carries a connotation that members may have immediate assignment to a PCP and access to appointments without the wait list process. Denver Health must further define what it means by "open panel" and more accurately describe the processes for access into the DHHA clinic system.

Although the Strategic Access Report and DHMC/DHMP's policies clearly stated that members may have access to out-of-network providers if providers are unavailable within the network, focus group discussions and on-site interviews described processes whereby members are placed on a wait list when access into the DHHA "closed system" is limited, thereby suspending ability for new members to schedule appointments, rather than looking to either contracted or out-of-network providers to fill the need. As both the CHP+ and Medicaid populations continue to increase, particularly as expansion populations are added to the Medicaid roles, DHMC/DHMP must either implement policies to provide out-of-network care when care within the network is not available or consider options to expand the DHMC/DHMP network through expansion of the DHHA provider network, or through contracts with non-DHHA providers.

DHMC/DHMP must determine what information exists within the DHHA system that can be used for monitoring appointment access and compliance with access and availability standards. DHMC/DHMP must develop an effective process for monitoring scheduling wait times, identifying barriers to complying with appointment guidelines delineated in the Medicaid and CHP+ managed care contracts, and taking appropriate action to ensure that appointment scheduling standards are met.

# Comparison of CHP+ Results

## *Review of Compliance Scores for All Standards*

Figure 2-1 shows the scores for all standards reviewed over the past two years of CHP+ compliance monitoring. (The Department chose not to assign scores for the FY 2011–2012 site reviews.)

**Figure 2-1—Denver Health CHP+ Compliance Scores for All Standards**

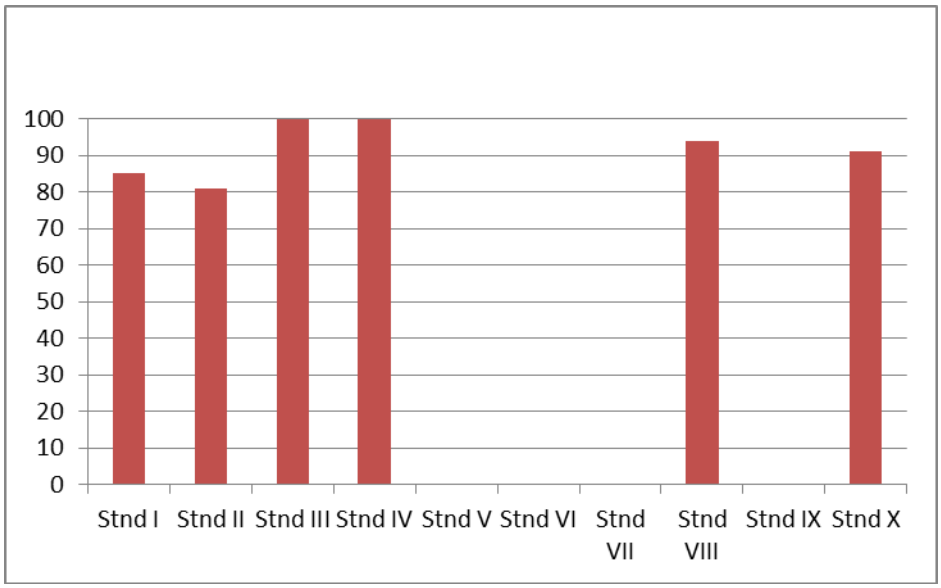



Table 2-1 presents the list of standards by review year.

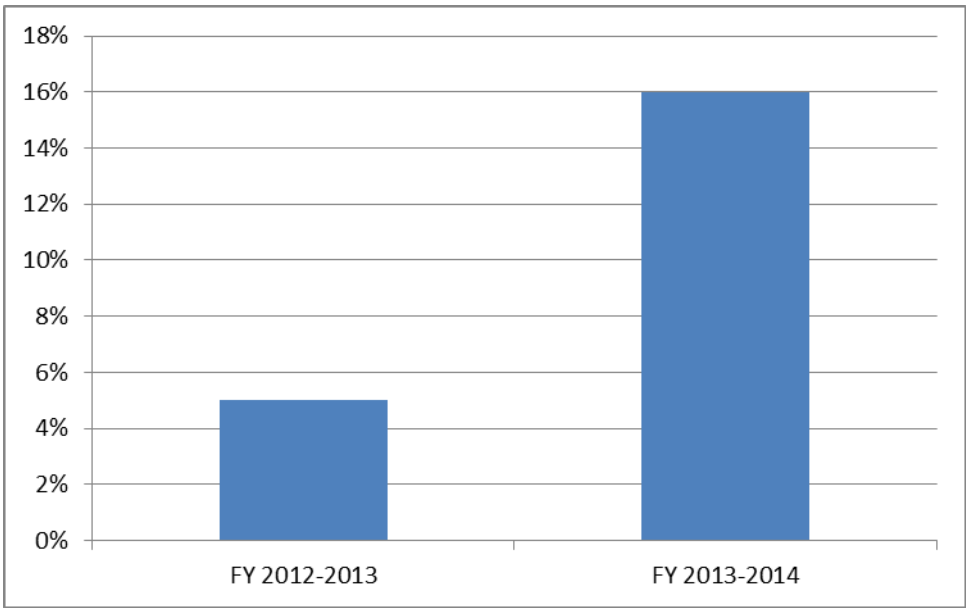
| Table 2-1—CHP+ List of Standards by Review Year | | | |
|---|---|---|---|
| **Standard** | **2011–12** | **2012–13** | **2013–14** |
| I—Coverage and Authorization of Services | | | X |
| II—Access and Availability | | | X |
| III—Coordination and Continuity of Care | | X | |
| IV—Member Rights and Protections | | X | |
| V—Member Information | X* | | |
| VI—Grievance System | X* | | |
| VII—Provider Participation and Program Integrity | X* | | |
| VIII—Credentialing and Recredentialing | | X | |
| IX—Subcontracts and Delegation | X* | | |
| X—Quality Assessment and Performance Improvement | | X | |

*These standards were reviewed but were not scored.

## Trending the Percentage of Required Actions

Figure 2-2 shows the percentage of requirements that resulted in required actions over the past two years of CHP+ compliance monitoring. (The Department chose not to assign scores to the CHP+ plans during the FY 2011–2012 site reviews.) Each year represents the results for review of different standards.

**Figure 2-2—Percentage of CHP+ Required Actions—All Standards Reviewed**

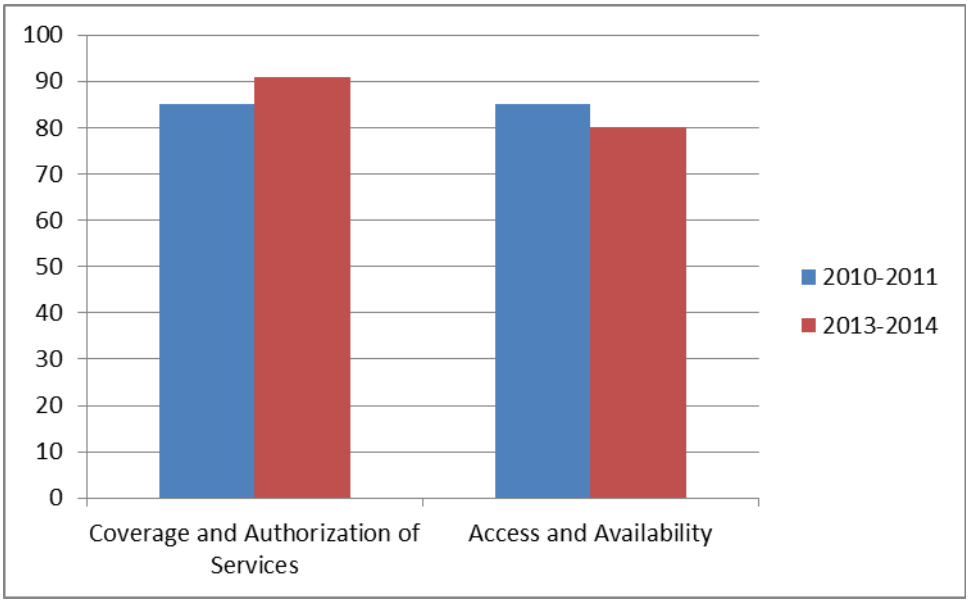


# Comparison of Medicaid Results

## *Comparison of FY 2010–2011 Results to FY 2013–2014 Results*

Figure 2-3 shows the scores from the FY 2010–2011 Medicaid site review, when Standard I and Standard II were previously reviewed, compared with the results from this year's Medicaid review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, Denver Health's contract with the State may have changed, and may have contributed to performance changes.

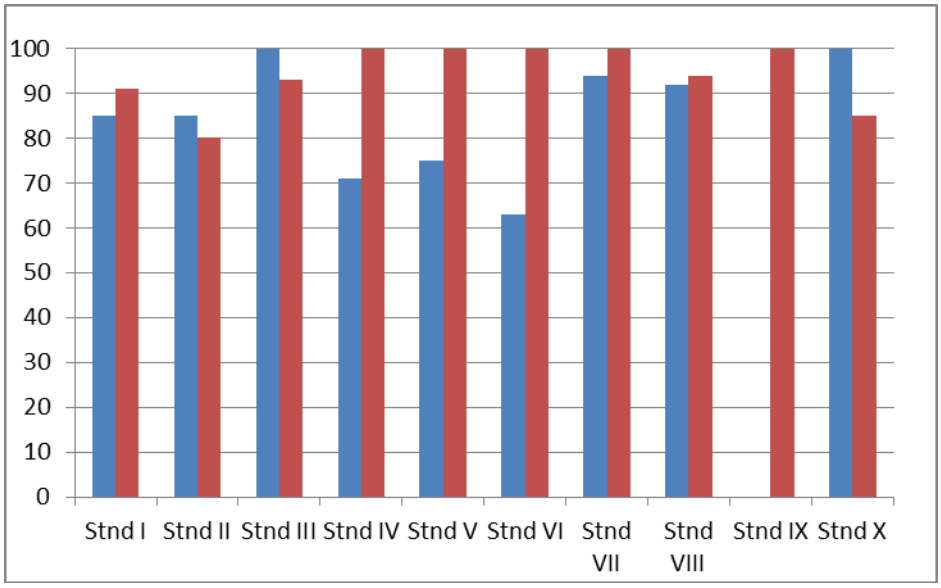
**Figure 2-3—Comparison of FY 2010–2011 Medicaid Results to FY 2013–2014 Medicaid Results**



## Review of Compliance Scores for All Standards

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

**Figure 2-4—Denver Health Medicaid Compliance Scores for All Standards**




Note: The older results are shown in blue. The most recent review results are shown in red. Also, Standard IX was not reviewed for DHMC during FY 2008–2009 because DHMC reported no delegated activities that year.

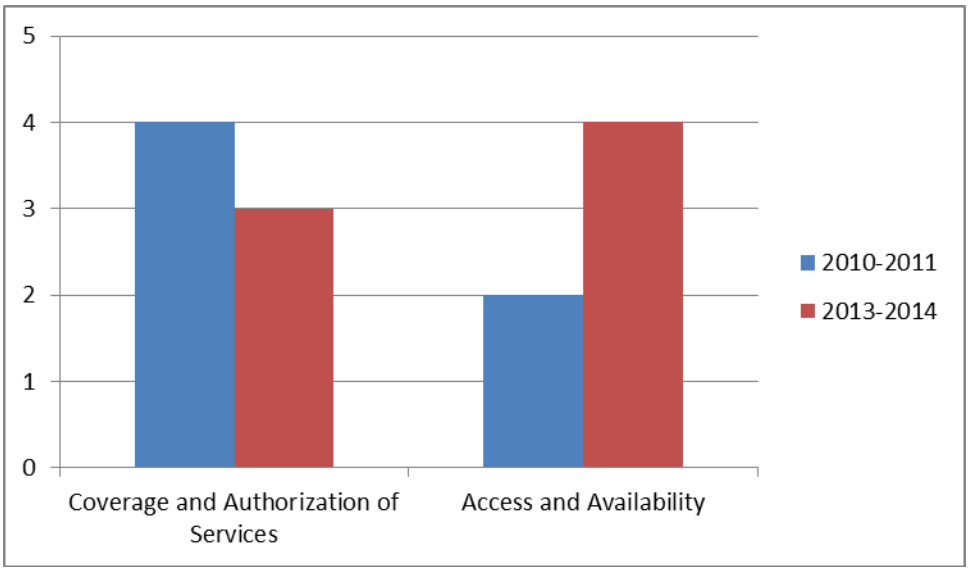
Table 2-2 presents the list of standards by review year.

| Table 2-2—Medicaid List of Standards by Review Year | | | | | | |
|---|---|---|---|---|---|---|
| **Standard** | **2008–09** | **2009–10** | **2010–11** | **2011–12** | **2012–13** | **2013–14** |
| I—Coverage and Authorization of Services | | | X | | | X |
| II—Access and Availability | | | X | | | X |
| III—Coordination and Continuity of Care | | X | | | X | |
| IV—Member Rights and Protections | | X | | | X | |
| V—Member Information | | X | | X | | |
| VI—Grievance System | | X | | X | | |
| VII—Provider Participation and Program Integrity | X | | | X | | |
| VIII—Credentialing and Recredentialing | | | X | | X | |
| IX—Subcontracts and Delegation | X | | | X | | |
| X—Quality Assessment and Performance Improvement | | X | | | X | |

## Trending the Number of Required Actions

Figure 2-5 shows the number of requirements with required actions from the FY 2010–2011 Medicaid site review, when Standard I and Standard II were previously reviewed, compared to the results from this year's review. Although the federal requirements did not change for the standards, Denver Health's contract with the State may have changed, and may have contributed to performance changes.

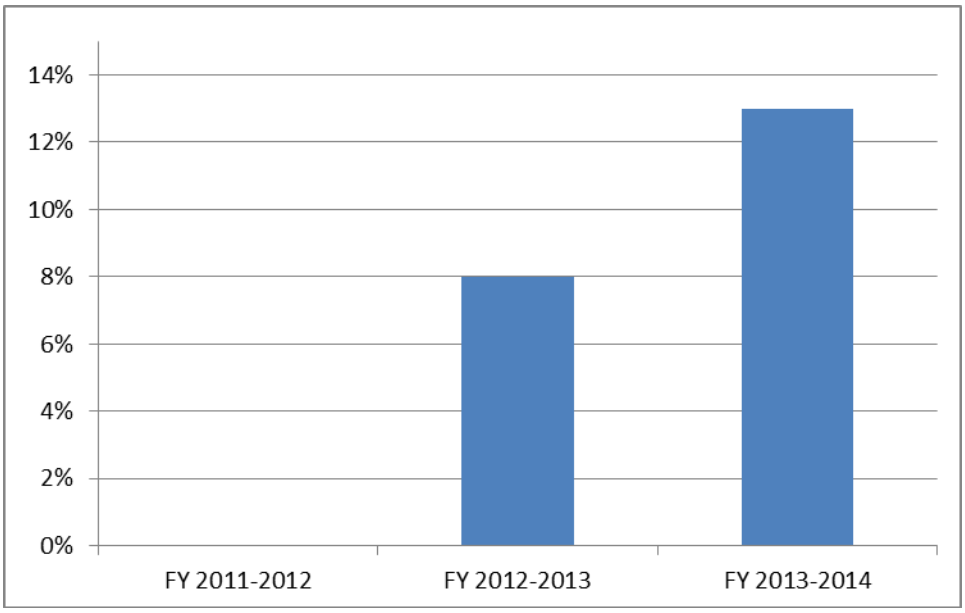
**Figure 2-5—Number of FY 2010–2011 and FY 2013–2014 Medicaid Required Actions per Standard**



## Trending the Percentage of Required Actions

Figure 2-6 shows the percentage of requirements that resulted in required actions over the past three year cycle of Medicaid compliance monitoring. Each year represents the results of review of different standards.

**Figure 2-6—Percentage of Medicaid Required Actions—All Standards Reviewed**




Note: DHMC received no required actions as a result of the FY 2011–2012 compliance site review.

## Overview of FY 2013–2014 Compliance Monitoring Activities

For the fiscal year (FY) 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

## Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ service and claims denials and Medicaid service and claims denials. In addition, HSAG conducted a high-level review of the health plan's authorization processes through a health plan demonstration of its electronic system used to document and process requests for CHP+ services and Medicaid services.

A sample of the health plan's administrative records were also reviewed to evaluate implementation of managed care regulations related to CHP+ and Medicaid service and claims denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG reviewed a sample of 10 records with an oversample of 5 records for Medicaid managed care and a sample of 10 records with an oversample of 5 records for CHP+. Using a random sampling technique, HSAG selected the samples from all applicable health plan CHP+ and Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated overall record review scores for Medicaid and for CHP+.

For the 2013–2014 compliance monitoring reviews, the Department requested that HSAG also review the Access and Availability standard for Denver Health's Medicaid line of business in more depth through an open shopper project and a focus group discussion with community partners regarding access and Medicaid appointment availability at Denver Health clinics.

HSAG conducted open shopper calls to appointment schedulers in the Denver Health Medicaid Choice primary care provider network to verify appointment availability and determine compliance with appointment standards as delineated in the Medicaid managed care contract. HSAG used a call guide to identify potential variations in central scheduling versus direct clinic scheduling and different times of day. HSAG made two calls to each Denver Health primary care clinic. HSAG used call scripts representing a variety of appointment scenarios and assigned each call script to a specific call time and provider location delineated in the call guide. This ensured that calls represented an adequate cross-section of urgent, non-urgent, and well-care visits for both children and adults. Calls were completed prior to the scheduled compliance monitoring site review, and results were considered in the scoring of applicable requirements in Standard II—Access and Availability. HSAG analyzed the summary of results and noted any patterns in the variables tested. Results are reported in the Executive Summary, and call logs and protocols are included in Appendix C of this report.

In addition to the open shopper calls, HSAG facilitated a focus group discussion with community organizations that refer members to Denver Health providers or provide services to Medicaid members who also receive services from Denver Health. The Department identified the focus group participants and made initial contact with the organizations to invite participation. Denver Health representatives were also invited to participate in the focus group. The objectives of the focus group were to gain insight from the community regarding access to services and barriers to obtaining appointments with Denver Health providers, as well as to begin problem solving potential solutions. HSAG designed and facilitated an interactive process and used prompts, questions, and discussion tools to assist the group in completing the objectives. HSAG designed applicable tools and catalyst questions with input from the Department. The number of participants was limited to enable active engagement of all participants. Eight participants representing seven organizations, four representatives from Denver Health, and two representatives from the Department participated in the focus group. Each participant was provided catalyst questions one month prior to the scheduled focus group to encourage participants to come prepared to represent their respective organizations. The focus group was held in a central Denver location and conducted prior to the scheduled compliance monitoring site review. HSAG analyzed and summarized the results of the focus group and provided observations and recommendations related to these results. Results are reported in the Executive Summary and Appendix D of this report.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Appendix G contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2013–2014 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

## Objective of the Site Review

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

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

## FY 2012–2013 Corrective Action Methodology

As a follow-up to the FY 2012–2013 site review, each health plan that received one or more *Partially Met* or *Not Met* score was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with Denver Health until it completed each of the required actions from the FY 2012–2013 compliance monitoring site review.

### *Summary of 2012–2013 Required Actions*

As a result of the 2012–2013 site review, Denver Health was required to address the following for both its CHP+ and Medicaid lines of business:

- Revise the Medical Staff Bylaws or develop policies and procedures that clearly describe the process for making credentialing and recredentialing decisions for DHHA allied health professionals (AHPs).
- Develop or revise documents to address notification to DHHA applicants regarding notification of rights under the credentialing program.
- Develop or revise documents that describe the range of actions available to DHHA for changing the conditions of a practitioner's status based on quality reasons.
- Revise policies to allow the public to access its clinical practice guidelines (CPGs) at no cost. Denver Health was required to communicate to members the availability of CPGs and inform members how to access or request them.

In addition, Denver Health was required to address the following two requirements related only to its Medicaid line of business:

- Develop and approve a policy and procedure that outlines the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening package and methods to ensure that screening requirements are met.
- Include a summary or statement of the overall impact and effectiveness of the QI program in the annual QI Impact Analysis Report.

## Summary of Corrective Action/Document Review

Denver Health submitted its CAP to HSAG and the Department in May 2013. After careful review, HSAG and the Department determined that, if implemented as written, Denver Health would achieve full compliance. Denver Health submitted documentation that demonstrated it had implemented its plan, and in October 2013, HSAG and the Department determined that Denver Health had successfully addressed all required actions.

## Summary of Continued Required Actions

Denver Health did not have any required actions continued from the 2012–2013 review cycle.

# *Appendix A.* Compliance Monitoring Tool *for* Denver Health

The completed compliance monitoring tool follows this cover page.

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.<br><br>*42CFR438.210(a)(3)(i)*<br><br>Medicaid Contract: II.C.1.a<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3; Exhibit K, 1.1 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• Pediatric Referral Guidelines.pdf<br>• Adult Referral Guidelines.pdf<br>• **MCD_CHP_UM27 v. 12 - Clinical Criteria for Utilization Management Decisions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• Pediatric Referral Guidelines.pdf<br>• **MCD_CHP_UM27 v. 12 - Clinical Criteria for Utilization Management Decisions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br><br>**Additional Documents Submitted On-site:**<br>• UM committee minutes October, November, and December 2013 | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2. The Contractor provides the same standard of care for all members regardless of eligibility category and makes all covered services as accessible in terms of timeliness, amount, duration and scope, to members, as those services are to non-CHP+/Medicaid recipients within the same area.<br><br>*42CFR438.210(a)(2)*<br><br>Medicaid Contract: II.C.1.b<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3.9 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_UM27 v. 12 - Clinical Criteria for Utilization Management Decisions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• MCD_TEMPLATE_SEC_3_2.pdf<br>• MCD_PROV_MANUAL_PG7.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_UM27 v. 12 - Clinical Criteria for Utilization Management Decisions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• DHMP_TEMPLATE_SEC_3_1.pdf<br>• CHP_PROV_MANUAL_PG7.pdf | **Medicaid:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

**Findings:**
Denver Health's Utilization Management Program Description and UM policies (all documents applicable both to Medicaid and CHP+) described the use of Milliman Utilization Review (UR) criteria as well as internal criteria to determine appropriateness of care. Provider manuals for CHP+ and Medicaid and provider contracts (used for independently contracted specialty providers) included a clause requiring that services provided under the contract be at least equal in quality, completeness, and promptness to health care rendered to persons not covered under the contract. During the focus group discussion, open shopper call project, and during on-site interviews, multiple DHHA staff members acknowledged that the DH schedulers must prioritize populations when scheduling due to limited appointment availability. Staff members stated that children and pregnant women are prioritized over new adult Medicaid members when scheduling and that a wait list is used for new adult Medicaid members. Limited appointment availability negatively impacts DHMC's ability to provide a standard of care to Medicaid and CHP+ members equally.

**Required Actions:**
DHMC must evaluate appointment capacity in the DH provider system and develop a mechanism to accommodate Medicaid and CHP+ populations equally.

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 3. The Contractor has a Utilization Management (UM) Program (Medicaid and CHP+)<br>The UM Program includes:<br>◆ Prospective, concurrent, and retrospective review (CHP+ only)<br>◆ Preauthorization system (Medicaid and CHP+)<br>◆ Medical Management Team oversight (CHP+ only)<br>◆ Transplant coordination (CHP+ only)<br>◆ On-site reviews (CHP+ only)<br>◆ Discharge planning (CHP+ only)<br>◆ Case management (CHP+ only)<br>◆ Appeals and grievances (Medicaid and CHP+)<br>◆ Mechanisms to detect over- and underutilization (Medicaid and CHP+)<br><br>Medicaid Contract: II.C.1.c, II.H.1.c & d<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.9.4.4; Exhibit K, 1.1.1.2 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• 2013 Utilization Management Program Description.pdf<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 4. Utilization Management shall be conducted under the auspices of a qualified clinician.<br><br>Medicaid Contract: II.H.1.f<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1. | **Medicaid:**<br>• 2013 Utilization Management Program Description.pdf<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 5. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.<br><br>*42CFR438.210(a)(3)(ii)*<br><br>Medicaid Contract: II.C.1.c<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3.10 | **Medicaid:**<br>• BHO List and Instructions.pdf<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf** | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 6. If the Contractor places limits on services, it is:<br>◆ On the basis of criteria applied under the State plan (medical necessity).<br>◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.<br><br>*42CFR438.210(a)(3)(iii)*<br><br>Medicaid Contract: II.H.1.a<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.2 and 2.6.3 | **Medicaid:**<br>• **MCD_CHP_UM27 v. 12 - Clinical Criteria for Utilization Management Decisions.pdf**<br>• **MCD_CHP_UM15 v. 12 – Home Health Care Referrals.pdf**<br>• **MCD_CHP_UM13 v. 12 – Guidelines for the ordering and authorization of Durable Medical Equipment and Consumable Supplies.pdf**<br>• **MCD_CHP_UM04 v.08 Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf**<br>• MCG – 17th Edition – sample guideline.pdf<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 7. The Contractor specifies what constitutes "medically necessary services" in a manner that:<br>◆ Is no more restrictive than that used in the State Medicaid/CHP+ program.<br>◆ Addresses the extent to which the Contractor is responsible for covering services related to the following:<br>• The prevention, diagnosis, and treatment of health impairments,<br>• The ability to achieve age-appropriate growth and development,<br>• The ability to attain, maintain, or regain functional capacity.<br>*42CFR438.210(a)(4)*<br>Medicaid Contract: Amendment 10, Exhibit A5<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.1 and 1.1.1.56 | **Medicaid:**<br>• **MCD_CHP_UM15 v. 12 – Home Health Care Referrals.pdf**<br>• **MCD_CHP_UM13 v. 12 – Guidelines for the ordering and authorization of Durable Medical Equipment and Consumable Supplies.pdf**<br>• **MCD_CHP_UM04 v.08 Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf**<br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 8. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services.<br>*42CFR438.210(b)*<br>Medicaid Contract: II.H.1.a<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.2 | **Medicaid:**<br>• **MCD_CHPUM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• **MCD_CHP_UM01 v.08 –Utilization Review Determinations including Approvals and Actions.pdf**<br>• Auth Instructions 2013.pdf<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 9. The Contractor has in place and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions.<br><br>*42CFR438.210(b)(2)(i)*<br><br>Medicaid Contract: II.H.1.b<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3 | **Medicaid:**<br>• **MCD_CHP_UM27 v. 12 – Clinical Criteria for Utilization Management Decisions.pdf**<br>• **MCD_CHP_UM05 v. 02 – Inter-Rater Reliability of Utilization Management.pdf**<br><br>**CHP+:**<br>See above documents.<br><br>**Additional Documents Submitted On-site:**<br>• 2013 DHMC/P Inter-rater Reliability Testing Report | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 10. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate.<br><br>*42CFR438.210(b)(2)(ii)*<br><br>Medicaid Contract: II.H.1.b<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• MCD_PROV_MANUAL_PG67.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• CHP_PROV_MANUAL_PG65.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 11. The Contractor has in place and follows written policies and procedures that include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.<br><br>*42CFR438.210(b)(3)*<br><br>Medicaid Contract: II.H.1.e<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.6 and 2.8.1.3.1 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• **MCD_CHP_UM27 v. 12 – Clinical Criteria for Utilization Management Decisions.pdf**<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 12. The Contractor has in place and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).<br><br>*42CFR438.210(c)*<br><br>Medicaid Contract: II.H.1.b; II.E.2.b; 10CCR2505–10, Sec 8.209.4.A.1<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.2 and 2.8.1.3.3; 10CCR2505–10, Sec 8.209.4.A.1 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 13. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed:<br>◆ For standard authorization decisions—10 calendar days.<br>◆ For expedited authorization decisions—3 business days.<br><br>*42CFR438.210(d)*<br><br>Medicaid Contract: II.E.2.b; 10CCR2505–10, Sec 8.209.4.B<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1; 10CCR2505–10, Sec 8.209.4.B | **Medicaid:**<br>• MCD_PROV_MANUAL_PG85.pdf<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br><br>**CHP+:**<br>• CHP_PROV_MANUAL_PG84.pdf<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf** | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area).<br><br>*42CFR438.404(a)*<br><br>Medicaid Contract: II.E.1.d.2; II.E.2.b; 10CCR2505–10, Sec 8.209.4.A.1<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.4.3.1.6; 10CCR2505–10, Sec 8.209.4.A.1 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• MCD Member Handbook, pg.24<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• CHP Member Handbook, pg. 34<br><br>*All member letters, including notices of action, are available in prevalent non-English languages | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Findings:**<br>DHMC/DHMP policies and procedures described the process to ensure that notices of action are easy to understand and available in non-English languages when necessary. Policies stated and staff members confirmed on-site that DHMC/DHMP maintains a record of members' preferred language based on the State's eligibility files. Notice of action (NOA) templates included fields for the required information and were in an easy-to-understand format. Medicaid denial records reviewed on-site demonstrated that the member-specific information inserted into the template was easy to understand to the extent possible. One CHP+ claims denial record reviewed on-site contained an NOA that was not easily understood due to inaccurate and incomplete information regarding the reason for the denial. The intake form in the authorization tracking system indicated that this was a retroactive review of a claim. The NOA to the member indicated that this was a new service request. The letter also stated that the denial reason was that this was not a covered benefit. In fact, this was a covered benefit; however, the provider was an out-of-network provider and prior authorization was required and not obtained. The denial reason was actually that no prior authorization was obtained. In addition to required actions stated below, DHMC/DHMP may want to consider informing members that the provider may not bill the member for services under these circumstances. | | |
| **Required Actions:**<br>DHMC/DHMP must develop a mechanism to review claims denials to ensure ease of understanding and provide clearer information to members as well as to ensure accuracy of the information. | | |
| 15. Notices of action must contain:<br>◆ The action the Contractor (or its delegate) has taken or intends to take.<br>◆ The reasons for the action.<br>◆ The member's, authorized representative's, and provider's (on behalf of the member) right to file an appeal and procedures for filing.<br>◆ The date the appeal is due.<br>◆ The member's right to a State fair hearing.<br>◆ The procedures for exercising the right to a State fair hearing.<br>◆ The circumstances under which expedited resolution is available and how to request it.<br>◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued.<br>◆ The circumstances under which the member may | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• MCD Member Handbook, pg. 24<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• CHP Member Handbook, pg. 34<br><br>*All member letters, including notices of action, are available in prevalent non-English languages | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| have to pay for the costs of services (if continued benefits are requested).<br><br>*42CFR438.404(b)*<br><br>Medicaid Contract: II.E.2.b; 10CCR2505–10, Sec 8.209.4.A.2<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.5.5; 10CCR2505–10, Sec 8.209.4.A.2 | | |
| **Findings:**<br>DHMC/DHMP policies included the list of required content for NOAs. NOA templates included fields for each required element. Medicaid denial records reviewed on-site contained NOAs that included all of the required information. One of the CHP+ records reviewed contained an Appeal Rights attachment that included appeal rights based on the Department of Insurance requirements rather than the current CHP+ contract requirements. | | |
| **Required Actions:**<br>DHMC/DHMP must ensure that NOAs include each of required elements. | | |
| 16. The notices of action must be mailed within the following time frames:<br>◆ For termination, suspension, or reduction of previously authorized CHP+/Medicaid-covered services, within the time frames specified in 431.211:<br>• The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214).<br>◆ For denial of payment, at the time of any action affecting the claim.<br>◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services.<br>◆ For service authorization decisions not reached within the required time frames on the date time frames expire. | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• MCD Member Handbook, pg.24<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• CHP Member Handbook, pg.34 | **Medicaid:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| ◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services.<br><br>*42CFR438.404(c)*<br>*42CFR438.400(b)(5)*<br><br>Medicaid Contract: II.E.2.b; 10CCR2505–10, Sec 8.209.4.A.3<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1; 10CCR2505–10, Sec 8.209.4.A.3 | | |
| **Findings:**<br>The Utilization Review Determinations policy included the required time frames for making authorization decisions and sending NOAs. Members and providers were notified of the NOA time frames via the member handbook and provider manual. The Drug Authorizations and Utilization Review policy stated that standard authorization decisions would be made within 10 calendar days and expedited decisions would be made within 3 business days. The policy then stated that following the authorization decision, the NOA would be sent within 3 working days of making the decision. The notice of action must be sent within the decision time frames. This could potentially cause DHMC/DHMP to be out of compliance with the time frames for sending the NOA. All of the CHP+ records reviewed on-site contained NOAs that were sent within the required time frame. One of the Medicaid records contained an NOA that was sent outside the required time frame. The NOA was sent 13 days following the request for service. | | |
| **Required Actions:**<br>DHMC must ensure that NOAs are sent within the required time frames. | | |
| 17. The Contactor may extend the authorization decision time frame if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions:<br>◆ Standard authorization decisions—up to 14 calendar days.<br>◆ Expedited authorization decisions—up to 14 calendar days. | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• MCD Member Handbook, pg.25<br>• MCD_PROV_MANUAL_PG85.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization,** | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| *42CFR438.210(d)*<br><br>Medicaid Contract: II.E.2.b; 10CCR2505–10, Sec 8.209.4.A.3<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2; 10CCR2505–10, Sec 8.209.4.A.3 | **Utilization Review and Formulary Management.pdf**<br>• CHP Member Handbook, pg.35<br>• CHP_PROV_MANUAL_PG84.pdf | |
| 18. If the Contractor extends the time frame for making a service authorization decision, it:<br>◆ Provides the member written notice of the reason for the decision to extend the time frame.<br>◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame.<br>◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.<br><br>*42CFR438.404(c)(4) and 438.210(d)(2)(ii)*<br><br>Medicaid Contract: II.E.2.b; 10CCR2505–10, Section 8.209.4.A.3<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3; 10CCR2505–10, Section 8.209.4.A.3 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 19. The Contractor has in place and follows written policies and procedures that provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.<br><br>*42CFR438.210(e)*<br><br>Medicaid Contract: II.H.1.a<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.1 | **Medicaid:**<br>• **MCD_CHP_UM05 v.02 Inter-Rater Reliability.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• MCD Member Handbook, pg.6 under Physician Incentive Plans<br><br>**CHP+:**<br>• **MCD_CHP_UM05 v.02 Inter-Rater Reliability.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• CHP Member Handbook, pg.6 under Physician Incentive Plans | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 20. The Contractor provides pharmacy medical management.<br><br>Medicaid Contract: II.F.1.6<br>CHP+ Contract: Amendment 02, Exhibit K, 1.1 | **Medicaid:**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• 2013 Utilization Management Program Description.pdf<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 21. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:<br>◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.<br>◆ Serious impairment to bodily functions.<br>◆ Serious dysfunction of any bodily organ or part.<br><br>*42CFR438.114(a)*<br><br>Medicaid Contract: Amendment 10, Exhibit A5<br>CHP+ Contract: Amendment 02, Exhibit A-2, 1.1.1.27 | **Medicaid:**<br>• MCD_PROV_MANUAL_PG48.pdf<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• MCD Member Handbook, pg.11<br><br>**CHP+:**<br>• CHP_PROV_MANUAL_PG48-PG50.pdf<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• CHP Member Handbook, pg.11 | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 22. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition.<br><br>*42CFR438.114(a)*<br><br>Medicaid Contract: I.13<br>CHP+ Contract: Amendment 02, Exhibit A-2, 1.1.1.28 | **Medicaid:**<br>• MCD_PROV_MANUAL_PG48.pdf<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• MCD Member Handbook, pg.11<br><br>**CHP+:**<br>• CHP_PROV_MANUAL_PG48-PG50.pdf<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_RX01 v.04 Drug Authorization, Utilization Review and Formulary Management.pdf**<br>• CHP Member Handbook, pg.11 | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.<br><br>*42CFR438.114(c)(1)(i)*<br><br>Medicaid Contract: II.C.4.a.4<br>CHP+ Contract: Amendment 02, Exhibit A-2,2.6.6.1.4 | **Medicaid:**<br>• MCD_PROV_MANUAL_PG48.pdf<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• MCD Member Handbook, pg.11<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br><br>**CHP+:**<br>• CHP_PROV_MANUAL_PG48-PG50.pdf<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • Urgent-Emergency Care Training.ppt<br>• CHP Member Handbook, pg.11<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf** | |
| 24. The Contractor does not require prior authorization for emergency or urgently needed services.<br><br>*42CFR438.10(f)(6)(viii)(B)*<br><br>Medicaid Contract: II.C.4.a.3<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.1.3 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• MCD Member Handbook, pg.11<br>• MCD_PROV_MANUAL_PG48.pdf<br>• MCD_PROV_MANUAL_PG49_PG50.pdf<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Urgent-Emergency Care Training.ppt<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• CHP Member Handbook, pg.11<br>• CHP_PROV_MANUAL_PG48-PG50.pdf<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Urgent-Emergency Care Training.ppt | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 25. The Contractor may not deny payment for treatment obtained under the following circumstances:<br>◆ A member had an emergency medical condition, and the absence of immediate medical attention would ***have*** had the following outcomes:<br>• Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Urgent-Emergency Care Training.ppt<br>• Auth Instructions 2013.pdf<br>• MCD_PROV_MANUAL_PG48.pdf | **Medicaid:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☐ Met |

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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| • Serious impairment to bodily functions.<br>• Serious dysfunction of any bodily organ or part.<br>◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes:<br>• Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.<br>• Serious impairment to bodily functions.<br>• Serious dysfunction of any bodily organ or part.<br>◆ A representative of the Contractor's organization instructed the member to seek emergency services.<br><br>*42CFR438.114(c)(1)(ii)*<br><br>Medicaid Contract: II.C.4.c<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.1.4, 2.6.6.3.1, and 2.6.6.4.1.3 | • MCD_PROV_MANUAL_PG49_PG50.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Urgent-Emergency Care Training.ppt<br>• Auth Instructions 2013.pdf<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | ☒ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Medicaid and CHP+ member handbooks stated that DHMC/DHMP is not responsible for payment if the emergency provider determines that the incident was not an emergency. | | |
| **Required Actions:**<br>While the member handbook statements are unclear as to whether the emergency physician would use a medical necessity standard or a prudent layperson standard, DHMC/DHMP must revise member handbook language to clarify that DHMC/DHMP uses a prudent layperson standard to determine payment for emergency services. | | |

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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 26. The Contractor does not:<br>◆ Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms.<br>◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor, or State agency of the member's screening and treatment within 10 days of presentation for emergency services.<br><br>*42CFR438.114(d)(1)*<br><br>Medicaid Contract: II.C.4.c<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2.1 and 2.6.6.1.6 | **Medicaid:**<br>• BHO List and Instructions.pdf<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Urgent-Emergency Care Training.ppt<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• MCD Member Handbook, pg.11<br>• MCD_PROV_MANUAL_PG48.pdf<br><br>**CHP+:**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Urgent-Emergency Care Training.ppt<br>• **MCD_CHPUM 10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• CHP Member Handbook pg.11<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The CHP+ member handbook stated that DHMP would not pay for an emergency admission if the member did not notify DHMP of the emergency within one day. | | |
| **Required Actions:**<br>DHMP must revise the CHP+ member handbook to clarify that DHMP will not refuse to cover emergency care based on DHMP's notification requirements. | | |

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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 27. The Contractor will be responsible for Emergency Services when:<br>◆ The member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures. (Medicaid and CHP+)<br>◆ The primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. (CHP+ only)<br><br>Medicaid Contract: II.C.4.g.2<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• BHO List and Instructions.pdf<br>• MCD Member Handbook, pg.11<br>• MCD_PROV_MANUAL_PG48.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• CHP Member Handbook, pg.11<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.<br><br>*42CFR438.114(d)(2)*<br><br>Medicaid Contract: II.C.4.d<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.1.7 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• MCD Member Handbook, pg.11<br>• MCD_PROV_MANUAL_PG48.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• CHP Member Handbook, pg.11<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.<br><br>*42CFR438.114(d)(3)*<br><br>Medicaid Contract: II.C 4.a.5<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.1.5 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• MCD Member Handbook, pg.11<br>• MCD_PROV_MANUAL_PG49_PG50.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• CHP Member Handbook, pg.11<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 30. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition.<br><br>*42CFR438.114(a)*<br><br>Medicaid Contract: Amendment 10, Exhibit A5<br>CHP+ Contract: Amendment 02, Exhibit A-2, 1.1.1.67 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• MCD Member Handbook, pg.11<br>• MCD_PROV_MANUAL_PG49_PG50.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• CHP Member Handbook, pg.11<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative.<br><br>*42CFR438.114(e)*<br>*42CFR422.113(c)*<br><br>Medicaid Contract: II.C.4.d<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.4 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• MCD Member Handbook, pg.11<br>• MCD_PROV_MANUAL_PG49_PG50.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• CHP Member Handbook, pg.11<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances:<br>◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services.<br>◆ The Contractor does not respond to a request for pre-approval within 1 hour.<br>◆ The Contractor cannot be contacted.<br>◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends.<br>*42CFR438.114(e)*<br>*42CFR422.113(c)*<br>Medicaid Contract: II.C.4.d<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.5 and 6 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• MCD Member Handbook, pg.11<br>• MCD_PROV_MANUAL_PG49_PG50.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• CHP Member Handbook, pg.11<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 33. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when:<br>◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care.<br>◆ A plan physician assumes responsibility for the member's care through transfer.<br>◆ A plan representative and the treating physician reach an agreement concerning the member's care.<br>◆ The member is discharged.<br><br>*42CFR438.114(e)*<br>*42CFR422.113(c)*<br><br>Medicaid Contract: II.C.4.d<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.8 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• MCD Member Handbook, pg.11<br>• MCD_PROV_MANUAL_PG49_PG50.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• CHP Member Handbook, pg.11<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 34. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor.<br><br>*42CFR438.114(e)*<br>*42CFR422.113(c)*<br><br>Medicaid Contract: II.C.4.d<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.7 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• MCD Member Handbook, pg.11<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP UM10 v.17 - Concurrent Utilization Management of Inpatient and Observation Stays.pdf**<br>• **CLM09 v.05 –Adjudication of Emergency Inpatient Stays.pdf**<br>• Auth Instructions 2013.pdf<br>• Urgent-Emergency Care Training.ppt<br>• CHP Member Handbook, pg.11-12 | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| **Medicaid:** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Results for Standard I—Coverage and Authorization of Services** | | | | | | | |
| **Total** | Met | = | 31 | X | 1.00 | = | 31 |
| | Partially Met | = | 3 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | NA |
| **Total Applicable** | | = | 34 | **Total Score** | | = | 31 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 91% |

| **CHP+:** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Results for Standard I—Coverage and Authorization of Services** | | | | | | | |
| **Total** | Met | = | 29 | X | 1.00 | = | 29 |
| | Partially Met | = | 5 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | NA |
| **Total Applicable** | | = | 34 | **Total Score** | | = | 29 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 85% |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements: | | |
| 1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services. In order for the Contractor's plan to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows:<br>◆ Appropriate access to certified nurse practitioners and certified nurse midwives.<br>◆ 1:2000 primary care physician (PCP)/provider-to-member ratio. PCP includes physicians designated to practice family medicine and general medicine (and for Medicaid: Pediatrics, Nurse Practitioners, and Physician Assistants).<br>◆ 1:2000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology/ear, nose, and throat (ENT), endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology (and for Medicaid: Infectious Disease).<br>◆ Physician specialists designated to practice internal medicine, infectious disease, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either PCP or physician specialist, but not both.<br>*42CFR438.206(b)(1)*<br>Medicaid Contract: Amendment 8, II.D.1.a.2<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.1.5, 2.7.1.1.6, and 2.7.1.1.9 | **Medicaid:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf** – a policy that defines how the Contractor monitors and maintains compliance with network adequacy<br>• Strategic Access Report FY_12_13 MCD and CHP+.pdf<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Findings:**<br>DH staff, during the focus group activity and during the on-site interviews, described DHMC/DHMP as a staff model health maintenance organization (HMO) and a closed system that only uses employed providers to provide primary care. Information obtained during the focus group discussion revealed that newly eligible adult Medicaid members are routinely placed on a wait list to obtain routine appointments. In addition, review of DHMC's grievance reports showed that the access and availability category had the highest percentage of grievances. These grievances related to appointment delay and wait time to get appointments. Further, Denver Health's member satisfaction survey data (CAHPS) showed that for Medicaid and CHP+, level of satisfaction on the *Getting Care Quickly* and the *Getting Needed Care* measures fell below the 25th percentile for FY 2012–2013. While ratios calculated in the Strategic Access Report were within the required parameters, ratios were calculated separately for each population (CHP+ and Medicaid). Denver Health should consider calculating ratios based on the total number of individuals (across all lines of business) its primary care and specialty physicians are expected to care for. Also, feedback obtained through a variety of quality activities indicated that DHMC's capacity to treat Medicaid and CHP+ members is not sufficient. | | |
| **Required Actions:**<br>DHMC must develop a mechanism to more fully explore wait list processes and develop a process to specifically track by individual, the length of time members remain on the wait list. DHMC must also work with the Department to problem solve solutions to barriers that create the need for the wait list and develop mechanisms to ensure that new adult Medicaid members are not wait-listed beyond the required access to care standards. (See Appendix D for focus group results and potential solutions.) | | |
| 2. In establishing and maintaining the network, the Contractor considers:<br>◆ The anticipated Medicaid/CHP+ enrollment,<br>◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid/CHP+ populations represented in the Contractor's service area,<br>◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid/CHP+ services,<br>◆ The numbers of network providers who are not accepting new Medicaid/CHP+ patients,<br>◆ The geographic location of providers and Medicaid/CHP+ members, considering distance, travel time, the means of transportation ordinarily used by Medicaid/CHP+ members, and whether the | **Medicaid:**<br>• Strategic Access Report FY_12_13 MCD and CHP+. pdf<br>• Pediatric Referrals Guidelines.pdf<br>• Adult Referral Guidelines.pdf<br><br>**CHP+:**<br>See above documents.<br><br>Description of Process:<br>The Network Adequacy Strategic Report is a report that is created by the Contractor and given to HCPF on a quarterly basis. | **Medicaid:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| location provides physical access for Medicaid/CHP+ members with disabilities.<br><br>*42CFR438.206(b)(1)(i) through (v)*<br><br>Medicaid Contract: II.D.1.a.3<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.5.10.1 | | |
| **Findings:**<br>The Strategic Access Report included an extensive discussion about anticipated enrollment and utilization of services and geographic location of clinics and stated that all primary and specialty care providers have open panels for new and existing Medicaid and CHP+ enrollees. The statement that all providers have an "open panel" carries a connotation that members may have immediate assignment to a PCP and access to appointments without the wait list process. | | |
| **Required Actions:**<br>DHMC/DHMP must, in subsequent Strategic Access Reports, further define what is meant by "open panel," and more accurately describe the processes for access into the DHHA clinic system. | | |
| 3. The Contractor ensures that its members have access to a provider within 30 miles or 30 minutes travel time, whichever is larger, to the extent such services are available and providers are qualified and willing to contract on reasonable terms.<br><br>Medicaid Contract: II.D.1.c<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.3.1 | **Medicaid:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf –** Page 5<br>• Strategic Access Report FY_12_13 MCD and CHP+. pdf<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 4. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist.<br><br>*42CFR438.206(b)(2)*<br><br>Medicaid Contract: II.D.1.a.4<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.1.7 | **Medicaid:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• MCD Member Handbook, pg.14<br>• MCD_PROV_MANUAL_PG69.pdf<br><br>**CHP+:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• CHP Member Handbook, pg.14<br>• CHP_PROV_MANUAL_PG76.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 5. The Contractor allows persons with special health care needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists.<br><br>*42CFR438.208(c)(4)*<br><br>Medicaid Contract: II.D.3.c<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.5.4 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_UM04 v.08 Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf**<br>• MCD Member Handbook, pg.16<br>• MCD_PROV_MANUAL_PG86.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_UM04 v.08 Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf**<br>• CHP Member Handbook, pg.16<br>• CHP_PROV_MANUAL_PG85.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 6. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.<br><br>*42CFR438.206(b)(3)*<br><br>Medicaid Contract: II.D.1.a.5<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.1.8 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• MCD Member Handbook, pg.10<br>• MCD_PROV_MANUAL_PG67.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• CHP Member Handbook, pg.10<br>• CHP_PROV_MANUAL_PG65.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 7. If the Contractor is unable to provide necessary primary or specialist services to a member in-network, the Contractor must make special arrangements for members to access out-of-network providers for as long as the Contractor is unable to provide them.<br><br>*42CFR438.206(b)(4)*<br><br>Medicaid Contract: II.D.1.b.1<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.2.1 | **Medicaid:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_UM04 v.08 Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf**<br>• MCD Member Handbook, pg.4<br>• MCD_PROV_MANUAL_PG86.pdf<br><br>**CHP+:**<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• **MCD_CHP_UM04 v.08 Coordination and Continuity of Care for Members with SHCN and Disabilities.pdf**<br>• MCD Member Handbook, pg.4<br>• CHP_PROV_MANUAL_PG85.pdf | **Medicaid:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>Although the Strategic Access Report and DHMC's policies clearly stated that members may have access to out-of-network providers if providers are unavailable within the network, focus group discussions and on-site interviews described processes whereby members are placed on the wait list when access into the DHHA "closed system" is limited, thereby suspending ability for new members to schedule appointments, rather than looking to either | | |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| contracted or out-of-network providers to fill the need. It was clear that scheduling issues applied across populations to some extent. During on-site interviews, the open shopper call project, and the focus group, DHMC/DHMP staff members acknowledged that children and pregnant women are prioritized for scheduling appointments; therefore, adult Medicaid members are more significantly impacted by limited appointment access. It was also clear that limited appointment availability impacted both the CHP+ and Medicaid populations. | | |
| **Required Actions:**<br>As both the CHP+ and Medicaid populations continue to increase (per the Strategic Access Report, the CHP+ net increase for FY 2013 was 1,295 members and the net increase for the Medicaid population for FY 2013 was 3,858 members), particularly as expansion populations are added to the Medicaid roles, DHMC/DHMP must either implement its policies to provide out-of-network care when care within the network is not available or consider options to expand the DHMC network through expansion of the DHHA provider network, or through contracts with non-DHHA providers. | | |
| 8. The Contractor works with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network.<br>*42CFR438.206(b)(5)*<br>Medicaid Contract: II.D.1.b.2<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.2.2.1 | **Medicaid:**<br>• MCD_TEMPLATE_PG9_PG10<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• MCD_PROV_MANUAL_PG86.pdf<br>**CHP+:**<br>• DHMP_TEMPLATE_PG9_PG10<br>• **MCD_CHP_UM01 v.08 – Utilization Review Determinations Including Approvals and Actions.pdf**<br>• CHP_PROV_MANUAL_PG85.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 9. The Contractor ensures that members within the service area have access to emergency services on a 24-hour-a-day, 7 days-a-week basis.<br>Medicaid Contract: II.D.1.d<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3.5 | **Medicaid:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• MCD_PROV_MANUAL_PG47.pdf<br>• MCD Member Handbook, pg.12<br>• Choice Matters Member Newsletter_Winter_2013<br>**CHP+:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• CHP_PROV_MANUAL_PG48-PG50.pdf<br>• CHP Member Handbook, pg.12<br>• Care Matters Member Newsletter_Winter_2013 | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 10. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services.<br><br>Medicaid Contract: II.C.4.a.2<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3.5 | **Medicaid:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• MCD Member Handbook, pg.13<br>• MCD_PROV_MANUAL_PG48.pdf<br>• MCD_PROV_MANUAL_PG49_PG50.pdf<br><br>**CHP+:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• CHP Member Handbook, pg.13<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 11. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members.<br><br>*42CFR438.206(c)(1)(ii)*<br><br>Medicaid Contract: None<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.5.1 | **Medicaid:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• MCD_PROV_MANUAL_PG6.pdf<br>• MCD_TEMPLATE_SEC3_2.pdf<br><br>**CHP+:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• CHP_PROV_MANUAL_PG7.pdf<br>• DHMP_TEMPLATE_SEC_3_1.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 12. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services:<br>◆ Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor.<br><br>*42CFR438.206(c)(1)(i)*<br><br>Medicaid Contract: Ammendment 8, II.D.1.e<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.1 | **Medicaid:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• Strategic Access Report FY_12_13 MCD and CHP+.pdf<br>• MCD Member Handbook, pg.12<br>• MCD_PROV_MANUAL_PG47.pdf<br>• Choice Matters Member Newsletter_Winter_2013.pdf<br><br>**CHP+:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• CHP Member Handbook, pg.12<br>• CHP_PROV_MANUAL_PG48-PG50.pdf<br>• Care Matters Member Newsletter_Winter_2013.pdf<br>• | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 13. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services:<br>Medicaid:<br>◆ Non-Urgent health care and Adult, non-symptomatic well care physical examinations within 30 days.<br>CHP+:<br>◆ Non-urgent, symptomatic health care is scheduled within 2 weeks.<br>◆ Non-emergent, non-urgent care for a medical problem is provided within 30 calendar days.<br>◆ Non-symptomatic well care physical examinations are scheduled within 4 months.<br><br>*42CFR438.206(c)(1)(i)*<br><br>Medicaid Contract: Ammendment 8, II.D.1.e<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2–4 | **Medicaid:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf –**<br>• Strategic Access Report FY_12_13 MCD and CHP+. pdf<br>• MCD Member Handbook, pg.13<br>• MCD_PROV_MANUAL_PG47.pdf<br><br>**CHP+:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf –**<br>• Strategic Access Report FY_12_13 MCD and CHP+. pdf<br>CHP Member Handbook, pg.13<br>• CHP_PROV_MANUAL_PG48-PG50.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 14. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: (CHP+ only)<br>◆ Diagnosis and treatment of a non-emergency, non-urgent mental health condition scheduled within 30 calendar days.<br>◆ Diagnosis and treatment of a non-emergent, non-urgent substance abuse condition scheduled within 2 weeks.<br><br>*42CFR438.206(c)(1)(i)*<br><br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.5 and 2.7.1.5.2.6 | **Medicaid:**<br>• MCD_PROV_MANUAL_PG47.pdf<br><br>**CHP+:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• CHP Member Handbook, pg.12<br>• CHP_PROV_MANUAL_PG48-PG50.pdf<br>• Care Matters Member Newsletter_Winter_2013.pdf | **Medicaid:**<br>☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 15. The Contractor communicates all scheduling guidelines to participating providers and members.<br><br>Medicaid Contract: Ammendment 8, II.D.1.e<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.5.4 | **Medicaid:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• ProviderNewsletter_MCD-CHP_12_13_13.pdf<br>• MCD_PROV_MANUAL_PG47.pdf<br>• Choice Matters Member Newsletter_Winter_2013.pdf<br>• MCD Member Handbook, pg.12<br><br>**CHP+:**<br>• **MCD_CHP_QI10 v.05 – Access to Care_Services.pdf**<br>• ProviderNewsletter_MCD-CHP_12_13_13.pdf<br>• CHP_PROV_MANUAL_PG48-PG50.pdf<br>• Care Matters Member Newsletter_Winter_2013.pdf<br>• CHP Member Handbook, pg.12 | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 16. The Contractor maintains an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and takes appropriate action. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, has mechanisms to monitor providers regularly to determine compliance, and to take corrective action if there is failure to comply.<br><br>*42CFR438.206(c)(1)(iv) through ( vi)*<br><br>Medicaid Contract: Amendment 8, II.D.1.e<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.4.1.1.1, and 2.7.1.5.4 | **Medicaid:**<br>• Strategic Access Report FY_12_13 MCD and CHP+. pdf<br>• MCD_PROV_MANUAL_PG47.pdf<br>• Adult Referral Guidelines.pdf<br>• Pediatric Referrals Guidelines.pdf<br><br>**CHP+:**<br>• Strategic Access Report FY_12_13 MCD and CHP+. pdf<br>• CHP_PROV_MANUAL_PG48-PG50.pdf<br>• Pediatric Referrals Guidelines.pdf<br><br>**Additional Documents Submitted On-site:**<br>• December 2013 Median Lag Time Report | **Medicaid:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

**Findings:**

The Strategic Access Report described a secret shopper project conducted in 2013 to study access issues; however, the metrics included average speed to answer the telephone, average time on hold, call abandonment rate, and call volume. While this study is important to understand and begin to develop quality initiatives related to customer service (another significant grievance category for DHMC) and processes and barriers to members' attempts to reach a live representative of DHHA, this was a missed opportunity to evaluate access to services and availability of providers. During the on-site interview, DHMC/DHMP staff reported that this was a planned revision to the project in 2014 (as was stated in the Strategic Access Report). Also during the on-site interview, DHMC/DHMP staff reported that there were no metrics that reported how long members are kept on the wait list before they are re-contacted to schedule an appointment. However, during the closing session, a DHMC/DHMP staff member reported that the DHHA call center does indeed keep lag time metrics and arranged for a report to be submitted. The December 2013 Median Lag Time Report presented only median times members are kept on the wait list and did not include the range. In addition, DHMC/DHMP management staff, not having awareness of this information, has been unable to monitor how long it takes a member to obtain an appointment from the time of the first contact requesting an appointment.

**Required Actions:**

DHMC/DHMP must determine what information exists within the DHHA system that can be used for monitoring appointment access and compliance with access and availability standards. DHMC/DHMP must develop an effective process for monitoring scheduling wait times, identifying barriers to complying with appointment guidelines delineated in the Medicaid and CHP+ managed care contracts, and taking appropriate action to ensure that appointment scheduling standards are met.

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 17. The Contractor maintains a comprehensive program of preventive health services for members that includes written policies and procedures, involves providers and members in their development and ongoing evaluation, and includes:<br>◆ Risk assessment by a member's PCP or other qualified professionals specializing in risk prevention who are part of the Contractor's participating providers or under contract to provide such services, to identify members with chronic or high-risk illnesses, a disability, or the potential for such condition.<br>◆ Health education and promotion of wellness programs, including the development of appropriate preventive services for members with a disability to prevent further deterioration. The Contractor will also include distribution of information to members to encourage member responsibility for following guidelines for preventive health.<br>◆ Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk members.<br>◆ Procedures to identify priorities and develop guidelines for appropriate preventive services.<br>◆ A process to inform and educate participating providers about preventive services, involve participating providers in development of programs, and evaluate the effectiveness of participating providers in providing such services.<br>And for Medicaid only:<br>◆ Integration of preventive health programs into the | **Medicaid:**<br>• QI Work Plan Yearly Planned Activities 2013-2014.docx – This is a dynamic work plan that goes over the integration of preventive health programs into the Quality Assurance program MCD_CHP+_QI_Program_Description.docx<br>• Denver Health Medicaid Choice and CHP+ Impact Analysis.pdf – This report evaluates the results of QI initiatives in measurable terms trended over time and compared with performance objectives as defined in the QI work plan.<br>• **MCD_CHP_QI02.v. 05 – Clinical Practice and Preventive Care Guidelines.pdf**<br>• BHWS Department Description 2013.pdf<br>• **MCD_CHP_MBR05 v.01 New Member Outreach Program.pdf**<br><br>**CHP+:**<br>• See above documents.<br><br>**Additional Documents Submitted On-site:**<br>• Weight Management QI workgroup Meeting Minutes, 7/10/2013<br>• Diabetes Quality Workgroup Meeting Minutes, 1/16/2013, 7/17/2013<br>• DHMC/P Quality Improvement Interventions list FY 2014<br>• Causal Barrier Analysis – 2013 Well Child Visits | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| Contractor's Quality Assurance program and describing specific preventive care priorities, services, accomplishments, and goals as part of required reporting in the Quality Improvement Plan, Program Impact Analysis, and Annual Report.<br><br>Medicaid Contract: II.D.6.d<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.8.1 | | |
| 18. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by:<br>◆ Maintaining policies to reach out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups.<br>◆ Maintaining policies to provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation.<br>◆ Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include:<br>• Inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls.<br>• Being served by participating providers.<br>• Improving access to health care through community outreach and Contractor publications.<br>◆ Developing and/or providing cultural competency | **Medicaid:**<br>• **MCD_CHP_GVT06 v.07 Creation, Review and Readability of Member Materials.pdf**<br>• **MCD_CHP_GVT10 v.10 Evaluating Member's Non-English Language Needs for Language Translation Services.pdf**<br>• **MCD_CHP_QI07 v. 06 Cultural and Linguistic Appropriate Services Program Description.pdf**<br>• MCD Provider Directory 2013.pdf<br>• Medicaid Readability Log.xls<br>• MCD Member Handbook, pg.3 notification of language services<br>• Denver Health Providers Race_Ethnicity_Language_Dec_2013.pdf<br>• November 2013_MCD_CHP+_RACE_ETHNICITY_LANG_LOB.pdf<br>• CLAS Charter for Community Stakeholders.pdf<br>• Cultural Resources Helpful Links DH.pdf<br>**DHA Cultural Policies List**<br>• **DHA Cultural Policies AmericansWithDisabilitiesAct.pdf** | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| training programs, as needed, to the network providers and Contractor staff regarding:<br>• Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services.<br>• The medical risks associated with the client population's racial, ethnic, and socioeconomic conditions.<br>◆ Making available written translation of Contractor materials, including member handbook, correspondence, and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area.<br>◆ Developing policies and procedures, as needed, on how the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in service areas where language may pose a barrier so that participating providers can:<br>• Conduct the appropriate assessment and treatment of non-English-speaking members (including members with a communication disability).<br>• Promote accessibility and availability of covered services, at no cost to members.<br>◆ Developing policies and procedures on how the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats.<br>◆ Making a reasonable effort, when appropriate, to | • **DHA Cultural Policies CulturalReligiousConsiderations.pdf**<br>• **DHA Cultural Policies Interpreter and Translation Services and Auxiliary Communication Devices.pdf**<br>• **DHA Cultural Policies Equal Employment Opportunity.pdf**<br>• **DHA Cultural Policies WorkforceDiversity.pdf**<br><br>**Description of Process**<br>• MCD_CHP_GVT06 v.07, MCD_CHP_GVT10 v.10, See also: DHA Cultural Policies List (above)<br>outlines how the organization provides health services that are responsive to members' culture and language needs<br><br>**Denver Health Training Materials**<br>outlines our cultural competency training for staff including providers<br>• DHA Staff Training Record.pdf<br>• DHA Training Materials (rev12 22 09) entire document.pdf<br>• Interpreter Services Annual online training DH Staff & Providers.pdf<br>• Culture & Diversity Annual Online Training DH Providers & Staff.pdf<br>• Health Literacy Training 11.5.13.ppt<br>• Health Literacy Training Evaluation Form.pdf<br>• Health Literacy Participants 2013 Denver Health Managed Care.pdf<br>• Managed Care Cultural TRAINING SUMMARY.pdf<br>• Managed Care_Attachment | |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| develop and implement a strategy to recruit and retain qualified, diverse, and culturally competent clinical providers that represent the racial and ethnic communities being served.<br>◆ Providing access to interpretative services by a qualified interpreter for members with a hearing impairment in such a way that it shall promote accessibility and availability of covered services.<br>◆ Developing and maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.<br>◆ Arranging for covered services to be provided through agreements with non-participating providers when the Contractor does not have the direct capacity to provide covered services in an appropriate manner, consistent with independent living, to members with disabilities.<br>◆ Providing access to Telecommunications Device for the Deaf (TDD) or other equivalent methods for members with a hearing impairment in such a way that it will promote accessibility and availability of covered services.<br>◆ Making member information available upon request for members with visual impairments, including, but not limited to, Braille, large print, or audiotapes. For members who cannot read, member information shall be available on audiotape.<br><br>*42CFR438.206(c)(2)*<br><br>Medicaid Contract: II.D.6.c<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.7.2 | A_Culture_Diversity_Calendar.pdf<br>• Managed care_Attachment B_C_DH CULTURAL TRAINING.pdf<br>• Managed Care_Attachment D_Culture_Diversity_KP_ Training Evaluation.pdf<br>• NEO - Diversity Information (2013).ppt<br>• NEO Agenda 2013.pdf<br>• NEO Booklet - Diversity Pages 2013.pdf<br><br>MCD Provider Directory 2013.pdf, Medicaid Readability Log.xls, Provider Newsletter no. 1_9_2013 shows that we have made a reasonable effort to address member needs based on the Member Demographic Assessment including language needs of providers, low literacy needs of members and available interpreter services within the organization and how to access services.<br><br>• MS_Alternate_Mbr_Materials_Process_2013.pdf<br>• MS_TTY Call Flow Process_2013.pdf<br><br>**CHP+:**<br>Also see Medicaid Documents<br><br>**<u>Items Unique to CHP+</u>**<br>• DHMP Provider Directory 2013.pdf<br>• CHP Member Handbook, pg.3notification of language services<br><br>**Additional Documents Submitted On-site:**<br>• CLAS Meeting 2014_2013 Data_2-5-2014.pdf (Training); | |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | • CLAS Meeting Agenda 2_5_2014.doc<br>• Did You Know Report (2013 Annual Report of In-House and Language Line Interpretation)<br>• Member Services Spanish Calls Report 2013<br>• 2012 CLAS Program Evaluation (Report Date June 2013)<br>• 2013 Medicaid Race and Ethnicity Assessment<br>• 2013 CHP+ Race and Ethnicity Assessment. | |
| 19. (CHP+) The Contractor analyzes and responds to results of HEDIS measures. HEDIS measures under review during the 2013–2014 review year:<br>◆ Well-Child Visits in the First 15 Months of Life<br>◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<br>◆ Adolescent Well-Care Visits<br><br>(Medicaid) The Contractor analyzes and responds to results of HEDIS measures. HEDIS measures under review during the 2013–2014 review year:<br>◆ Well-Child Visits in the First 15 Months of Life<br>◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life<br>◆ Adolescent Well-Care Visits<br>◆ Percentage of members 20–44 years of age with a preventive/ambulatory visit<br>◆ Percentage of members 45–64 and 65+ years of age with a preventive/ambulatory visit<br><br>Medicaid Contract: II.I.2.c.1.b<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.9.4.1.2 | **Medicaid:**<br>• HEDIS 2013 DHMC & CHP Measure Trend Table.xls<br>• Analysis of MCD AAP and subsequent interventions.pdf<br>• Medicaid Choice_WCV Summary Analysis.pdf<br><br>**CHP+:**<br>• HEDIS 2013 DHMC & CHP Measure Trend Table.xls<br>• HEDIS 2013 HCPF Health Plan CHP Measures.pdf<br>• CHP+_WCV Summary Analysis.pdf | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 20. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor uses tools including member surveys, anecdotal information, grievance and appeals data, and enrollment and disenrollment information.<br><br>Medicaid Contract: II.I.2.d.1<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.9.4.3.2 | **Medicaid:**<br>• Denver Health Medicaid Choice and CHP+ Impact Analysis.pdf<br>• Strategic Access Report FY_12_13 MCD and CHP+.pdf<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 21. The Contractor develops and implements a corrective action plan for all areas of the CAHPS survey that report a score that is less than the 50th percentile. (CHP+)<br><br>The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. (Medicaid)<br><br>Medicaid Contract: II.I.2.d.3<br>CHP+ Contract: Amendment 02, Exhibit A-2, 2.9.4.3.5 | **Medicaid:**<br>• Denver Health Medicaid Choice and CHP+ Impact Analysis.pdf<br><br>Pages 56-62 contain CAHPS and associated corrective action plans.<br><br>**CHP+:**<br>See above documents. | **Medicaid:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A<br><br>**CHP+:**<br>☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| **Medicaid:** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Results for Standard II—Access and Availability** | | | | | | | |
| **Total** | Met | = | 16 | X | 1.00 | = | 16 |
| | Partially Met | = | 4 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 1 | X | NA | = | NA |
| **Total Applicable** | | = | 20 | **Total Score** | | = | 16 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 80% |

| **CHP+:** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Results for Standard II—Access and Availability** | | | | | | | |
| **Total** | Met | = | 17 | X | 1.00 | = | 17 |
| | Partially Met | = | 4 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | NA |
| **Total Applicable** | | = | 21 | **Total Score** | | = | 17 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 81% |

The completed record review tool follows this cover page.

# *Appendix B.* Colorado Department of Health Care Policy and Financing
# FY 2013–2014 Denials Record Review Tool
# *for* Denver Health Medical Plan

| | |
|---|---|
| **Review Period:** | January 1, 2013–December 31, 2013 |
| **Date of Review:** | January 27, 2014 |
| **Reviewer:** | Barbara McConnell |
| **Participating Plan Staff Member:** | Nettie Finn |

| Requirement | File 1 | File 2 | File 3 | File 4 | File 5 |
|---|---|---|---|---|---|
| 1. Member ID | ****** | ***** | ***** | ***** | |
| 2. Date of initial request | 8/8/13 | NA | NA | | |
| 3. What type of denial? (termination [T], new request [NR], or claim [CL]) | CL | CL | CL | | |
| 4. Standard (S) or Expedited (E) | S | S | S | | |
| 5. Date notice of action sent | 8/9/13 | 7/23/13 | 12/26/13 | | |
| 6. Notice sent to provider and member? (C or NC) | C | C | C | | |
| 7. Number of days for decision/notice | NA | NA | NA | | |
| 8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before) | C | C | C | | |
| 9. Was authorization decision timeline extended? (Y or N) | N | N | N | | |
| a. If extended, extension notification sent to member? (C or NC, or NA) | NA | NA | NA | | |
| b. If extended, extension notification includes required content? (C or NC, or NA) | NA | NA | NA | | |
| 10. Notice of Action includes required content? (C or NC) | C | NC | C | | |
| 11. Authorization decision made by qualified clinician? (C or NC, or NA) | NA | NA | NA | | |
| 12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA) | NA | NA | NA | | |
| 13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA) | NA | NA | NA | | |
| 14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC) | C | C | C | | |
| 15. Was correspondence with the member easy to understand? (C or NC) | C | C | NC | | |
| **Total Applicable Elements** | 5 | 5 | 5 | | |
| **Total Compliant Elements** | 5 | 4 | 4 | | |
| **Score (Number Compliant / Number Applicable) = %** | 100% | 80% | 80% | | |

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

Comments:

Record #2: The Appeal Rights attachment to the NOA was an outdated attachment and included time frames and information based on the DOI requirements rather than current CHP+ contract requirements.

Record # 3: The NOA letter contained inaccurate and incomplete information. The intake form in the authorization tracking system indicated that this was a retroactive review of a claim. The NOA to the member indicated that this was a new service request. The letter also stated that the denial reason was that this was not a covered benefit. In fact, this was a covered benefit; however, this was an out-of-network provider and prior authorization was required. The denial reason was actually that no prior authorization was obtained. DHMP should provide clearer information to members and consider informing members that the provider may not bill the member for services under these circumstances.

Record #4: This record was included in the sample by mistake. The claim was not denied.

DHMP reported only four CHP+ denials during the review period. During the site review, HSAG determined that the fourth record was actually an approval and not a denial.

| Requirement | File 6 | File 7 | File 8 | File 9 | File 10 |
|---|---|---|---|---|---|
| 1. Member ID | | | | | |
| 2. Date of initial request | | | | | |
| 3. What type of denial? (termination [T], new request [NR], or claim [CL]) | | | | | |
| 4. Standard (S) or Expedited (E) | | | | | |
| 5. Date notice of action sent | | | | | |
| 6. Notice sent to provider and member? (C or NC) | | | | | |
| 7. Number of days for decision/notice | | | | | |
| 8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before) | | | | | |
| 9. Was authorization decision timeline extended? (Y or N) | | | | | |
| a. If extended, extension notification sent to member? (C or NC, or NA) | | | | | |
| b. If extended, extension notification includes required content? (C or NC, or NA) | | | | | |
| 10. Notice of Action includes required content? (C or NC) | | | | | |
| 11. Authorization decision made by qualified clinician? (C or NC, or NA) | | | | | |
| 12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA) | | | | | |
| 13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA) | | | | | |
| 14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC) | | | | | |
| 15. Was correspondence with the member easy to understand? (C or NC) | | | | | |
| **Total Applicable Elements** | | | | | |
| **Total Compliant Elements** | | | | | |
| **Score (Number Compliant / Number Applicable = %)** | | | | | |
| Comments: | | | | | |

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

| Requirement | OS 1 | OS 2 | OS 3 | OS 4 | OS 5 |
|---|---|---|---|---|---|
| 1. Member ID | | | | | |
| 2. Date of initial request | | | | | |
| 3. What type of denial? (termination [T], new request [NR], or claim [CL]) | | | | | |
| 4. Standard (S) or Expedited (E) | | | | | |
| 5. Date notice of action sent | | | | | |
| 6. Notice sent to provider and member? (C or NC) | | | | | |
| 7. Number of days for decision/notice | | | | | |
| 8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before) | | | | | |
| 9. Was authorization decision timeline extended? (Y or N) | | | | | |
| a. If extended, extension notification sent to member? (C or NC, or NA) | | | | | |
| b. If extended, extension notification includes required content? (C or NC, or NA) | | | | | |
| 10. Notice of Action includes required content? (C or NC) | | | | | |
| 11. Authorization decision made by qualified clinician? (C or NC, or NA) | | | | | |
| 12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA) | | | | | |
| 13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA) | | | | | |
| 14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC) | | | | | |
| 15. Was correspondence with the member easy to understand? (C or NC) | | | | | |
| **Total Applicable Elements** | | | | | |
| **Total Compliant Elements** | | | | | |
| **Score (Number Compliant / Number Applicable = %)** | | | | | |
| Comments: | | | | | |

| Total Record Review Score | Total Applicable Elements: 15 | Total Compliant Elements: 13 | Total Score: 87% |
|---|---|---|---|

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

# *Appendix B.* Colorado Department of Health Care Policy and Financing
# FY 2013–2014 Denials Record Review Tool
# *for* Denver Health Medicaid Choice

| | |
|---|---|
| **Review Period:** | January 1, 2013–December 31, 2013 |
| **Date of Review:** | January 27, 2014 |
| **Reviewer:** | Rachel Henrichs |
| **Participating Plan Staff Member:** | Nettie Finn |

| Requirement | File 1 | File 2 | File 3 | File 4 | File 5 |
|---|---|---|---|---|---|
| 1. Member ID | ***** | ***** | ***** | ***** | ***** |
| 2. Date of initial request | 4/19/13 | 2/7/13 | 2/12/13 | 9/19/13 | 10/23/13 |
| 3. What type of denial? (termination [T], new request [NR], or claim [CL]) | NR | NR | NR | NR | NR |
| 4. Standard (S) or Expedited (E) | S | S | S | S | S |
| 5. Date notice of action sent | 5/16/13 | 2/15/13 | 2/15/13 | 10/2/13 | 10/25/13 |
| 6. Notice sent to provider and member? (C or NC) | C | C | C | C | C |
| 7. Number of days for decision/notice | 10 | 8 | 3 | 13 | 2 |
| 8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before) | C | C | C | NC | C |
| 9. Was authorization decision timeline extended? (Y or N) | N | N | N | N | N |
| a. If extended, extension notification sent to member? (C or NC, or NA) | NA | NA | NA | NA | NA |
| b. If extended, extension notification includes required content? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 10. Notice of Action includes required content? (C or NC) | C | C | C | C | C |
| 11. Authorization decision made by qualified clinician? (C or NC, or NA) | C | C | C | C | C |
| 12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA) | C | C | NA | NA | NA |
| 13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC) | C | C | C | C | C |
| 15. Was correspondence with the member easy to understand? (C or NC) | C | C | C | C | C |
| **Total Applicable Elements** | 7 | 7 | 6 | 6 | 6 |
| **Total Compliant Elements** | 7 | 7 | 6 | 5 | 6 |
| **Score (Number Compliant / Number Applicable) = %** | 100% | 100% | 100% | 83% | 100% |

Comments:

Record #4: The notice of action was mailed 13 days after the request for service. DHMC is required to make decisions and sent the notice of action within 10 calendar days.

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

| Requirement | File 6 | File 7 | File 8 | File 9 | File 10 |
|---|---|---|---|---|---|
| 1. Member ID | ****** | ***** | ***** | ***** | ***** |
| 2. Date of initial request | 8/2/13 | 2/19/13 | 10/15/13 | 12/10/13 | 12/7/13 |
| 3. What type of denial? (termination [T], new request [NR], or claim [CL]) | NR | NR | NR | NR | NR |
| 4. Standard (S) or Expedited (E) | E | S | S | S | E |
| 5. Date notice of action sent | 8/6/13 | 2/26/13 | 10/22/13 | 12/11/13 | 12/9/13 |
| 6. Notice sent to provider and member? (C or NC) | C | C | C | C | C |
| 7. Number of days for decision/notice | 4 | 7 | 7 | 1 | 1 |
| 8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before) | C | C | C | C | C |
| 9. Was authorization decision timeline extended? (Y or N) | N | N | N | N | N |
| a. If extended, extension notification sent to member? (C or NC, or NA) | NA | NA | NA | NA | NA |
| b. If extended, extension notification includes required content? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 10. Notice of Action includes required content? (C or NC) | C | C | C | C | C |
| 11. Authorization decision made by qualified clinician? (C or NC, or NA) | C | C | C | NA | NA |
| 12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC) | C | C | C | C | C |
| 15. Was correspondence with the member easy to understand? (C or NC) | C | C | C | C | C |
| **Total Applicable Elements** | 6 | 6 | 6 | 5 | 5 |
| **Total Compliant Elements** | 6 | 6 | 6 | 5 | 5 |
| **Score (Number Compliant / Number Applicable = %)** | 100% | 100% | 100% | 100% | 100% |

Comments:

Record # 6: This was an expedited case. Although the NOA was sent at 4 days, it was 3 *business* days and therefore was within the required time frame.

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

| Requirement | OS 1 | OS 2 | OS 3 | OS 4 | OS 5 |
|---|---|---|---|---|---|
| 1. Member ID | ***** | ***** | ***** | ***** | ***** |
| 2. Date of initial request | | | | | |
| 3. What type of denial? (termination [T], new request [NR], or claim [CL]) | | | | | |
| 4. Standard (S) or Expedited (E) | | | | | |
| 5. Date notice of action sent | | | | | |
| 6. Notice sent to provider and member? (C or NC) | | | | | |
| 7. Number of days for decision/notice | | | | | |
| 8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before) | | | | | |
| 9. Was authorization decision timeline extended? (Y or N) | | | | | |
| a. If extended, extension notification sent to member? (C or NC, or NA) | | | | | |
| b. If extended, extension notification includes required content? (C or NC, or NA) | | | | | |
| 10. Notice of Action includes required content? (C or NC) | | | | | |
| 11. Authorization decision made by qualified clinician? (C or NC, or NA) | | | | | |
| 12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA) | | | | | |
| 13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA) | | | | | |
| 14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC) | | | | | |
| 15. Was correspondence with the member easy to understand? (C or NC) | | | | | |
| **Total Applicable Elements** | | | | | |
| **Total Compliant Elements** | | | | | |
| **Score (Number Compliant / Number Applicable = %)** | | | | | |
| Comments: | | | | | |

| Total Record Review Score | Total Applicable Elements: 60 | Total Compliant Elements: 59 | Total Score: 98% |
|---|---|---|---|

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

The Department requested that HSAG perform open shopper calls to verify compliance with Medicaid managed care appointment access standards in a sample of provider offices within the DHMC network. HSAG developed the methodology for the provider survey and met with the Department to confirm the objectives and the approach to be used by HSAG callers. HSAG selected all of the DHMC primary care clinics using the online Denver Health (DH) clinic directory. HSAG developed numerous hypothetical scenarios which represented urgent, symptomatic non-urgent, and well-visit appointment types. HSAG callers tested a cross-section of appointment types using a call guide to instruct callers on the specific hypothetical scenarios to be used, and ensure that an adequate sample of each type of appointment was tested. HSAG planned to make two calls, one directly to the clinic and one to the DH central scheduling center, for each of the eight primary care clinics. However, shortly after initiating the calls, it became apparent that all calls are automatically routed to the central scheduling center. Therefore, the caller surveyor placed one call applicable to each clinic and varied the call times throughout the day.

HSAG conducted the provider access survey prior to the DHMC site visit. Callers identified themselves upon contact with the scheduler and described the purpose of the call. Multiple call scenarios were tested within a single call, and results were documented in an individual call log. The results of the appointment times offered for each hypothetical scenario were evaluated as met/not met using the following appointment standards:

- Urgently needed services are provided within 48 hours of notification of the primary care physician
- Non-urgent health care is scheduled within 30 days
- Adult non-symptomatic well-care physical examinations are scheduled within four months.

Summarized results of the survey were verbally shared with DHMC during the on-site visit. Results of the survey of each appointment type were considered in the applicable Access and Availability (Standard II) compliance review requirements.

## Summary of Results

Ten pre-defined call scenarios representing a cross-section of appointment types were tested as follows: two for urgent care, five for non-urgent/symptomatic care, and three for well-child/well-adult visits. Schedulers routinely asked the caller if the appointment was for an existing patient or a new patient. **All of the appointments offered in response to the various scenarios for *existing* Medicaid members met the required time frames**. Appointments for urgent situations were offered within 48 hours, and most other appointments were available within a few days. In many instances, same-day appointments were available. The longest wait period was 19 days for an adult physical exam. The scheduling staff further described to the surveyor the process for scheduling established patients as follows:

> Central schedulers will attempt to schedule members with their usual primary care provider. If the appointment available is not acceptable to the member, the scheduler will offer the member the first available appointment with another primary care provider. If the call center is unable to obtain any appointment satisfactory to the member, the call center refers the request to the specific clinic. A nurse at each clinic reviews the member's situation and may make arrangements to provide an earlier appointment to accommodate the member's needs.

However, upon further dialogue with the schedulers, HSAG callers were informed that the wait time for *new* adult Medicaid members to obtain any appointment could be much longer. The scheduler described the process for obtaining an appointment for a new member as follows:

> The central scheduler collects the member information and refers it to the clinic of the member's choosing. That individual clinic will call the member back in 30–60 days to schedule an appointment. If a new Medicaid member calls the Denver Health call center and describes current symptoms of an urgent nature, the scheduler collects the member's information, and then refers the person to the Nurse Advice Line, who will triage the member to an urgent care center or emergency room, as needed. Meanwhile, the scheduler will contact the clinic and make arrangements for an appointment, which the scheduler described is usually within two weeks.

**Based on the process described to the HSAG surveyor, the appointment standards for any type of appointment for a new, unestablished patient would not be met**. Anecdotally, HSAG was informed by a direct clinic staff member that it was his understanding that it could take 6 months to get a well-adult appointment at a DH clinic. HSAG also was made aware of a complaint from a new Medicaid member seeking a well-adult appointment who was told by the scheduler that it could take 18 months to get an appointment.

## Observations

Based on the information obtained by HSAG callers during the provider survey, it appears that any DHMC member who is an existing patient in the DH primary care clinic system will be able to obtain an appointment within the required scheduling timelines. Conversely, DHMC members who are new, non-established patients may need to wait considerable time for an appointment with a primary care provider and have their urgent care needs accommodated through urgent care clinics or emergency rooms. Once the new member is able to gain an initial appointment in the primary care network, the member would qualify as an existing patient and obtain services within the required time frames. However, given the transient nature of the some of the Medicaid population as well as the cycles of enrollment and disenrollment in the population, many members may experience ongoing difficulty in gaining access to a primary care provider in the DH system.

The completed open shopper call logs begin on page C-6.

# Scripts for Appointment Access Calls

## *Introduction*

Hello. My name is _____. I am calling on behalf of Health Services Advisor Group. We are doing a study for the Colorado Medicaid program, and would like to get some information on your scheduling process.

Ask for name/position (i.e. scheduler, receptionist, nurse, etc.)

I would like to give you two hypothetical scenarios of someone calling for an appointment, and would like to know the appointment time that you would offer this person.

## *Urgent Scenarios*

1. (Adult): A 32-year-old woman on Medicaid describes that she has had some abdominal pain, burning when urinating, and has some pink color in her urine. What is the appointment time you can offer her? (What if this were a child?)

2. (Child): A mother describes that her daughter got a big cut on her leg while playing at school. It has been several days, and the leg is still painful and swollen and kind of oozy. They have Medicaid. What is the appointment time you would offer her? (Adult: A 60-year-old woman says that she banged into something, and has a big cut on her lower leg that is painful and swollen/red, and kind of oozy).

3. (Child): A mother with a 24-month-old states that the child has a wet cough, is very fussy, is not sleeping, and feels feverish. They have Medicaid. What is the appointment time that you would offer the mother?

4. (Adult): A 45-year-old man on Medicaid is complaining of stomach pain, vomiting, and diarrhea, and can't even keep fluids down. What is the appointment time you would offer this man? (Child: An 8-year-old child is complaining of the same symptoms).

## *Non-urgent Scenarios*

1. (Adult): A 55-year-old man on Medicaid has a large bruise on his thigh and reports a lot of on-and-off aching in his leg over several days. Says ibuprofen is not helping, and would like the doctor to see him and prescribe something else. What is the appointment time you would offer? (What if this were a child?)

2. (Adult): A 40-year-old woman on Medicaid describes that she tweaked her back lifting something and it is really stiff. It has been about four days and she can't sleep very well. She would like to have the doctor evaluate her back. When can she get an appointment?

3. (Child): Mother states that her son woke up with a sore throat and a sniffle and a slight fever and is really miserable. They have Medicaid. When would she be offered an appointment? (What is this were an adult)

4. (Child): Mother describes that her teenage daughter has had watery eyes and sneezing for several days, and she thinks she may have allergies. They have Medicaid. What is the first appointment available for her? (What if this were an adult?)

5. (Child): Mother describes that her 10-year-old has seemed really tired and complains that he doesn't "feel good." There is no fever or pain, but she says he doesn't eat much, and he is always thirsty and drinks lots of water. She wants to have someone evaluate what is going on. They have Medicaid. When could she get an appointment for her son? (Adult: 30-year-old calls with same symptoms).

6. (Adult): A 30-year-old woman on Medicaid sees doctor on periodic basis for her asthma. She says she is doing OK most of the time, but needs to schedule an appointment to talk to the doctor. When is the next available appointment for her? (Child: Same circumstances, but is an 8-year-old child).

7. (Adult): A 50-year-old man on Medicaid calls to set up an initial appointment because he just moved to town, and his other doctor told him to get set up with someone right away to monitor his diabetes and high blood pressure. What is the appointment time available for him?

8. (Adult): A 50-year-old man on Medicaid describes that he has ongoing back problems and on-and-off pain. He has been doing some physical therapy and taking medication, but would like to have the doctor re-evaluate him. What is the first appointment you could offer him?

9. (Adult): A 35-year-old woman on Medicaid states that she thinks she may be pregnant, and has had "all the symptoms" for a couple of months. When can she get an appointment? (Child: What if this were a 15-year-old?)

### *Well-child*

1. Mother calls and says her Medicaid handbook said that her son is supposed to have a well-child exam under the EPSDT program. (He is 7 years old and hasn't had a physical exam since he was around 4). When can you get her an appointment for that?

2. Mother states that she received a card in the mail that her 2-year-old daughter needs some immunizations and should have a physical exam. They have Medicaid. When can she get an appointment?

3. Mother calls and states she would like to have her 16-year-old daughter have a physical and possibly get birth control. They have Medicaid. What is the appointment time that you could offer to her?

### *Well-adult*

1. A 60-year-old female on Medicaid states she got a card in the mail that it is time for her annual physical. What is the appointment time that you offer?

2. A 50-year-old male on Medicaid needs an annual physical for his work. When can he get an appointment?

3. Any Medicaid adult calls and just states he/she would like an appointment for a physical—has not had one in three years. When can he or she get an appointment?

# Call #1

**Name of Provider/Clinic:** La Casa **Telephone #:** 303-602-6700

**Person who made call:** Rachel Henrichs

**Person you spoke with**: C

**Call Date:** November 6, 2013 **Time:** 9:50 a.m.

**Type of Appointment Requested:**

Non-urgent (Scenario 6 for child and adult)

**Date and Time Appointment Offered (non-urgent adult):** November 12, 2013

**Date and Time Appointment Offered (non-urgent child):** November 12, 2013

**Comment:**

When the reviewer explained the scenario, C asked, "Are you pregnant?" to which the reviewer answered, no. C asked, "Have you been seen at a Denver Health clinic in the last 3 years?" and the reviewer answered, yes. C explained that appointment availability depends on the doctor. They try to schedule patients with the PCP as much as possible. The reviewer asked for the earliest available appointment, regardless of the doctor. C offered three appointments on 11/12.

The reviewer asked what days and times were available for a child. C asked, "Is the child sick?" When the reviewer answered, no, C offered the same three appointments on 11/12/13; however, if the child is sick, they will see that child the same day.

**Did appointment offered meet standard?** Yes

# Call #2

**Name of Provider/Clinic:** Lowry **Telephone #:** 303-436-4545 and 303-602-4545

**Person who made call:** Rachel Henrichs

**Person you spoke with**: A and J

**Call Date:** November 6, 2013 **Time:** 11:40 a.m.

**Type of Appointment Requested:**

Non-urgent (Scenario 9 for adult and child)

**Date and Time Appointment Offered (non-urgent adult):** November 11 at 11:00 a.m. or 1:30 p.m.

**Date and Time Appointment Offered (non-urgent child):** November 11 at 11:00 a.m. or 1:30 p.m.

**Comment:**

The reviewer called 303-436-4545 and received a message that the telephone number had changed to 303-602-4545. The recording was repeated in English and Spanish. As of 11/13, the old number was still listed on the Web site.

After the reviewer explained who she was and why she was calling, A suggested she speak to the "team leader"; J. J was very helpful. When the reviewer explained the scenario, J offered two appointments on November 11. She said initial OB appointments take about an hour and the provider would explain the entire process (all the different appointments, why they are important, what the woman should expect). J said they try to schedule initial OB appointments within a few days, depending on the clinic the woman wishes to visit.

**Did appointment offered meet standard?** Yes

# Call # 3

**Name of Provider/Clinic:** Montbello **Telephone #:** 303.602.4000

**Person who made call:** Rachel Henrichs

**Person you spoke with**: F

**Call Date:** November 6, 2013 **Time:** 11:50 a.m.

**Type of Appointment Requested:**

Urgent (Scenario 4 for adult and child)

**Date and Time Appointment Offered (urgent adult):** November 7

**Date and Time Appointment Offered (urgent child):** November 6 at 2:00 p.m. or November 7

**Comment:**

When the reviewer explained the urgent scenario, F asked if I had been seen at a Denver Health clinic within the last three years, which clinic I wanted to visit, and what insurance I had. The reviewer answered that she was an existing member requesting an appointment at the Montbello clinic and that she was a Medicaid member. F said there are three appointments available for an adult on 11/7. The reviewer asked, "What if I was calling for an 8-year-old child?" F offered an appointment at 2:00 that same day or three appointments on 11/7.

**Did appointment offered meet standard?** Yes

# Call # 4

**Name of Provider/Clinic:** Park Hill **Telephone #:** 303-602-3720

**Person who made call:** Rachel Henrichs

**Person you spoke with**: E

**Call Date:** November 7, 2013 **Time:** 8:50 a.m.

**Type of Appointment Requested:**

Well-child and well-adult exams

**Date and Time Appointment Offered (adult):** November 26, 2013

**Date and Time Appointment Offered (child):** November 11, 2013

**Comment:**

E told the reviewer that they try to schedule routine well-care appointments within 30 days. The adult appointment will take longer to schedule because a 60-year-old needs to be seen by an MD, whereas a child can be seen by a PA. The reviewer asked why new patients or patients that have not been seen within 3 years are routed differently than existing patients. E explained that if a new patient calls, the call center will collect information and then call the clinic to ask for an appointment. The clinic will then call the new patient back with the intake appointment time. They try to schedule new intake appointments within 30 days.

**Did appointment offered meet standard?** Yes

# Call # 5

**Name of Provider/Clinic:** Web Primary Care **Telephone #:** 303-602-8080

**Person who made call:** Rachel Henrichs

**Person you spoke with**: N1, N2, and M

**Call Date:** November 5 and 6, 2013 **Time:** 3:45 p.m. (11/5) and 4:00 (11/6)

**Type of Appointment Requested:**

Urgent (Scenario 1)

**Date and Time Appointment Offered (non-urgent adult):** November 7, 2013

**Date and Time Appointment Offered (non-urgent child):** November 7, 2013

**Comment:**

The call was originally answered in the call center by N1. The reviewer explained who she was and why she was calling. N1 said it would be best for me to speak to the clinic directly and transferred my call. N2 at the clinic answered. After the reviewer explained who she was and why she was calling, N2 said she could not help and suggested the reviewer speak with someone at Medicaid. When N2 said she could not answer the reviewer's questions, the reviewer asked to speak with the manager. N2 said the interim clinic manager was with a patient and she took the reviewer's name and telephone number.

M called back about the same time the next day. The reviewer explained who she was, the purpose of the call, and read the urgent scenario. M said she could offer me an appointment for the next day (it was late in the afternoon). She said they try to get urgent appointments in the same day—even if they need to send members to a different clinic, but never more than 3 days. This holds true for *both adults and children.*

**Did appointment offered meet standard?** Yes

# Call # 6

**Name of Provider/Clinic:** Eastside/Gipson **Telephone #:** 303.436.4600

**Person who made call:** Rachel Henrichs

**Person you spoke with**: A

**Call Date:** November 21, 2013 **Time:** 10:00 a.m.

**Type of Appointment Requested:**

Well-child and well-adult

**Date and Time Appointment Offered (child):** Within 2 weeks

**Date and Time Appointment Offered (adult):** See comments

**Comment:**

The reviewer asked A to please explain the process for scheduling *a new* Medicaid adult member. She said she would take down my information, contact the clinic, and the clinic will call me back to schedule an appointment. I asked if this was the same process for new child Medicaid members. She said, no. Denver Health prioritizes children and she can schedule a new Medicaid child appointment for me right away. She said they usually get new child well-care visits scheduled *within two weeks*. She said she was not able to tell me how long it will take to get an appointment for an adult.

**Did appointment offered meet standard?** The well-child appointment would meet the standard. HSAG was unable to determine if a well-adult exam for new Medicaid members would meet the standard.

# Call # 7

**Name of Provider/Clinic:** Westside **Telephone #:** 303-436-4200

**Person who made call:** Rachel Henrichs

**Person you spoke with**: E

**Call Date:** November 13, 2013 **Time:** 10:20 a.m.

**Type of Appointment Requested:**

Non-urgent (Scenarios 7 and 9)

**Date and Time Appointment Offered (non-urgent adult):** November 15, 2013, at 1:20 p.m.

**Date and Time Appointment Offered (non-urgent child):** November 15, 2013, at 1:20 p.m.

**Comment:**

The reviewer noted she was on hold for 4 1/2 minutes before speaking with a scheduler.

The reviewer spoke to M in central scheduling. When the reviewer asked about a pregnancy appointment, M said that if the reviewer had called sooner, she would have been able to offer an appointment at 10:50 (it was 10:30). M offered an appointment at 1:20 p.m. on November 15. M said it doesn't matter how old the member is for pregnancy intake—everyone is treated the same.

The reviewer asked about an appointment for a *new Medicaid member*. M said there is a waiting list for new members. The reviewer clarified that she was requesting available appointment times for new Medicaid members. M explained that the protocol for new Medicaid members is that the scheduler takes my information, and then calls the clinic to arrange an appointment. The clinic will call me back to schedule an appointment in about 30 to 60 days. She offered to transfer me to the clinic. She said the clinics have slightly different protocols and they might be able to get me in sooner. (The reviewer was put on hold for another 5 minutes.) The woman at the clinic (no name given) said there is a *waiting list for new patients*. The reviewer asked about new Medicaid members and she said new Medicaid members have to call central scheduling at 303-436-4949.

**Did appointment offered meet standard?** Yes, for existing members. HSAG was not able to determine the wait time for new members.

# Call # 8

**Name of Provider/Clinic:** Westwood **Telephone #:** 303-602-4660

**Person who made call:** Rachel Henrichs

**Person you spoke with**: V transferred the caller to S. The reviewer called back and spoke to C.

**Call Date:** November 13, 2013 **Time:** 2:10 p.m.

**Type of Appointment Requested:**

Non-urgent (Scenarios 2 and 5)

**Date and Time Appointment Offered (Scenario 2):** November 18, 2013

**Date and Time Appointment Offered (Scenario 5):** November 18, 2013

**Comment:**

V misunderstood the reason for the reviewer's call, and she transferred the reviewer to the clinic. S (at the clinic) said she cannot schedule appointments and referred the reviewer to central scheduling. The reviewer called the number again and spoke to C. C explained that they always attempt to schedule members with their PCP. If that appointment is not acceptable to the member, then they will search for the next available. If there is no appointment soon enough to meet my needs, the central scheduler will add my information into a SharePoint database. The clinic personnel will access this database and fit patients in as soon as possible. C explained that they will triage the patients and squeeze in the most urgent cases first.

One of the scenarios was for a 10-year-old child who was not eating and who didn't "feel good." The earliest appointment available was on November 18, so C said she would put my information in the SharePoint database and have the clinic call me back.

**Did appointment offered meet standard?** Yes

The Department requested that HSAG design and facilitate a focus group discussion with community organizations that refer members to the Denver Health and Hospital Authority (DHHA) clinic system providers or provide services to Denver Health Medicaid Choice (DHMC) members. The objectives of the focus group were to gain insight from the community regarding access to services and barriers to obtaining appointments with DHHA providers, as well as to begin problem solving potential solutions. The focus group was held in Denver on December 5, 2013. A list of participants can be found in Appendix E, Table E–2.

## Methodology

HSAG and the Department met several times to discuss the methodology, potential discussion topics, and tools designed to facilitate the focus group discussion. The Department identified potential participants and extended the initial invitation to the targeted community organizations and referring providers. In addition, representatives from DHMC and the DHHA provider system were invited to participate in the focus group discussion. DHMC selected the individual participants to represent DHHA and DHMC. HSAG followed up with each attendee who agreed to participate, providing details of the purpose and logistics of the focus group discussion. HSAG requested that participants arrive to the discussion prepared to discuss their satisfaction with appointment access to DHHA providers, and provided tools for participants to use to organize their feedback. These tools were used to facilitate the focus group discussion process. Flip charts were used to record the on-site discussion and to maintain a focal point for exploration of the diverse interests and concerns of the group. Following the conclusion of the three-hour discussion, HSAG organized the input from the discussion into the common themes regarding barriers to care and potential solutions that were prioritized during the discussion. Following is the summary of the focus group discussion, as well as HSAG observations and recommendations.

## Summary of Focus Group Discussion

### *Introduction*

At the start of the meeting, each invitee explained the types of clients that they represent and briefly described their experiences referring clients to DHHA providers. Participants included physicians and representatives from community clinics and organizations such as those that serve indigent populations and persons with developmental disabilities and organizations that provide early childhood intervention services, all of which attempt to arrange primary care and specialty services for clients who are DHMC or Regional Care Collaborative Organization (RCCO) members.

DHHA representatives explained that, similar to all provider systems, DHHA has limited resources with which to provide care to patients. To meet its contractual obligations, DHHA prioritizes access to its primary care providers as follows:

- Enrolled DHMC members receive first priority.
- Members attributed to the Region 5 RCCO receive second priority.
- Non-RCCO fee-for-service Medicaid members are next on the priority list.
- Although DHMC staff members describe themselves as the safety net provider for the city and county of Denver, last on the priority list are members using other payor sources and the uninsured, including those served by the Colorado Indigent Care Program (CICP).

Due to the general shortage of specialists, access to DHHA specialist providers is limited to referrals from primary care providers within the DHHA system. DHHA representatives stated that DHHA operates as a closed system and is not obligated to accept provider referrals from non-DHHA providers.

DHHA representatives stated that all requests for appointments are routed to DHHA's centralized scheduling system. Established members (defined as those who have had an appointment at a Denver Health clinic within the past 3 years) are scheduled for appointments with their primary care provider (PCP) based on urgency of the need and availability of the provider. If newly enrolled Medicaid members need care for an urgent or emergency situation, that member is triaged by the Nurse Advice Line and sent to an urgent care facility or emergency department, as needed. New members who are pregnant and children are given priority access. DHHA representatives stated that there is no wait list for children or pregnant women. New adult Medicaid members who call for a routine appointment are placed on a waiting list until an opening occurs.

DHHA representatives acknowledged that DHHA's primary care clinics are currently operating at capacity; however, openings for new Medicaid members are created through an estimated 20 percent turnover in clients who move out of the area, disenroll, lose coverage, or die. Therefore, DHHA participants reported that when an opening becomes available, a representative from the clinic contacts the wait-listed member to schedule an appointment. DHHA representatives estimated the wait time to be less than two weeks.

Participants of the focus group agreed that, while the processes described by DHHA representatives may be the way access to DHHA clinics is intended to work, their experiences and the experiences of their clients have been different than described. Through further exploration in the focus group discussions, participants identified four major barriers to care for DHMC members: the scheduling process, appointment availability, the closed system, and the passive enrollment process.

### *Scheduling Process*

Participants described the following experiences with the DHHA scheduling system:

- When a person calls any of the DHHA clinics, there is an automated answering system that channels callers wishing to make an appointment to the central scheduling system. Participants identified the following dynamics that caused confusion and frustration on the part of those trying to make an appointment:
  - The mechanics of call transfers causing the caller to be placed on hold for exceptionally long wait times.

  - Callers receiving inconsistent information from schedulers regarding access to appointments or waiting lists.
  - The automated telephone system was described as nearly impossible for members who speak a language other than English or Spanish to navigate. Participants stated that there are increasing numbers of refugee and immigrant populations that speak other languages.
- Although it is DHHA's policy to call members when openings for new members are available, participants stated that members are not receiving these calls, and that providers outside the DHHA system and case workers calling on behalf of members are also not receiving return telephone calls regarding appointment availability.

Participants were consistent in their statements that the scheduling system does not work in the way that DHHA representatives stated it is intended to operate.

### *Appointment Availability*

As stated above, DHHA representatives acknowledged that the DHHA primary care clinic system is operating at capacity and stated that DHHA will not overburden its providers with patient loads beyond capacity limits. This creates the need for a wait list and the priority access criteria described. Focus group participants listed the following consequences of limited access to DHHA primary care providers.

- DHHA representatives estimated that new adult members wait less than two weeks on the wait list before gaining access to DHHA providers. Focus group participants stated that members have commonly experienced wait times between two months and six months. DHHA representatives stated that these circumstances are the exception rather than the rule. The group discussed that some mechanism to further explore and establish the real frequency with which extended wait times are experienced would be useful in addressing perceptions regarding access.
- Delayed access prohibits members who receive services through other Medicaid waiver programs, such as persons with developmental disabilities, from getting a primary care provider to complete paperwork that certifies members' eligibility to continue receiving community-based services or home-based services. Participants stated that this includes members who have already received services through the DHHA system but who cannot get access to a timely appointment because they do not have an acute illness.
- Some DHMC members are receiving care from primary care providers outside the DHHA system because they cannot get appointments with DHHA providers. However, these providers cannot be reimbursed for services because they are not DHHA-employed providers, and as a staff model HMO using a closed system of providers, DHMC does not contract with primary care providers outside the DHHA system. One participating physician stated that DHHA has instructed him to send members needing care to the emergency room. He feels that sending a child (for example) across town to seek treatment for a sore throat in the emergency room is a waste of dollars, so he chooses to continue to treat these members without any reimbursement. Furthermore, several provider participants described difficulties they experienced when requesting to contract with DHMC to provide services.

- Due to the need to prioritize access to DHHA providers as described above, DHHA acknowledged that it is improbable that populations for which DHMC is not contracted to provide care would obtain access to DHHA providers unless they use the emergency room.

### Closed System

DHHA participants explained that the DHHA clinic system operates as a closed system, and that referral to limited system resources is reserved for the providers employed by DHHA and prioritized for members that DHMC, through its contracts with the Department, is obligated to serve. This system intentionally prevents outside providers and referring agencies from gaining access to DHHA diagnostic tests and specialty providers. During the discussions, participants noted examples of Medicaid members who needed DHHA services, such as pharmacy services or obtaining the preparatory diagnostic tests required to gain access to a specialist, but were not allowed access because the services were ordered by a primary care provider outside the DHHA system. Simultaneously, the member could not get an appointment with a DHHA primary care provider to obtain timely, necessary services, presumably because he or she was a new member who was placed on the wait list. In essence, while non-DHHA providers might be treating DHMC members for various needs, these providers are unable to order or refer members for additional tests and other services. DHMC representatives explained that the system is designed for members with symptomatic needs to be able to get access through one of the DHHA urgent care clinics if a primary care appointment is not available.

### Passive Enrollment Process

The State's managed care passive enrollment process automatically assigns new Medicaid members who reside in Denver County to the DHMC MCO. Members may opt out of DHMC through a prescribed "opt-out system." Focus group participants described several issues related to the passive enrollment process.

- Medicaid recipients from surrounding metro area counties who move to an address in Denver County are automatically enrolled in DHMC, even though they may have an existing provider(s) in another county they wish to continue seeing. Any of the member's previous providers, outside of the DHHA system, cannot be reimbursed for services as long as the member is assigned to DHMC, therefore potentially disrupting the member's continuity of care.
- The passive enrollment system assigns Medicaid members to a provider system that admittedly is operating at capacity and has minimal additional capacity in its primary care system for new adult Medicaid members.
- Members are informed that they may opt out of the DHMC system through the member handbook and member mailings; however, participants reported that:
  - Due to lack of current or accurate address information in member enrollment files, many member mailings are returned, so the member is unaware of the opt-out process.
  - When members do receive notification of the opt-out option, they either ignore it or do not understand the process or the implications.

  - The window of time for members to opt out is within 90 days after enrollment or within 2 months prior to the member's birthday. If a member overlooks or misses this window of opportunity, he or she must remain enrolled in the DHMC system until the next open enrollment period.
  - Some members who have opted out of DHMC are automatically reassigned to DHMC, perhaps because they lose Medicaid eligibility for a period of time and are reassigned on re-enrollment, or for other unknown reasons. DHMC representatives stated that this should not happen and needs further investigation.
  - DHMC has personnel dedicated to assist members with the opt-out process but are often unaware that the member wishes to opt out.

- Providers and other organizations working with Medicaid members are expending considerable resources attempting to assist members with disenrollment from the DHMC system. In the meantime, participants stated that they believe members feel trapped in a system that does not have the capacity to provide services to them and simultaneously does not allow them to obtain services outside the system. Additionally, providers who choose to meet the needs of these patients are not eligible for reimbursement by DHMC.
- DHMC representatives stated that there are also many positive aspects of the passive enrollment system, but focus group time constraints did not allow for adequate discussion of this assertion.

### *Potential Solutions*

DHHA representatives stated that it is the purview of DHHA to determine how access to the limited resources of DHHA is designed and administered, as long as DHMC is meeting its contractual obligations. However, representatives stated that DHHA is continuously evaluating its systems and internally evaluating opportunities for improvement. DHHA representatives indicated that DHHA is considering the following:

- DHHA is planning to expand its panel of both specialists and primary care providers in 2014, while noting that obtaining more primary care providers will be easier than identifying an increased number of specialists.
- DHMC is considering contracting with select primary care and other providers outside the DHHA system in order to expand its network and access to care. The focus group participants felt that many of the access issues could be alleviated if DHMC contracted with providers outside the DHHA system.
- DHMC welcomes the opportunity to have further focused discussions with community representatives and appropriate State departments, such as the enrollment broker, regarding issues with the managed care passive enrollment process.
- DHMC recognizes the need and is committed, at a minimum, to working on improvements related to access for members DHMC is contractually obligated to serve through both the managed care contract with the State and the contract with the RCCO serving Denver County.

- DHMC and Early Intervention Colorado representatives indicated a mutual willingness to meet separately and discuss potential solutions regarding access for children's early intervention services.
- DHMC and RCCO representatives will continue to meet to discuss and resolve issues related to care for RCCO members.
- DHMC expressed that it has mechanisms and resources to resolve some of the described issues, but it needs to be made aware of them and is therefore open to further discussion with community providers and partners regarding opportunities for improvement in access to care, perhaps through an established advisory or stakeholder group.

- DHHA representatives stated that DHHA has been evaluating its scheduling system and has determined that the centralized scheduling system will remain the primary mechanism for scheduling appointments with DHHA providers. However, DHHA representatives expressed willingness to consider input that will assist in making improvements to the process.

## Observations and Recommendations

The lack of capacity in the DHHA primary care clinics has resulted in a closed system of care that is not capable of accommodating all populations as the "safety-net" provider for the region, despite its efforts to provide timely access to at least Medicaid populations. Access to primary care providers as the gateway for obtaining access to DHHA specialists and other needed services is of particular concern, especially for new Medicaid members. Expansion of the DHMC network of providers by contracting with primary care providers outside of the DHHA system seems to be the most expedient method of increasing provider capacity. Although DHHA stated that it is also committed to identifying and employing additional providers within the DHHA system, it has acknowledged that this is a longer-term solution due to the general shortage of providers. HSAG encourages DHMC to continue pursuing strategies to expand its network of providers, with particular emphasis on primary care.

Due to the capacity issues within the DHHA provider system, DHHA has established priorities for allowing access based on members' payor sources or identified demographic population (indigent, Medicaid managed care, or Medicaid fee-for-service). However, despite the intent of the described procedures, it appeared that there were conflicting perceptions among focus group participants of the effectiveness in the processes that have been implemented. DHMC is encouraged to continue to obtain meaningful feedback from Medicaid members and community organizations, and take action to improve any identified inadequacies in the intended processes. In addition, DHMC must develop mechanisms to ensure that new adult Medicaid members are not wait-listed beyond the required access to care standards.

DHHA and DHMC staff members stated that they would welcome opportunities to further discuss the passive enrollment process with the Department. The Department may want to initiate and participate in follow-up discussions with DHMC to identify and alleviate the unintended consequences of the passive enrollment process, including its impact on Medicaid recipients' access to care, as well as the burden on the capacity of the DHHA system. Simultaneously, DHMC is

encouraged to pursue more effective mechanisms for identifying and assisting members who desire disenrollment from DHMC.

DHMC representatives indicated that they were willing to meet individually with some of the focus group organizations to have follow-up discussions and pursue solutions to any unique problems with timely access to providers. HSAG encourages DHMC to initiate those discussions, and the Department may want to consider follow-up with DHMC and the focus group participants to determine progress.

# Appendix E. Site Review Participants for Denver Health

Table E-1 lists the participants in the FY 2013–2014 site review of Denver Health. Table E-2 lists the focus group participants.

| Table E-1—HSAG Reviewers and Health Plan Participants | |
|---|---|
| **HSAG Review Team** | **Title** |
| Barbara McConnell, MBA, OTR | Director, State & Corporate Services |
| Rachel Henrichs | Project Coordinator |
| **Denver Health Participants** | **Title** |
| Analicia Baer | Government Products Specialist |
| Ann Anaebere | Registered Nurse, Quality Improvement |
| Craig Gurule | Government Products Manager |
| David Brody | Medicaid Director—Medicaid Choice |
| Jessica Guido | Clinical Project Manager/Utilization and Care Management |
| LeeAnn Donovan | Executive Director of Managed Care |
| Marilyn Gaipa LCSW, CAC III | Director of Quality Improvement and Accreditation |
| Michelle Beozzo | Director of Pharmacy |
| Nettie Finn | Supervisor of Inpatient and Outpatient Services |
| Patricia Williams | Claims Manager |
| Rachel Meir | Clinical Director, Behavioral Health and Wellness |
| Ron Aguilar | Director of Provider Relations |
| Shelly Siedelberg, MPA, CPHQ | HEDIS Project Manager |
| Stacy Lewis | Health Plan Compliance Analyst |
| **Department Observers** | **Title** |
| Russell Kennedy | Quality and Compliance Specialist |
| Teresa Craig | CHP+ Contract Manager |
| Jeremy Sax | Medicaid Contract Manager |

| Table E-2—Focus Group Participants | |
|---|---|
| **Participants** | **Organization** |
| Katherine Bartilotta, BSN | Health Services Advisory Group, Inc. |
| Rachel Henrichs | Health Services Advisory Group, Inc. |
| Russell Kennedy | Department of Health Care Policy and Financing |
| Camille Harding | Department of Health Care Policy and Financing |
| Paul MelinKovich | Denver Health |
| Greg Bogdan | Denver Health |
| Cristina Morales | Denver Health |
| Craig Gurule | Denver Health |
| Julie Holtz | Region 5 Regional Care Collaborative Organization |
| David Otto | Colorado Coalition for the Homeless |
| Joan Barker | Colorado Coalition for the Homeless |
| Lynnette Craig | Denver Rescue Mission |
| Amanda Van Andel | Rocky Mountain Human Services |
| PJ Parmar | Ardas Family Medicine |
| Beth Cole | Early Intervention Colorado |
| Leslie Anderson | Children's Hospital |

# *Appendix F.* Corrective Action Plan Template for FY 2013–2014 *for* Denver Health

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

**Table F-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 compliance monitoring site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification to HSAG and the Department. The health plan must submit the CAP using the template provided.<br><br>For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions. |
| **Step 2** | **Prior approval for timelines exceeding 30 days** |
| | If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing. |
| **Step 3** | **Department approval** |
| | Following review of the CAP, the Department or HSAG will notify the health plan via e-mail whether:<br><br>◆ The plan has been approved and the health plan should proceed with the interventions as outlined in the plan.<br>◆ 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 F-1—Corrective Action Plan Process | |
|---|---|
| | |
| **Step 6** | **Documentation substantiating implementation of the plans is reviewed and approved** |
| | Following a review of the CAP and all supporting documentation, the Department 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.<br><br>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 health care regulations and managed care contract requirements. |

The template for the CAP follows.

**The following corrective actions apply to both the CHP+ and Medicaid lines of business.**

| Table F-2—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard I—Coverage and Authorization of Services** | | |
| **Requirement** | **Findings** | **Required Action** |
| 16. The notices of action must be mailed within the following time frames:<br>◆ For termination, suspension, or reduction of previously authorized CHP+/Medicaid-covered services, within the time frames specified in 431.211:<br>• The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214).<br>◆ For denial of payment, at the time of any action affecting the claim.<br>◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services.<br>◆ For service authorization decisions not reached within the required time frames on the date time frames expire.<br>◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services. | The Drug Authorizations and Utilization Review policy stated that standard authorization decisions would be made within 10 calendar days and expedited decisions would be made within 3 business days. The policy then stated that following the authorization decision, the NOA would be sent within 3 working days of making the decision. One of the Medicaid records contained an NOA that was sent outside the required time frame. | DHMC must ensure that NOAs are sent within the required time frames. |
| **Planned Interventions:** | | |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |

| Table F-2—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard I—Coverage and Authorization of Services** | | |
| **Requirement** | **Findings** | **Required Action** |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

| Table F-2—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard I—Coverage and Authorization of Services** | | |
| **Requirement** | **Findings** | **Required Action** |
| 25. The Contractor may not deny payment for treatment obtained under the following circumstances:<br>◆ A member had an emergency medical condition, and the absence of immediate medical attention would ***have*** had the following outcomes:<br>• Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.<br>• Serious impairment to bodily functions.<br>• Serious dysfunction of any bodily organ or part.<br>◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes:<br>• Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.<br>• Serious impairment to bodily functions.<br>• Serious dysfunction of any bodily organ or part.<br>◆ A representative of the Contractor's organization instructed the member to seek emergency services. | The Medicaid and CHP+ member handbooks stated that DHMC/DHMP is not responsible for payment if the emergency provider determines that the incident was not an emergency. | While the member handbook statements are unclear as to whether the emergency physician would use a medical necessity standard or a prudent layperson standard, DHMC/DHMP must revise member handbook language to clarify that DHMC/DHMP uses a prudent layperson standard to determine payment for emergency services. |
| **Planned Interventions:** | | |

| Table F-2—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard I—Coverage and Authorization of Services** | | |
| **Requirement** | **Findings** | **Required Action** |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

| Table F-3—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard II—Access and Availability** | | |
| **Requirement** | **Findings** | **Required Action** |
| 1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services. In order for the Contractor's plan to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows:<br>◆ Appropriate access to certified nurse practitioners and certified nurse midwives.<br>◆ 1:2000 primary care physician (PCP)/provider-to-member ratio. PCP includes physicians designated to practice family medicine and general medicine (and for Medicaid: Pediatrics, Nurse Practitioners, and Physician Assistants).<br>◆ 1:2000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology/ear, nose, and throat (ENT), endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology (and for Medicaid: Infectious Disease).<br>◆ Physician specialists designated to practice internal medicine, infectious disease, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either PCP or physician specialist, but not both. | Information obtained during the focus group discussion revealed that newly eligible adult Medicaid members are routinely placed on a wait list to obtain routine appointments. In addition, review of DHMC's grievance reports showed that the access and availability category had the highest percentage of grievances. These grievances related to appointment delay and wait time to get appointments. Further, Denver Health's member satisfaction survey data (CAHPS) showed that for Medicaid and CHP+, level of satisfaction on the *Getting Care Quickly* and the *Getting Needed Care* measures fell below the 25th percentile for FY 2012–2013. While ratios calculated in the Strategic Access Report were within the required parameters, ratios were calculated separately for each population (CHP+ and Medicaid). Denver Health should consider calculating ratios based on the total number of individuals (across all lines of business) its primary care and specialty physicians are expected to care for. Also, feedback obtained through a variety of quality activities indicated that DHMC's capacity to treat Medicaid and CHP+ members is not sufficient. | DHMC must develop a mechanism to more fully explore wait list processes and develop a process to specifically track by individual, the length of time members remain on the wait list. DHMC must also work with the Department to problem solve solutions to barriers that create the need for the wait list and develop mechanisms to ensure that new adult Medicaid members are not wait-listed beyond the required access to care standards. |
| **Planned Interventions:** | | |

| Table F-3—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard II—Access and Availability** | | |
| **Requirement** | **Findings** | **Required Action** |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

| Table F-3—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard II—Access and Availability** | | |
| **Requirement** | **Findings** | **Required Action** |
| 2. In establishing and maintaining the network, the Contractor considers:<br>◆ The anticipated Medicaid/CHP+ enrollment,<br>◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid/CHP+ populations represented in the Contractor's service area,<br>◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid/CHP+ services,<br>◆ The numbers of network providers who are not accepting new Medicaid/CHP+ patients,<br>◆ The geographic location of providers and Medicaid/CHP+ members, considering distance, travel time, the means of transportation ordinarily used by Medicaid/CHP+ members, and whether the location provides physical access for Medicaid/CHP+ members with disabilities. | The Strategic Access Report included an extensive discussion about anticipated enrollment and utilization of services and geographic location of clinics and stated that all primary and specialty care providers have open panels for new and existing Medicaid and CHP+ enrollees. The statement that all providers have an "open panel" carries a connotation that members may have immediate assignment to a PCP and access to appointments without the wait list process. | DHMC/DHMP must, in subsequent Strategic Access Reports, further define what is meant by "open panel," and more accurately describe the processes for access into the DHHA clinic system. |
| **Planned Interventions:** | | |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

| Table F-3—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard II—Access and Availability** | | |
| **Requirement** | **Findings** | **Required Action** |
| 7. If the Contractor is unable to provide necessary primary or specialist services to a member in-network, the Contractor must make special arrangements for members to access out-of-network providers for as long as the Contractor is unable to provide them. | Although the Strategic Access Report and DHMC's policies clearly stated that members may have access to out-of-network providers if providers are unavailable within the network, focus group discussions and on-site interviews described processes whereby members are placed on the wait list when access into the DHHA "closed system" is limited, thereby suspending ability for new members to schedule appointments, rather than looking to either contracted or out-of-network providers to fill the need. It was clear that scheduling issues applied across populations to some extent. During on-site interviews, the open shopper call project, and the focus group, DHMC/DHMP staff members acknowledged that children and pregnant women are prioritized for scheduling appointments; therefore, adult Medicaid members are more significantly impacted by limited appointment access. It was also clear that limited appointment availability impacted both the CHP+ and Medicaid populations. | As both the CHP+ and Medicaid populations continue to increase (per the Strategic Access Report, the CHP+ net increase for FY 2013 was 1,295 members and the net increase for the Medicaid population for FY 2013 was 3,858 members), particularly as expansion populations are added to the Medicaid roles, DHMC/DHMP must either implement its policies to provide out-of-network care when care within the network is not available or consider options to expand the DHMC network through expansion of the DHHA provider network, or through contracts with non-DHHA providers. |
| **Planned Interventions:** | | |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

| Table F-3—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard II—Access and Availability** | | |
| **Requirement** | **Findings** | **Required Action** |
| 16. The Contractor maintains an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and takes appropriate action. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, has mechanisms to monitor providers regularly to determine compliance, and to take corrective action if there is failure to comply. | The Strategic Access Report described a secret shopper project conducted in 2013 to study access issues; however, the metrics included average speed to answer the telephone, average time on hold, call abandonment rate, and call volume. While this study is important to understand and begin to develop quality initiatives related to customer service (another significant grievance category for DHMC) and processes and barriers to members' attempts to reach a live representative of DHHA, this was a missed opportunity to evaluate access to services and availability of providers. During the on-site interview, DHMC/DHMP staff reported that this was a planned revision to the project in 2014 (as was stated in the Strategic Access Report). Also during the on-site interview, DHMC/DHMP staff reported that there were no metrics that reported how long members are kept on the wait list before they are re-contacted to schedule an appointment. However, during the closing session, a DHMC/DHMP staff member reported that the DHHA call center does indeed keep lag time metrics and arranged for a report to be submitted. The December 2013 Median Lag Time Report presented only median times members are kept on the wait list and did not include the range. In addition, DHMC/DHMP management staff, not having awareness of this information, has been | DHMC/DHMP must determine what information exists within the DHHA system that can be used for monitoring appointment access and compliance with access and availability standards. DHMC/DHMP must develop an effective process for monitoring scheduling wait times, identifying barriers to complying with appointment guidelines delineated in the Medicaid and CHP+ managed care contracts, and taking appropriate action to ensure that appointment scheduling standards are met. |

| Table F-3—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ and Medicaid | | |
|---|---|---|
| **Standard II—Access and Availability** | | |
| **Requirement** | **Findings** | **Required Action** |
| | unable to monitor how long it takes a member to obtain an appointment from the time of the first contact requesting an appointment. | |
| **Planned Interventions:** | | |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

**The following corrective actions apply only to the CHP+ line of business.**

| Table F-4—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ | | |
|---|---|---|
| **Standard I—Coverage and Authorization of Services** | | |
| **Requirement** | **Findings** | **Required Action** |
| 14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). | One CHP+ claims denial record reviewed on-site contained an NOA that was not easily understood due to inaccurate and incomplete information regarding the reason for the denial. The intake form in the authorization tracking system indicated that this was a retroactive review of a claim. The NOA to the member indicated that this was a new service request. The letter also stated that the denial reason was that this was not a covered benefit. In fact, this was a covered benefit; however, the provider was an out-of-network provider and prior authorization was required and not obtained. The denial reason was actually that no prior authorization was obtained. | DHMP must develop a mechanism to review claims denials to ensure ease of understanding and provide clearer information to members as well as to ensure accuracy of the information. |
| **Planned Interventions:** | | |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

| Table F-4—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ | | |
|---|---|---|
| **Standard I—Coverage and Authorization of Services** | | |
| **Requirement** | **Findings** | **Required Action** |
| 15. Notices of action must contain:<br>◆ The action the Contractor (or its delegate) has taken or intends to take.<br>◆ The reasons for the action.<br>◆ The member's, authorized representative's, and provider's (on behalf of the member) right to file an appeal and procedures for filing.<br>◆ The date the appeal is due.<br>◆ The member's right to a State fair hearing.<br>◆ The procedures for exercising the right to a State fair hearing.<br>◆ The circumstances under which expedited resolution is available and how to request it.<br>◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued.<br>◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). | One of the CHP+ records reviewed contained an Appeal Rights attachment that included appeal rights based on the Department of Insurance requirements rather than the current CHP+ contract requirements. | DHMP must ensure that NOAs include each of required elements. |
| **Planned Interventions:** | | |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

| Table F-4—FY 2013–2014 Corrective Action Plan *for* Denver Health CHP+ | | |
|---|---|---|
| **Standard I—Coverage and Authorization of Services** | | |
| **Requirement** | **Findings** | **Required Action** |
| 26. The Contractor does not:<br>◆ Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms.<br>◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor, or State agency of the member's screening and treatment within 10 days of presentation for emergency services. | The CHP+ member handbook stated that DHMP would not pay for an emergency admission if the member did not notify DHMP of the emergency within one day. | DHMP must revise the CHP+ member handbook to clarify that DHMP will not refuse to cover emergency care based on DHMP's notification requirements. |
| **Planned Interventions:** | | |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

**The following corrective action applies only to the Medicaid line of business.**

| Table F-5—FY 2013–2014 Corrective Action Plan *for* Denver Health Medicaid | | |
|---|---|---|
| **Standard I—Coverage and Authorization of Services** | | |
| **Requirement** | **Findings** | **Required Action** |
| 2. The Contractor provides the same standard of care for all members regardless of eligibility category and makes all covered services as accessible in terms of timeliness, amount, duration and scope, to members, as those services are to non-CHP+/Medicaid recipients within the same area. | During the focus group discussion, open shopper call project, and during on-site interviews, multiple DHHA staff members acknowledged that the DH schedulers must prioritize populations when scheduling due to limited appointment availability. | DHMC must evaluate appointment capacity in the DH provider system and develop a mechanism to accommodate Medicaid and CHP+ populations equally. |
| **Planned Interventions:** | | |
| **Person(s)/Committee(s) Responsible and Anticipated Completion Date:** | | |
| **Training Required:** | | |
| **Monitoring and Follow-up Planned:** | | |
| **Documents to Be Submitted as Evidence of Completion:** | | |

# Appendix G. Compliance Monitoring Review Protocol Activities *for* Denver Health

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

**Table G–1—Compliance Monitoring Review Activities Performed**

| For this step, | HSAG completed the following activities: |
|---|---|
| **Activity 1:** | **Establish Compliance Thresholds** |
| | Before the site review to assess compliance with federal health care regulations and managed care contract requirements:<br>◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies.<br>◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates.<br>◆ HSAG submitted all materials to the Department for review and approval.<br>◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans. |
| **Activity 2:** | **Perform Preliminary Review** |
| | ◆ HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed.<br>◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via 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 two standards, and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested.<br>◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ and Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. HSAG used a random sampling technique to select records for review during the site visit.<br>◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review. |
| **Activity 3:** | **Conduct Site Visit** |
| | ◆ During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance.<br>◆ HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ and Medicaid service and claims denials and notices of action. |

| Table G–1—Compliance Monitoring Review Activities Performed | |
|---|---|
| **For this step,** | **HSAG completed the following activities:** |
| | ◆ Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.)<br>◆ At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings. |
| **Activity 4:** | **Compile and Analyze Findings** |
| | ◆ HSAG used the FY 2013–2014 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities.<br>◆ HSAG analyzed the findings.<br>◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings. |
| **Activity 5:** | **Report Results to the State** |
| | ◆ HSAG populated the report template.<br>◆ HSAG submitted the site review report to the health plan and the Department for review and comment.<br>◆ HSAG incorporated the health plan's and Department's comments, as applicable and finalized the report.<br>◆ HSAG distributed the final report to the health plan and the Department. |