Colorado Medicaid Managed Care Program

FY 2011–2012 SITE REVIEW REPORT for Denver Health Medicaid Choice

April 2012

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



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1.		1-1
	Overview of FY 2011–2012 Compliance Monitoring Activities	1-2
	Objective of the Site Review	
2.	Summary of Performance Strengths and Required Actions	2-1
	Overall Summary of Performance	
	Standard V—Member Information	
	Standard VI—Grievance System	
	Standard VII—Provider Participation and Program Integrity	
	Standard IX—Subcontracts and Delegation	
3.	Follow-Up on FY 2010–2011 Corrective Action Plan	3-1
	Methodology	
	Summary of 2010–2011 Required Actions	
	Summary of Corrective Action/Document Review	
	Summary of Continued Required Actions	3-2
_	ppendix A. Compliance Monitoring Tool	
Αŗ	ppendix B. Appeals Record Review Tool	.B-i
Αŗ	ppendix C. Site Review Participants	C-1
Αŗ	ppendix D. Corrective Action Plan Process for FY 2011–2012	D-1
Ap	ppendix E. Compliance Monitoring Review Activities	E-1





for Denver Health Medicaid Choice

Overview of FY 2011–2012 Compliance Monitoring Activities

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

This is the fourth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Managed Care Program. For the fiscal year (FY) 2011–2012 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The health plan's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to Medicaid member appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable health plan Medicaid appeals that were filed between January 1, 2011, and December 31, 2011. For the record review, the health plan received a score of M (met), N (not met), or NA (not applicable) for each of the elements evaluated. For cases in which the reviewer was unable to determine compliance due to lack of documentation, a score of U (unknown) was used and did not impact the overall record review score. Compliance with federal regulations was evaluated through review of the four standards and appeal records. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2011–2012 site review activities for the review period—January 1, 2011, through the dates of the on-site review, February 14–16, 2012. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the health plan was successful in completing corrective actions required as a result of the 2010–2011 site review activities. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the appeals record review. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action process the health plan will be required to complete for FY 2011–2012 and the required template for doing so.



Methodology

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

The four standards chosen for the FY 2011–2012 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

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

Objective of the Site Review

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

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



Summary of Results

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

Table 1-1 presents the score for **Denver Health Medicaid Choice** (**DHMC**) for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

	Table 1-1—Summary of Scores for the Standards							
Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of <i>Met</i> Elements)
V	Member Information	21	21	21	0	0	0	100%
VI	Grievance System	26	26	26	0	0	0	100%
VII	Provider Participation	13	13	13	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
	Totals	66	66	66	0	0	0	100%

Table 1-2 presents the scores for **DHMC** for the Appeals Record Review. Details of the findings for the record review follow in Appendix B—Appeals Record Review Tool.

Table 1-2—Summary of Scores for Appeals Record Review						
Description of Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of <i>Met</i> Elements)
Appeals Record Review	18	15	14	1	3	93%



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

Overall Summary of Performance

For the four standards reviewed by HSAG, **DHMC** achieved an overall compliance score of 100 percent, earning 100 percent compliance scores in each separate standard. **DHMC**'s staff members demonstrated a clear understanding of Medicaid managed care regulations and the managed care contract. Although HSAG identified several opportunities for improvement with specific processes and discussed recommendations related to those opportunities, HSAG determined that **DHMC** remained compliant with the regulations reviewed.



Standard V—Member Information

Summary of Findings and Opportunities for Improvement

Many of the policies and procedures and member materials were recently initiated or revised to ensure compliance with requirements. Given HSAG review (during previous audits) of the preceding documents, which were in place during the 2011 audit period, HSAG accepted the replaced or revised documents. The documents effective for 2012 were fully compliant with the managed care requirements reviewed. The Medicaid Choice Member Handbook and other member materials comprehensively defined member benefits and access to care, as well as member rights and grievance and appeals procedures, in an easy-to-understand format. Written materials frequently directed members to member services as the resource for questions and assistance. Members were notified in a timely and appropriate manner of any changes that might affect access to services (e.g., provider termination, changes in plan benefits). The provider directory adequately informed members of a variety of provider characteristics and options for accessing the provider network. Involvement with advance directives was primarily the responsibility of providers. HSAG recommended that **DHMC** consider offering general information (e.g., pamphlets) or advance directives references to members through member services or the member Web site. HSAG also recommended that future medical record audits routinely check for provider notation of the presence or absence of advance directives.

The Medicaid Choice member Web site contained basic downloadable information for members, such as the member handbook and provider directory, yet was somewhat awkward to navigate and did not incorporate the depth of information that may be useful to members. HSAG staff members recommended that **DHMC** upgrade the Web site to correct functionality problems (e.g., the translation link was not functional during the on-site review) and maintain current and accurate information on the site (e.g., the provider information link contained an outdated version of the member handbook). HSAG suggested that **DHMC** also make general enhancements to the Web site (e.g., add the new member orientation video) that would encourage increased use of the Web site as a member and provider communication tool in the future.

In addition, HSAG recommended that **DHMC** revise the member handbook and the provider manual for clarity and to avoid offering materials that do not exist (e.g., **DHMC** physician incentive plans).

Summary of Strengths

The Medicaid Choice Member Handbook and other member communication materials, including complex medical information and process descriptions, were written in an easy-to-understand language and format, and most materials distributed to members were produced bilingually within the same document. The handbook thoroughly described the benefits and services available to members. Policies and procedures specifically addressed the requirements of the standards, and HSAG found evidence that **DHMC** followed its policies and procedures. Provider communications and instructions accurately reinforced information being provided to members and member-related processes and requirements.

Summary of Required Actions



Standard VI—Grievance System

Summary of Findings and Opportunities for Improvement

DHMC had a well-defined grievance system that included policies and procedures to address grievances, appeals, and State fair hearings. The policies and procedures were clear and included the required content and accurate time frames for standard reviews, expedited reviews, and extension processes. HSAG found ample evidence that providers and members were notified of member rights related to the grievance system. **DHMC** kept records related to grievances and appeals and reported to the Department, as required.

The on-site record review demonstrated that **DHMC** implemented its policies, as written. **DHMC** sent acknowledgement letters and resolution letters, as required. Although HSAG found the resolution letters used with the appeal files reviewed difficult to understand, **DHMC** provided evidence that it had revised the templates. The new, easier-to-understand templates had been implemented in July 2011; however, no appeals had been filed since the new templates were implemented. Moving forward, HSAG encourages **DHMC** to ensure it uses the new template for all appeal resolutions.

Summary of Strengths

During the on-site interview, **DHMC** staff expressed a clear and thorough understanding of the Medicaid managed care grievance and appeal processes. **DHMC** demonstrated good communication and coordination between departments responsible for specific tasks involved in grievance and appeal processing grievances and appeals. **DHMC** had developed new templates for acknowledgement and resolution of grievances and appeals. These new templates were simple, easy to understand, and included all requirements. **DHMC**'s system to use attachments to the notice of action letters and appeal resolution letters for notifying members of the process for appeals and State fair hearing met the requirements and improved readability of the letters.

Summary of Required Actions



Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

Many of the policies and procedures, plans, and other documents related to program integrity were recently initiated or revised to ensure compliance with requirements. Given HSAG review (during previous audits) of the preceding documents, which were in place during the 2011 audit period, HSAG accepted the replaced or revised documents. The documents effective for 2012 were fully compliant with the requirements. Compliance with the requirements related to provider participation and program integrity were addressed through the integration of DHHA and **DHMC** policies, processes, and activities. Credentialing policies and processes were thorough and the monitoring of provider quality and appropriateness was comprehensive and adequately reported. Systems were in place to ensure compliance with provider non-discrimination, sanctions and exclusions, and freedom to act on behalf of members. The **DHMC** corporate compliance plan, accomplished through the joint efforts of **DHMC** and DHHA, was robust and adequately addressed training, monitoring, and reporting related to fraud and abuse.

The inter-relationships between the managed care staff and delivery systems processes within the DHHA system may present a challenge related to oversight of the Medicaid managed care requirements and accountabilities. HSAG recommended that **DHMC** establish centralized tracking systems for compliance with the various components and time lines of managed care contact requirements.

Summary of Strengths

The staff model provider network, which consisted largely of employed physicians of DHHA, resulted in increased control over the processes, systems, and performance of the provider system. **DHMC** has adequately integrated the activities, and resources of DHHA with those of **DHMC** to achieve compliance with the Medicaid managed care requirements regarding provider participation.

Summary of Required Actions



Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

DHMC's policies and procedures related to subcontracts and delegation included the required information. HSAG found evidence of a signed, executed agreement with each delegate that also included all of the required provisions. The agreements also outlined a process for **DHMC** to provide oversight and monitoring of its subcontractors and delegates while maintaining ultimate responsibility of all delegated tasks.

Summary of Strengths

HSAG found evidence of **DHMC** having performed predelegation review of the potential delegate, a process that culminated in a new contractual arrangement effective 2012. The process for predelegation review was implemented as written in the policies and procedures. HSAG also found ample evidence of thorough ongoing monitoring and formal review of each delegate.

Summary of Required Actions



3. Follow-Up on FY 2010-2011 Corrective Action Plan

for Denver Health Medicaid Choice

Methodology

As a follow-up to the FY 2010–2011 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether the health plan successfully completed each of the required actions. HSAG and the Department continued to work with **DHMC** until the health plan completed each of the required actions from the FY 2010–2011 compliance monitoring site review.

Summary of 2010–2011 Required Actions

In the Standard area of Coverage and Authorization of Services, **DHMC** was required to revise its policy related to several specific requirements. Policy revisions were required as follows:

- **DHMC** was required to ensure that policies, procedures, and manuals are consistent in their use of three working days, three calendar days, or 72 hours, and include extension time frames for standard and expedited authorization decisions. Also, **DHMC** was required to ensure that its policy does not require written follow-up to oral requests for an expedited appeal.
- **DHMC** was also required to ensure that its policy states that a member must be notified of an expedited authorization decision as expeditiously as the member's health condition requires but no later than three working days after receipt of the request for service, not "two business days" from the day the determination decision was made.
- **DHMC** must ensure that its policies are consistent and state that there are no incentives for any individual involved in UM activities to deny, limit, or discontinue medically necessary services.
- **DHMC** should ensure that its policies and claims payment processes are congruent with 42CFR 438.114(e).

In the Standard area of Access and Availability **DHMC** was required to address inconsistences related to appointment standards, as written in its policies and in its member handbook. **DHMC**'s quality improvement activities showed inadequate satisfaction or capacity to provide services. **DHMC** was required to ensure that it has sufficient resources available to Medicaid members to provide adequate access to all services covered under the contract.

In the standard area of Credentialing and Recredentialing, **DHMC** was required to develop a process for conducting on-site quality assessments of organizational providers, when applicable. As part of that process **DHHA/DHMC** was required to develop its own criteria for organizational



provider assessment for each type of organizational provider, determine if CMS or State site visits evaluate each of DHHA's assessment and site visit standards, and develop a process for ensuring that its organizational providers credential their own practitioners.

Summary of Corrective Action/Document Review

DHMC submitted a corrective action plan (CAP) in May 2011. HSAG and the Department reviewed **DHMC**'s planned interventions and timelines and approved **DHMC**'s CAP as written in May 2011. In July 2011 and August 2011 **DHMC** submitted documents as evidence that had completed all but one required actions, with an appropriate plan and timeline for submitted documents related to the last required action. In September 2011, **DHMC** submitted documents related to the final required action. HSAG and the Department informed **DHMC** that the evidence provided was insufficient to bring **DHMC** into full compliance with the requirement in question. In October 2011, **DHMC** submitted additional documentation related to the final required action. In February 2012, HSAG informed **DHMC** that it had successfully completed all required actions related to the FY 2010–2011 Site Review process.

Summary of Continued Required Actions

DHMC successfully completed all FY 2010–2011 corrective actions. There were no required actions continued from FY 2010–2011.



Appendix A. Compliance Monitoring Tool for Denver Health Medicaid Choice

The completed compliance monitoring tool follows this cover page.



Standard V—Member Information			
Requirement	Evidence as Submitted by Health Plan	Score	
1. Written information provided to Members shall be written, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department. ◆ The Contractor makes written information available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency and informs members of how to access those formats. 42CFR438.10(b)(1),(d) DH Contract: II.E.1.d.2 RMHP Contract: II.F.1.d.2	 Member Handbook – page 1, first column DHMC_Prov_Manual_P57.pdf Provider Directory_DHMC.pdf – page 3, "Important Information" CHOICE_ADM116.pdf – entire document Forms & Letters Log.xlsx – column I, "Health Literacy Advisor Results" BRAILLEWORKS_Invoice_11-9-11_DHMC.pdf – entire document Description of Process: The Member Handbook explains to members that written information is available in other forms such as braille, large print, audiotapes, among other languages. The Provider Manual informs providers of the same information. The Provider Directory also informs members that written information is available in other formats. CHOICE_ADM116, Readability of Member Materials, explains to DHMC employees the process for ensuring that member materials are, to the extent possible, at a 6th grade reading level or below. Forms & Letters Log.xlsx is a master spreadsheet of written DHMC member materials. Member materials are given form numbers for tracking, and are assessed by special Microsoft Word software (as explained in CHOICE_ADM116) for readability results are "stamped" into the master file to indicate the reading level of each member material. BRAILLEWORKS_Invoice_11-9-11_DHMC.pdf is an invoice from Braille Works, a company that creates braille versions of member materials for DHMC upon request. 	Met Partially Met Not Met N/A	

The Denver Health Medicaid Choice (DHMC) member handbook included a statement on page 1 informing members that the handbook and all other member information is available in other languages, Braille, large print, and audiotapes by calling member services and included a statement in Spanish



Informing members that materials were available in Spanish. The handbook was written in easy-to-understand language, provided the member services telephone numbers on each page, and instructed members to call with questions. During the on-site interview, DHMC staff members stated that the revised member handbook was being distributed to new enrollees, and that revisions did not represent major variations from the previous handbook. The new member handbook was also available on the member Web site in both English and Spanish. The Readability of Member Materials policy stated that all DHMC member materials were to be written at the 6th grade level and assessed through the Health Literacy Advisor software. The policy stated that the document and readability results were logged in the forms and letters spreadsheet, a sample of which was provided. During the on-site interview, staff members confirmed that a one-page Braille communication was inserted in all member welcome packets, which informed members regarding how to obtain member information in alternative formats.
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welcome packets, which informed members regarding now to obtain member information in alternative formats.
The DHMC Provider Directory was written in easy-to-understand language and informed members that the directory and other member information was
available in alternative formats by calling member services (contact information provided). The DHMC Provider Manual informed providers that members available in alternative formats by calling member services (contact information provided).
materials were written in prevalent non-English languages and alternative formats and could be requested through member services. During the on-site
interview, staff members stated that the provider manual was distributed at the time of provider contracting through the Intranet or by mail.
Required Actions:
None.
2. The Contractor has in place a mechanism to help ◆ Member Handbook – page 4, "Come Meet Your DHMC Met Met
members understand the requirements and benefits of Health Plan Team"
the plan. • DHMC_Prov_Manual_P55.pdf, "Member Information" \square \square \text{Not Met}
http://www.dhmedicaidchoice.com/Home.aspx - bottom right-
42CFR438.10(b)(3) hand corner, "Come Meet Your DHMC Health Plan Team" DH Contract: II.E.1.d.9.a New Member Orientation Powerpoint 7-2011 pdf - entire
PMIID Contract, H.E. I. d.0. a
presentation
◆ Visio-MCD_Benefit_Inquiries_Call_Flow_2011.12.pdf
Description of Process:
The Member Handbook informs members of the DHMC New
Member Lunch (formerly called "New Member Orientation"), a
monthly orientation for new and existing DHMC members to learn
more about the requirements and benefits of DHMC. New Member
Orientation Powerpoint 7-2011.pdf is the slideshow that is
presented at each New Member Lunch. The DHMC Web site,



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
	www.dhmedicaidchoice.com, provides the New Member Lunch announcement as in the handbook. The Provider Manual informs providers of the DHMC Member Handbook, and explains that members receive this handbook in order to help understand the requirements and benefits of DHMC. Visio-MCD_Benefit_Inquiries_Call_Flow_2011.12.pdf is an example of the resource/training material available to Member Services call center representatives that they utilize when members call and ask about the requirements and benefits of the DHMC plan.	

Findings:

The DHMC member handbook included information on:

- Where to get care with a map of the Denver Health clinics including family health centers, urgent care clinics, and school-based clinics
- Benefits in broad categories such as hospitalization; preventive care; and oral/dental, prescriptions, etc.
- How to get care including emergency and urgent care, pharmacy, women's health services, and children's health services
- Special programs such as EPSDT, health coaching for chronic conditions, and case management
- Extra services such as mental health, transportation, and wrap-around services
- How the health plan works, including choosing a PCP and specialist referrals

The member handbook and member Web site (www.dhmedicaidchoice.com) informed members of a monthly orientation lunch to learn more about plan benefits. The New Member Orientation PowerPoint included information presented in both English and Spanish that described services available, where and how to access services, and support services with numerous contact numbers to obtain more information or request assistance. During the on-site interview, DHMC staff members stated that the orientation was generally not well attended. Staff members stated that the presentation was not available to members on the member Web site, and HSAG staff members recommended that this be considered. The Member Services (MS) Process: Medicaid Benefit Inquiries flow chart outlined the process for assisting members with questions regarding their benefits, including the electronic information available to MS representatives to share with the member.

Required Actions:

None.



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
3. The Contractor makes its written information available in the prevalent non-English languages in its particular service area and notifies its members that written information is available in prevalent non-English languages and how to access those materials. 42CFR438.10(c)(3) and (5) DH Contract: II.E.1.d.2 RMHP Contract: II.F.1.d.2	 Member Handbook – page 1, first column DHMC_Prov_Manual_P57.pdf, "Medical Interpretation and Translation Services" Provider Directory_DHMC.pdf – page 3, "Important Information" CHOICE_QIM1305.pdf – page 3, Procedure 2.a. page 4, Procedure 2.j. ViaLanguage_Invoices_2011.pdf – entire document Description of Process: The Member Handbook explains to members that written information is available to them in different languages, and that members should call Member Services to request written information in a different language. The Provider Manual provides the same information to DHMC providers. The DHMC Provider Directory also explains to members, on page 3, that written materials are available in different languages and to call Member Services if written materials are needed in another language. Policy & Procedure CHOICE_QIM1305, Cultural and Linguistic Appropriate Services (CLAS) Program, outlines the access and availability of language services within the DHMC Plan. ViaLanguage_Invoices_2011.pdf shows several invoices from ViaLanguage, a translation service company that DHMC uses for the translation of written member materials. 	

Findings:

The Culturally and Linguistically Appropriate Services (CLAS) Program policy described the process for monitoring and identifying prevalent non-English languages of the Medicaid population through the State Medicaid application, member services contacts, and the language line. The policy stated that monthly and annual reports were used to identify the prevalence of need for translation of materials and that members and providers were to be notified in the member handbook, provider directory, provider manuals, and member and provider newsletters regarding how to obtain member materials in prevalent non-English languages. The DHMC Member Handbook (page 1) informed members that the handbook and all member information was available in other languages by calling member services and included this statement in Spanish. The provider directory and provider manual also stated



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
English and Spanish. During the on-site interview, DHMC staff members reported versions of the member handbook were available on the men into Spanish and was being distributed to members. Staff me	ges (MS contact provided). The New Member Orientation PowerPoin that printed member materials included both the English and Spanish or Web site. Staff members also stated that the newly revised handben bers stated that other language translations were performed upon recommendations.	translation and both
systems indicated that Russian and Vietnamese were the eme	erging non-English languages of most frequency.	
Required Actions: None.		
4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. 42CFR438.10(c)(4)&(5) DH Contract: II.E.1.d.2 RMHP Contract: II.F.1.d.2	 Member Handbook – page 1, top of second column DHMC_Prov_Manual_P57.pdf, "Medical Interpretation and Translation Services" Provider Directory_DHMC.pdf – page 3, "Important Information" DHHA_Language Line Services Agreement_Amendment1_072911.pdf – entire document DHHA_P-2.100 Interpreter and Translation Services and Auxiliary Communication Devices.pdf – page 3, Section IV.C.1 CHOICE_QIM1305.pdf – page 3, Procedure 2.a. page 4, Procedure 2.j. 	
	Description of Process: Page 1 of the Member Handbook explains to members that oral interpretation services are available free of charge, and instructs members to request interpretation services through the Appointment Center or through Member Services. The Provider Manual informs providers of the translation services available to members and how to request such services. In the Provider Directory, members are also made aware of the free-of-charge interpreter services available to them through DHMC. Denver	



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
	Health & Hospital Authority Policy & Procedure DHHA_P-2.100,	
	Interpreter and Translation Services and Auxiliary Communication	
	Devices, explains the process for providing interpreter services to	
	members who access such services at the clinic or hospital level.	
were referred to the DHHA Language Line, that providers we for hearing, visual, and speech disabilities would be provided Communication Devices policy defined the responsibility of interpretation/translation services and provision of communication The DHMC Member Handbook and the provider directory in visits or for other health care services (contact numbers providering impaired. The Language Line Services Agreement provider manual informed providers that medical interpretation and the provider services, and that a hotline was available to help provider that medical interpretation and the provider services, and that a hotline was available to help providers.	AS) Program policy stated that language services not provided by a bilitere expected to utilize the language line to deal with patient language be a upon request. The DHHA Interpreter and Translation Services and Alothe Denver Health (DH) clinical social work department to arrange for cation aids for non-English or special needs patients. Informed members that interpreter services were available free of charged ded), provided TDD/TTY telephone numbers, and offered sign language rovided evidence of a current contract for over-the-phone language interestation and translation services were available at no cost to the member viders access a medical interpreter. During the on-site interview, DHM services for clinical appointments and that many member services staff	e to assist in clinic age interpreters for the erpretation services. Er by contacting
Required Actions: None.		
5. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information, upon request (information required at 438.10(f)(6) and 438.10(g)(and (h) and Exhibit D in the Contract).	 Member Handbook – page 1, first column DHMC_Prov_Manual_P55.pdf, "Member Information" Member Newsletter_Choice Matters 12_11.pdf – page 10, "Do You Have a Member Handbook?" CHOICE_ADM114.pdf – page 2, Procedure 1 	
42CFR438.10(f)(2) DH Contract: II.E.1.d.9 RMHP Contract: II.F.1.d.9	Description of Process: The Member Handbook explains to members that at any time they may request a new Member Handbook (which contains all information found at 438.10(f)(6) and 438-10(g)(h)), and to call Member Services to receive a new Member Handbook. The Provider Manual informs providers of the Member Handbook, and how it is the member's right to request the handbook at any time.	



Requirement	Evidence as Submitted by Health Plan	Score
e c r u H r	Member Newsletter_Choice Matters 12_11.pdf is the most recent edition of the Medicaid Choice Member Newsletter; page 10 contains an article that informs Medicaid Choice members of their right to obtain the Medicaid Choice Member Handbook at any time upon request. CHOICE_ADM114, Member Newsletter Content Requirements, is a Policy & Procedure that outlines the process and requirements of the DHMC Member Newsletter, including information to members about their right to request a new DHMC Member Handbook at any time.	
42CFR438.10, which is included in the member handbook, and request a copy of the handbook through member services at an notification. The member handbook (page 1) and the DHMC P member services. Required Actions:	at members must be notified once per year of their right to request in d stated that each quarterly member newsletter would remind member time. The Winter 2011 <i>Choice Matters</i> newsletter provided an exa Provider Manual stated that members may request a new handbook at	ers that they may mple of this
None. 6. The Contractor gives written notice of any significant	 Member Handbook – page 6, "If your Benefits, Provider, or 	Met



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
information (defined in 42CFR 438.10) through the member handbook informed members and the provider manual inform benefit plan at least 30 days prior to the change. During the oduring the audit period, and that letters were sent to each men	that members would be notified in writing of any significant change in newsletter at least 30 days in advance of the effective date of the change and providers that members would be notified in writing of any significant-site interview, staff members stated that the pharmacy benefit managember notifying them of the change and providing new ID cards. Staff in verified notification 30 days prior to the effective date of the change. Surrent with any significant change in benefits or the plan.	ge. The member cant changes in the ger was changed nembers provided a
 7. The Contractor makes a good faith effort to give written notice of the termination of a participating provider agreement within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary health care from, or was seen by, the terminated provider. Such notice describes how the services provided by the participating provider will be replaced, and informs the members of disenrollment procedures. 42CFR438.10(f)(5) DH Contract: II.F.9.b RMHP Contract: II.G.8.b 	• CHOICE_PRR704.pdf – Entire Policy & Procedure Description of Process: CHOICE_PRR704, <i>PCP Terminations</i> , outlines the process in which DHMC informs members of terminating PCP providers. This policy and procedure includes a template letter that is to be used when notifying members of a PCP termination, which specifies that members may see any other DHMC provider or switch to another Medicaid plan.	Met Partially Met Not Met N/A
Findings: The PCP Terminations policy and the Contracting with Mediwithin 15 days of receiving notice of termination. The policy who has received services from the PCP within the last 90 days that they may see any DH clinic PCP or could choose to char that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose to chart that any member who had not changed PCPs within 30 days of the PCP or could choose	ical Providers policy stated that DHMC would notify members in writing stated the notice will be provided through a mailing to any member as anys. The policies stated that the letter (template letter reviewed) would ange Medicaid plans, and to call member services with any questions. The of the notice would automatically be assigned a new PCP. During the cation of members regarding a terminated provider and provided documents.	signed to the PCP or inform the member he policies also stated on-site interview, staff



Requirement	Evidence as Submitted by Health Plan	Score
 3. The Contractor provides to all members, including new members, a member handbook that includes general information about services offered by the Contractor within a reasonable time after notification of the enrollment and includes: Location of facilities/offices. The Contractor's hours of service. 42CFR438.10(f)(3) DH Contract: II.E.1.d.1, Exhibit D RMHP Contract: II.F.1.d.1, Exhibit D	 Member Handbook – page 3, "Where you can get Care" and map of clinics CLARITY_OCT11_Invoice_New Member Packets.pdf – entire document Description of Process: The Member Handbook provides members a list of clinics and a map of where they may obtain care within the DHMC network. Members are instructed to call a particular clinic on the page to find out specific clinic hours of service. CLARITY_OCT11_Invoice_New Member Packets.pdf shows invoices from Clarity, DHMC's mail house vendor that mails out Member Handbooks to new members on a monthly basis. 	

The DHMC Member Handbook was distributed in the monthly new member packets and was also accessible to members and providers on the DHMC Web site. (HSAG staff members noted that the member handbook available on the provider information section of the Web site was an outdated version.) The handbook included a map and corresponding addresses and telephone numbers of all Denver Health clinics, as well as addresses and telephone numbers of school-based clinics. The handbook instructed members to call the individual clinic to obtain hours of clinic operation. The handbook contained numerous references to the DHMC member services contact number, including listing the member services telephone numbers on each page. The provider directory, mailed to members on enrollment and available on the Web site, listed all provider names organized by clinic location and the address and hours of operation for Denver Health Managed Care. During the on-site interview, staff members stated that the enrollment welcome letter also included the address of DHMC and hours of member services operation. DHMC staff members also stated that the Choice Web site was under revision to become Medicare compliant and the provider information section of the Web site would be corrected to include the current member handbook.

Required Actions:

None.



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
 9. The member handbook includes: Procedures for obtaining the names, qualifications, and titles of professionals providing and/or responsible for members' care, including identification of providers who are not accepting new patients. How to obtain the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member's service area, including identification of providers who are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals. Information on, restrictions, if any, on the member's freedom of choice among network providers. 42CFR438.10(f)(6)(i) and (ii) DH Contract: Exhibit D RMHP Contract: Exhibit D 	 Member Handbook – page 1, first column page 3, "Where You Can Get Care," paragraph above clinic map Provider Directory_DHMC.pdf – page 1, First paragraph (above map) page 4, second and third paragraphs Description of Process: The Member Handbook informs the member that all necessary information about contracted providers can be found in the Provider Directory, and notifies the member about how to obtain the Provider Directory. The Member Handbook also explains that members may see any DHMC provider, subject to Specialist referral requirements. The Provider Directory informs the member of names, locations, telephone numbers, and languages spoken by providers in the DHMC network. The Provider Directory also explains that Members may see any DHMC providers, subject to Specialist referral requirements. 	
Findings:		

The member handbook directed members to the DHMC Provider Directory, distributed on request or available online, to select a PCP and stated that the directory provided information on names, location, specialty, languages spoken, and other DHMC providers. The handbook stated that members may see any provider within the network (specialist services may require referral) and provided a map and listing of all Denver Health Family Care Centers and school-based clinics with contact information. During the on-site interview, staff members stated that the hard-copy provider directory was distributed to members through the State's enrollment broker prior to the member selecting DHMC as their managed care plan.

The provider directory included individual provider names with credentials, non-English languages spoken, specialty, board certification, and provider address and contact information. In addition, the provider directory included the contact number for a central appointment line, and stated that all providers within the network were accepting new patients. The directory instructed members that PCP referral was required for specialist services with the exception of emergency or OB/GYN services, described acceptable out-of-network services, and listed the types of services for which authorization must be obtained.

Required	Actions:
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None.



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
 The member handbook includes a complete statement of member rights and responsibilities as specified in 42CFR438.100(b)(2)–(3) and in the 10 CCR 2505. 8.205.3. A member has the right to: Be treated with respect and with due consideration for his or her dignity and privacy. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. Participate in decisions regarding his or her health care, including the right to refuse treatment and the right to a second opinion. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. Obtain family planning services from any provider duly licensed or certified to provide such services without regard to enrollment in the MCO, without referral. Request and receive a copy of his or her medical records, and request that they be amended or corrected (as specified in 45CFR part 164). Be furnished health care services in accordance with federal healthcare regulations for access and availability, care coordination and quality. Exercise his or her rights, without any adverse effect on the way he or she is treated. A2CFR438.10(f)(6)(iii)	 Member Handbook – page 9, "Your Rights" DHMC_Prov_Manual_P59-60.pdf, "Member Rights & Responsibilities" CHOICE_ADM115.pdf – entire policy & procedure Description of Process: The Member Handbook and Provider Manual include a full list of the member's rights and responsibilities. CHOICE_ADM115, Member Rights and Responsibilities, outlines for DHMC employees the rights and responsibilities of members. 	Met □ Partially Met □ Not Met □ N/A



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
and responsibilities, listed the specific rights and responsibilities. The member handbook contained a non-discrelanguage, including all of the rights listed above. The provide	procedures for DHMC staff to treat members in a manner consistent water, and stated that members and providers would be informed of the rimination statement and listed member rights and responsibilities in ear manual listed all member rights as outlined in 42CFR 438.10, and starespectful relationship, and provide care consistent with the member's	member's rights and asy-to-understand ated that providers
 11. The member handbook includes: Covered services and any additional benefits and services offered by the Contractor (including EPSDT services). Excluded or non-covered services. Circumstances under which members may have to pay for care. Information about the Contractor's standards for the availability and accessibility of services including points of access for primary care, specialty, hospital, and other services. Information about how to request accommodations for special needs. How to request information about the Contractor's quality management and improvement program. 42CFR438.10(f)(6)(v) through (vii) DH Contract: Exhibit D RMHP Contract: Exhibit D	 Member Handbook – page 17-19, "Your DHMC Benefits" page 20, "Services Not Covered" page 6, "When Will You Have to Pay for Your Care?" page 11, "DHMC Appointment Standards" page 15-16, "Special Health Care Programs" page 15, "Special Health Care Programs", first paragraph page 20, "Quality" DHMC_Prov_Manual_P63-78.pdf, "Covered Services & Exclusions" DHMC_Prov_Manual_P49-53.pdf, "Quality Improvement" DHMC_Prov_Manual_P46.pdf, "Appointment Standards" 	Met □ Partially Met □ Not Met □ N/A

Findings:

The member handbook outlined an extensive list of covered services, including any special requirements or limitations of coverage for each category, additional benefits provided by DHMC (eye care, transportation, over-counter prescriptions), plan benefits provided outside of DHMC (mental health, wrap-around services), and specific non-covered benefits (cosmetic or investigational treatment). The handbook also described special services available at no cost, such as women's health/pregnancy care, care of children, the EPSDT program, case management, health coaching, and flu shots. The handbook defined expected appointment standards for emergent, urgent, and non-urgent care, and described circumstances in which the member may



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
have to pay for care, such as non-covered or out-of-network services. The handbook described examples of special needs circumstances and instructed members to discuss special needs with their PCP or member services. The handbook briefly described the DHMC quality program and invited members to call member services to request more information.		
The DHMC Provider Manual stated that covered services must be medically necessary and provided a detailed listing of covered services (including EPSDT) with applicable limitations and referral requirements. The manual also listed services that are specifically excluded from coverage and provided an extensive listing of wrap-around services. The manual also provided an overview of the DHMC Quality Improvement Program, and invited providers to call member services for more detailed information.		
Required Actions: None.		
 12. The member handbook includes: Maximum number of days between appointment request and actual visit with appropriate provider, as follows: Urgent care within 48 hours. Non-urgent care and EPSDT screens within two weeks. Adult non-symptomatic well-care physical examinations within four months. Policies on referral for specialty care. Family planning policies. Procedures for arranging transportation. Information on how members will be notified of any changes in services or service delivery sites. 	 Member Handbook – Page 11, "DHMC Appointment Standards" Page 5, "Getting a Referral to see a Specialist" Page 13, "Family Planning" Page 20, "Transportation" Page 6, "If Your Benefits, Provider or Services Change" Page 20, "Quality" Page 8, "Being on the Consumer Advisory Committee" DHMC_Prov_Manual_P46.pdf "Appointment Standards" DHMC_Prov_Manual_P6.pdf, "Provider Responsibilities" DHMC_Prov_Manual_P66.pdf, "Family Planning Services" DHMC_Prov_Manual_P57-58.pdf, "Non-Emergency Medical Transportation (NEMT)" DHMC_Prov_Manual_P59-60.pdf, "Member Rights & Responsibilities" 	

Findings:

The member handbook described appointment availability standards as follows: emergency care 24 hours a day and 7 days a week, urgent care within 2 days, non-urgent care within 2 weeks, well-care visits for children within 2 weeks, and well-care visits for adults within 4 months. The handbook stated that the PCP must provide a referral for specialty care, and must obtain approval for other types of services, with the exception of emergency care, family planning services, routine eye appointment, or OB/GYN services. The handbook provided contact information to arrange no-cost transportation to



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
provider appointments and informed members that they would be notified of any significant changes to benefits or plan requirements at least 30 days before any change was effective. The handbook described the role and composition of the Consumer Advisory Committee and invited members to contact member services to join the Consumer Advisory Committee. The DHMC Provider Manual, available to employed providers through the system-wide DHHA intranet, described the role of the PCP in making referrals for specialty care, stated that family planning services were covered in network or out of network without a referral, and provided contact		
information for members to arrange transportation to clinic a time and after-hours call response standards. The manual inf secret shopper calls, office visits, and review of member con	appointments. The manual also defined appointment standards as requiformed providers that compliance with appointment standards would be applaints. During the on-site interview, staff members stated that appoint y clinic managers, with reporting to DHMC staff members regarding of	red, as well as waiting e monitored through ntment center data
Required Actions:	y chine managers, with reporting to Drivie stair memoers regarding to	outhors.
None.		
 13. The member handbook includes the following information regarding the grievance, appeal, and fair hearing procedures (and includes a complaint form): The right to file grievances and appeals. The requirements and time frames for filing a grievance or appeal. The right to a State fair hearing: The method for obtaining a State fair hearing, and The rules that govern representation at the State fair hearing. The availability of assistance in the filing process. The toll-free numbers the member may use to file a grievance or an appeal by telephone. The fact that, when requested by the member: Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing, and the service authorization has not expired. 	 Member Handbook – pages 21-24, Grievance, Appeals, State fair hearing Sections DHMC_Prov_Manual_P40-45.pdf 	Met Partially Met Not Met N/A



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
 The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. The right that providers may file an appeal on behalf of the member with the member's written consent. 42CFR438.10(f)(6)(iv) and438.10 (g)(1)(i-vii) DH Contract: Exhibit D RMHP Contract: Exhibit D 		

Findings:

The member handbook defined a grievance in easy-to-understand language with examples, and informed members of the following time frames for filing and processing a grievance: filing within 30 days of the occurrence; DHMC written acknowledgement within 2 days; DHMC written resolution to the member within 15 working days of the filing; and a possible extension of 14 days. The handbook informed members that a grievance could be filed verbally or in writing through member services and included a grievance form and the toll-free member services number for assistance. The handbook also provided contact information for the Department if the member is dissatisfied with the grievance resolution.

The appeals section of the member handbook described a notice of action (NOA), stated that a member may appeal an action in writing (form included) or verbally through member services (followed by a written appeal unless requesting an expedited appeal), and may request a State fair hearing. The handbook stated that an appeal must be filed within 30 days from the date of the NOA or, for services already being received, within 10 days of the NOA or prior to the effective date of the action. The toll-free Member Services number and contact information for the Medicaid Ombudsman were listed for assistance in filing. The handbook also described an expedited appeal and the State fair hearing process, and explained that the member may have a DCR, including the provider, assist in an appeal. The handbook described the time frames for processing an appeal as follows: DHMC written acknowledgement within 2 days; DHMC written decision to the member within 10 days for a standard appeal and 3 days for an expedited appeal; a possible extension of 14 days. The handbook informed the member that he or she may present information/evidence during an appeal and have access to DHMC case information related to the appeal. The handbook explained that the member may request to continue benefits during an appeal, defined the time frames for requesting continuation, described the criteria for how long benefits would continue, and stated the payment implications if the appeal outcome was not in the member's favor. The handbook stated that the member has a right to a State fair hearing if requested within 30 days of the NOA, provided information on how to request a State fair hearing, and described the options for representation at the hearing.

Required Actions:

None.



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
 14. The member handbook includes the extent to which and how after hours and emergency coverage are provided, including: What constitutes an emergency medical condition, emergency services, and poststabilization care services with reference to the definitions in 42CFR438.114(a). The fact that prior authorization is not required for emergency services. The process and procedures for obtaining emergency and poststabilization services, including the use of the 911 telephone system or its local equivalent. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services. The fact that the member has the right to use any hospital or other setting for emergency care. Appropriate use of and procedures for obtaining after-hours care and emergency care within the service area. Appropriate use of and procedures for obtaining after-hours and emergency care when out of the service area. Instructions about accessing urgently needed services. 	 Member Handbook – page 10, "Emergency Care," "Urgent Care," and "Post-Stabilization Care" DHMC_Prov_Manual_P47-48.pdf, definitions of "Emergency Medical Condition", "Emergency Services", "Post-Stabilization Care Services" and "Urgently Needed Services" DHMC_Prov_Manual_P46.pdf, "After Hours Calls and Coverage Standard" 	Met □ Partially Met □ Not Met □ N/A

Findings:

The member handbook defined emergency, stabilization, and urgent care and stated that these services would be covered in network or out of network (including outside the service area) without prior approval. The handbook instructed members to call 911 or go to the nearest hospital for emergency



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
	ontact number provided) for assistance with after-hours or urgent care. t care clinics and advised members of the option to use the nearest urg	
PCPs should refer members to 911 or the nearest emergency notify the PCP within 48 hours. The manual defined post-sta approval was not required for urgent care services delivered Required Actions:	e provided to the member in network or out of network without prior a room for emergency care. The manual stated that the treating emerger bilization care and the circumstances used to determine coverage, and in network or out of network or out of the service area.	ncy provider should
None.		
15. The member handbook includes enrollment procedures of the Contractor, including how to change primary care providers, and disenrollment information (as required in section III of the contract) to ensure that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so, and members are informed about how to access the Department concerning disenrollment. **DH Contract: Exhibit D**	 Member Handbook – page 4, "How to Change Your PCP" page 4, "Enrolling and Disenrolling" page 5, "Open Enrollment" DHMC_Prov_Manual_P55.pdf, "Assignment of Primary Care Providers" DHMC_Prov_Manual_P56-57.pdf, "Enrollment and Disenrollment" 	
RMHP Contract: Exhibit D	Description of Process: Members are informed in the Member Handbook of how to change their PCP, and that members who wish to enroll/disenroll with DHMC must contact HealthColorado. Providers are made aware of these processes as well, in the Provider Manual.	
Findings:	Members are informed in the Member Handbook of how to change their PCP, and that members who wish to enroll/disenroll with DHMC must contact HealthColorado. Providers are made aware of	o a PCP, and that

The member handbook informed members that they should choose a PCP on enrollment or that DHMC would assign the member to a PCP, and that members may change their PCP at any time by contacting member services. The handbook stated that enrollment in DHMC is voluntary, provided an extensive listing of the reasons why the member may voluntarily disenroll, described the procedures for disenrollment, and included the contact information for *Health*Colorado. In addition, the handbook described the reasons why DHMC or the provider may request that the member be involuntarily disenrolled. During the on-site interview, staff members stated that *Health*Colorado pursues any grievances expressed by the member during the disenrollment process.



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
The manual also described the reasons that a PCP may reque disenrolled from the plan, and suggested that the provider us described the reasons that a member may voluntarily disenrolled to initiate enrollment or disenrollment. Required Actions: None.	ned PCP and that member services would assist members in selecting st dismissal of a member from their practice or the reasons a member re the grievance system to assist the member in resolving member probable from the DHMC plan, and provided the <i>Health</i> Colorado contact info	may be involuntarily lems. The manual also ormation for the
 16. The member handbook includes information about the Contractor's utilization management program and how it is used to determine medical necessity of services. Information includes: Appropriate points of contact with the utilization management program. Contact persons or telephone numbers for information or questions. Information about how to initiate appeals related to utilization management decisions. 	 Member Handbook – page 16, "Utilization Management" DHMC_Prov_Manual_P82.pdf, "Utilization Management" Description of Process: Members are given an overview of the DHMC Utilization Management program, which explains how the program works to determine medical necessity of requested service. Members are instructed, in the overview, to contact Member Services for Utilization Management questions. Providers are made aware of Utilization Management program functions in the Provider Manual. 	
DH Contract: Exhibit D RMHP Contract: Exhibit D		
Findings: The member handbook described the utilization management (UM) program for approval of services, referred members to the covered services section of the handbook for a description of services with limitations or requiring approval, and invited members to call member services to obtain authorization decision-making guidelines. The handbook stated that the member's provider would obtain authorization for necessary services, and described the process for appeal of service denials. The provider manual described the utilization management process, the use of Milliman clinical criteria for decision-making, and the timelines for making pre-service, concurrent, and retrospective decisions (expedited and standard). The manual provided the contact number for the Medical Management Department to request copies of criteria or obtain additional UM information. The provider Web site also contained the UM criteria. The appeals section of the manual described the denial decision process, the notice of action, and how to initiate an appeal.		
Required Actions:		

None.



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
 17. Advance directives requirements: The Contractor maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the Contractor. Advance directives policies and procedures include: A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. The difference between institution-wide conscientious objections and those raised by individual physicians. Identification of the State legal authority permitting such objection. Description of the range of medical conditions or procedures affected by the conscientious objection. Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. 	 Member Handbook – page 7, "What are Advance Medical Directives?" DHMC_Prov_Manual_P86-96.pdf CHOICE_UMG1008.pdf, Advance Medical Directives – Policy F, page 2 Procedure K.5.a, page 8 Procedure A, page 4 Procedure E, page 5 Policy E., page 2 Responsibility F, page 4 Procedure H, page 6 Description of Process: Advance directives are explained to the member through the Member Handbook. Providers are informed of Advance Directives requirements in the Provider Manual. DHMC employees are informed of Advance Directives requirements in CHOICE_UMG1008, Advance Medical Directives. 	Met Partially Met Not Met N/A



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
 Provisions for ensuring compliance with State laws regarding advance directives. Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. Provisions for the education of staff concerning the Contractor's policies and procedures on advance directives. Provisions for community education regarding advance directives that includes: What constitutes an advance directive. Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. Description of applicable State law concerning advance directives. 		
 The member information materials regarding advance directives include: The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. The Contractor's policies respecting implementation of advance directives. The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the Colorado Department of Public Health and Environment. 		
42CFR438.10(g)(2) and 42CFR422.128 DH Contract:II.F.7, Exhibit D RMHP Contract: II.G.6, Exhibit D		



Standard	V—Mem	ber Inf	formation
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Requirement Evidence as Submitted by Health Plan Score

Findings:

The Advance Medical Directives policy stated that:

- Competent adults have the right to formulate advance directives (AD)
- DHMC will provide written information to members about AD at the time of admission to a facility or through discussions between the member and the provider
- DHMC will comply with the member's AD
- Members are not required to have AD and will not be discriminated against based on whether or not they have AD
- Providers who cannot comply with AD will provide a clear and concise statement of limitations and transfer the member to another provider
- If a member is incapacitated at time of admission, AD information is provided to the family/surrogate and to the member when they are no longer incapacitated
- AD information will be maintained in the member's medical record
- DHMC will notify members and providers of any changes in State laws concerning AD within 90 days of the change
- Denver Health will provide staff members and community education regarding what constitutes AD, the purpose of AD, and applicable laws, and will provide periodic staff in-services regarding AD

The member handbook informed members that they have a right to approve or refuse treatment and described the purpose of various advance directives, including Medical Power of Attorney, Living Wills, and Do Not Resuscitate directives. The handbook stated that the member would be informed in writing if the provider cannot carry out the member's advance directives and that DHMC would assist the member in finding a different provider. The handbook also described the role of proxy and surrogate decision makers and how to register a Designated Client Representative (DCR) with DHMC. The handbook provided the contact information for the Colorado Department of Public Health and Environment for members to report when advance directives were not followed. The DHMC Provider Manual contained the Advance Medical Directives policy and procedures, as defined above.

The DHMC Newsletter Content Requirements policy stated that any changes in State laws concerning advance directives would be provided to members through the quarterly member newsletter within 90 days following the change. The Medical Records Standards and Audits policy stated that the medical record standards for DHMC providers <u>may</u> include documentation of AD. The medical record audit tool did not assess whether AD was noted in the record. HSAG recommends that future medical record audits routinely check for provider notation of the presence/absence of AD. In addition, while the member handbook instructed members to call member services to obtain more information on AD, during the on-site interview, staff members stated that the providers were responsible for discussing advance directives with the members. Staff members stated that the managed care staff did not directly enter into discussions with members regarding AD, and referred the member to other resources. HSAG staff members provided an on-site recommendation that DHMC consider offering general information (e.g., pamphlets) or advance directives references to members through member services or the member Web site.



Standard V—Member Information				
Requirement	Evidence as Submitted by Health Plan	Score		
member's AD. Also during the on-site review, staff members outpatient clinical staff concerning AD, and stated that comp Required Actions: None.	had been no instances in which a provider notified DHMC of the inabises provided an overview of the annual employee training modules for Deletion of training modules is tracked electronically within the intranet state.	HHA inpatient and system.		
 18. The member handbook includes: Notice that additional information that is available upon request includes information on: The structure and operation of the Contractor. 	 Member Handbook – Page 1, second column, third paragraph Page 6, "Physician Incentive Plans" DHMC_Prov_Manual_P55.pdf, "Member Information" 			
Physician incentive plans. 42CFR438.10(g)(3) DH Contract: Exhibit D RMHP Contract: Exhibit D	Description of Process: While DHMC does not utilize a Physician Incentive Plan, members are made aware of Physician Incentive Plans in the Member Handbook and are instructed to call Member Services if they would like more information about Physician Incentive Plans. Providers are notified of the same information in the Provider Manual and are also instructed to contact DHMC for more information. Members are instructed to also call Member Services if they would like more information on the structure and operation of DHMC.			
request more information on the structure and operation of D handbook stated that DHMC does not have a physician incer	managed care plan with oversight by the Department (HCPF), and that PHMC or physician incentive plans by calling member services. In anotative plan. The provider manual informed providers that members may tentive plans. HSAG recommended that DHMC revise materials for claplans).	ther section, the request information		



Standard V—Member Information					
Requirement	Evidence as Submitted by Health Plan	Score			
 19. The member handbook includes information concerning: The member's responsibility for providing the Contractor with written notice after filing a claim or action against a third party responsible for illness or injury to the member. The member's responsibility for following any protocols of a liable third party payor prior to receiving non-emergency services. 	 Member Handbook – page 7, "When Another Party Causes your Injuries or Illness" DHMC_Prov_Manual_P15.pdf, "Third Party Resources" Description of Process: The Member Handbook explains to members their responsibilities when another party causes their injuries or illness. Providers are informed of third party liability information in the Provider Manual. 	Met Partially Met Not Met N/A			
DH Contract: Exhibit D RMHP Contract: Exhibit D					
Findings: The member handbook defined third party liability (with examples) and provided an extensive description of the rules for DHMC payment or collection of payment from a responsible third party. The handbook described the responsibility of the member to notify DHMC of third party information within 30 days of becoming ill or injured, advised members that they must follow the rules of the other insurance company to have their bills paid, and stated that DHMC would not pay any medical bills that should have been paid by another party. The provider manual informed providers of DHMC's responsibility to pursue third party resources applicable to a member's injury or illness and instructed providers to question members regarding third party claims. Required Actions: None.					
 20. Member information materials sent following enrollment must also include the poststabilization care services rules at 422.113(c) and include: The Contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are pre-approved by a plan provider or other plan representative The Contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are not pre-approved by a plan provider or other plan representative, That charges to members for poststabilization services must be limited to an amount no greater 	 Member Handbook – page 10, "Post-Stabilization Care" DHMC_Prov_Manual_P47-48.pdf, "Post-Stabilization Care Services" Description of Process: Members are made aware of Post-Stabilization care services and rules in the Member Handbook. Providers are made aware of this same information through the Provider Manual. 				



Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
 than what the organization would charge the member if he or she had obtained the services through the Contractor. That the organization's financial responsibility for poststabilization services it has not approved ends when: A plan physician with privileges at the treating hospital assumes financial responsibility for the member's care; A plan physician assumes responsibility for the member's care through transfer; A plan representative and the treating physician reach an agreement concerning the member's care; or The member is discharged. 		
42CFR438.10(f)(6)(ix) and 42CFR422.113(c) DH Contract: NONE RMHP Contract: NONE		

Findings:

The member handbook and the provider manual defined post-stabilization care and stated that DHMC would pay for post-stabilization care in network or out of network if pre-approved by DHMC, and would pay for non-approved post-stabilization if approval was sought and could not be obtained. The handbook and manual stated that non-approved services would be paid until a DHMC provider assumed responsibility for care, the member was healthy enough to be transferred to a Denver Health provider, an agreement regarding treatment was reached with the out-of-network provider, or the member was discharged. The handbook also stated that DHMC would assist in transferring the member safely back to a Denver Health facility when stabilized.

The Utilization Review Determinations Including Approvals and Actions for DHMC Members policy stated that it is the goal of DHMC to provide post-stabilization services within a DH facility, and described DHMC financial responsibility for approved or non-approved poststabilization services as defined in 42 CFR 422.113 (c).

Required Actions:



Requirement	Evidence as Submitted by Health Plan	Score
21. Member information materials sent following	◆ Member Handbook – page 20, "Wrap Around Benefits"	Met Met
enrollment must also include:How and where to access any benefits available	• DHMC_Prov_Manual_P77-78.pdf , "Wrap Around Benefits"	Partially Met Not Met
under the State plan but not covered under the Medicaid managed care contract.	Description of Process: The Member Handbook explains and specifies Wrap Around	□ N/A
42CFR438.10(f)(6)(x) through (xii) DH Contract: NONE RMHP Contract: NONE	Benefits that are available to members, and informs members how to obtain those benefits. Providers are also made aware of Wrap Around benefits in the Provider Manual.	

The member handbook described where to access extra services available to members, such as mental health benefits through the local behavioral health organization, transportation services through a choice of two companies (contact information provided), and wrap-around services through Colorado Medicaid Customer Service (contact information provided). The handbook included an extensive listing of wrap-around services. The provider manual described an extensive listing of specific wrap-around benefits available to members outside the DHMC health plan through the Medicaid fee-for-service program, and instructed providers to work through the Medicaid Customer Service department (contact number provided) to obtain services for members.

Required Actions:

Results for Standard V—Member Information							
Total	Met	=	<u>21</u>	Χ	1.00	=	<u>21</u>
	Partially Met	=	<u>0</u>	Χ	.00	=	<u>0</u>
	Not Met	=	<u>0</u>	Χ	.00	=	<u>0</u>
	Not Applicable	=	<u>0</u>	Χ	NA	=	
Total Ap	plicable	=	<u>21</u>	Total	Score	=	<u>21</u>

Total Score + Total Applicable	=	<u>100%</u>
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Requirement	Evidence as Submitted by Health Plan	Score
The Contractor has a system in place that includes a grievance process, an appeal process, and access to the State fair hearing process. 42CFR438.402(a) DH Contract: II.E.2.b RMHP Contract: II F.2.b Grievance and Appeal State Rule (version 11—January 2011): 8.209(DH: Exhibit I, RMHP Exhibit B)	 Member Handbook – page 21-24, Grievances, Appeals, State Fair Hearing sections DHMC_Prov_Manual_P40-45.pdf, Grievances, Appeals, State Fair Hearing sections CHOICE_MBR803.pdf – entire document CHOICE_QIM1303.pdf – entire document CHOICE_UMG1002.pdf – page 13, Procedure 4. "Appeals" Description of Process: The grievance, appeal, and State fair hearing processes are explained to members through the Member Handbook and to providers through the Provider Manual. CHOICE_MBR803, Denver Health Medicaid Choice Grievance Process, outlines the grievance procedures that DHMC follows in the event of a member grievance. CHOICE_QIM1303, Notification and Investigation of Potential Quality of Care Concerns contains the process for when a quality of care concern is identified through the grievance process. CHOICE_UMG1002, Utilization Review Determinations Including Approvals and Actions for DHMC Members, outlines the appeal process that DHMC follows in the event of a member appeal. 	Met □ Partially Met □ Not Met □ N/A

Findings:

The Denver Health Medicaid Choice Grievance Process policy (Grievance Process policy) described DHMC's grievance processes. The Notification and Investigation of Potential Quality of Care Concerns policy described the processes for handling grievances related to the quality of care provided. The Utilization Review Determinations Including Approvals and Actions for DHMC Members policy (UR Determinations policy) described DHMC's internal appeal processes and processes to assist members with accessing the State's fair hearing process. The Denver Health Medicaid Choice Member Handbook (member handbook) informed members of their right to file grievances and appeals and to request a State fair hearing and informed members how to do so. The DHMC Provider Manual (provider manual) informed providers about DHMC's member grievance and appeal processes and how members may access the State's fair hearing process. Through on-site review of screen prints from the grievance and appeals database, review of appeals records, and discussions during the on-site interviews, HSAG confirmed DHMC's grievance and appeal processes.

Required Actions:



Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
 The Contractor defines Action as: The denial or limited authorization of a requested service, including the type or level of service, The reduction, suspension, or termination of a previously authorized service, The denial, in whole, or in part, of payment for a service, The failure to provide services in a timely manner, The failure to act within the time frames for resolution of grievances and appeals. For a resident of a rural area with only one MCO or PIHP, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: The service or type of provider (in terms of training, expertise, and specialization) is not available within the network, The provider is not part of the network, but is the main source of a service to the member—provided that:	 Member Handbook – page 22, "What is a Notice of Action Letter?" DHMC_Prov_Manual_P40-45.pdf, "Notice of Action Letter" CHOICE_UMG1002.pdf – page 2, definition of "Action" 	Met □ Partially Met □ Not Met □ N/A
(42CFR438.52(b)(2)(ii) State Rule: 8.209.2		



Standard VI—Grievance System				
Requirement	Evidence as Submitted by Health Plan	Score		
Findings: The Grievance Process policy and the UR Determinations police definition of action that was consistent with Medicaid managed	cy both included the required definition of an action. The member hard care regulations and described situations under which members were iew demonstrated that appeals and DHMC's appeal process was based. • Member Handbook – page 22, "What is an Appeal?" • DHMC_Prov_Manual_P40-45.pdf, "Appeals"	adbook included a e entitled to an appeal d on the correct Met Partially Met		
42CFR438.400(b) State Rule: 8.209.2	 CHOICE_MBR803.pdf – page 2, Definition B CHOICE_UMG1002.pdf – page 2, Definition of "Appeal" 	☐ Not Met ☐ N/A		
Findings: The Grievance Process policy and the UR Determinations policy both stated the definition of appeal as a request for review of an action. The member handbook informed members about the situations (actions) under which members have the right to an appeal and defined action consistently with the Medicaid managed care regulations. The provider manual also included a correct definition of action. The on-site review of appeals records confirmed DHMC's appeal process as consistent with Medicaid managed care regulations. Required Actions: None.				
4. The Contractor defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action. 42CFR438.400(b) State Rule: 8.209.2	 Member Handbook – page 21, "What is a Grievance?" DHMC_Prov_Manual_P40-45.pdf, "Grievances (Complaints)" CHOICE_MBR803.pdf – page 2, Definition E CHOICE_UMG1002.pdf – page 4, Definition "Grievance" 			
Findings: The Grievance Process policy defined grievance, as required. The member handbook informed members, in a manner that was easily understood, of their right to file grievances and provided examples of possible grievance situations. The provider manual also included a correct definition of grievance. Required Actions: None.				



Requirement	Evidence as Submitted by Health Plan	Score
 The Contractor has provisions for who may file: A member may file a grievance, a health plan-level appeal, and may request a State fair hearing. A provider may file a grievance on behalf of a member, given that the State permits the provider to act as the member's authorized representative. A provider, acting on behalf of the member and with the member's written consent may file an appeal. A provider may request a State fair hearing on behalf of a member, given that the State permits the provider to act as the member's authorized representative. 42CFR438.402(b)(1) State Rule: 8.209.2	 Member Handbook – page 21, "What to do if you have a Grievance" page 22, "What is an Appeal?" page 23, "State Fair Hearing" DHMC_Prov_Manual_P40-45.pdf, "Acting on Behalf of a Member" CHOICE_MBR803.pdf – page 2, Definition G CHOICE_UMG1002.pdf – page 4, definition of "Member" Description of Process: Members are informed about who may file grievances and appeals on their behalf in the Member Handbook. The Provider Manual specifies that providers may act on behalf of a member, with member's written consent. CHOICE_MBR803.pdf and CHOICE_UMG1002.pdf clarify that providers and DCRs may act on behalf of a member, by defining "Member" specifically to include providers and DCRs.	Met □ Partially Met □ Not Met □ N/A
The UR Determinations policy stated that members or DCRs in prievance, an appeal, or request for a State fair hearing. The more	ed client representatives (DCRs) may express dissatisfaction through the many file appeals. Members were informed in the member handbook that ember handbook also stated that a provider may file on the member's multiple that members, DCRs and providers, acting on behalf of members,	at a DCR may file a behalf and act as th

and appeals, or request a State fair hearing. The on-site appeals record review included appeals that had been filed by members and providers as the DCR.

Required Actions:



Requirement	Evidence as Submitted by Health Plan	Score
. The Contractor accepts grievances orally or in writing.	 Member Handbook – page 21, "What to do if you have a Grievance" 	
42CFR438.402(b)(3)(i) State Rule: 8.209.5.D	• DHMC_Prov_Manual_P40-45.pdf , "Grievances (Complaints)"	☐ Not Met ☐ N/A
State Rate: 0.209.3.D	• CHOICE_MBR803.pdf – page 3, Procedure A.1.	
	Description of Process:	
	Members are made aware that they may file grievances orally or in writing through the Member Handbook. The Provider Manual includes language that specifies members may file grievances	
	orally or in writing. CHOICE_MBR803 explains that DHMC may accept grievances orally or in writing.	

The Grievance Process policy defined a grievance as an oral or written expression of dissatisfaction about any matter other than an action, and provided examples of common grievances. The policy also stated that members (or DCRs) may express dissatisfaction through the grievance process either orally or in writing. The member handbook provided members the option to call the Member Services department, complete the grievance form provided in the member handbook, or write a letter to DHMC. The handbook provided the address and the telephone number for filing. The provider manual informed providers that grievances may be oral or written. During the on-site interview, DHMC staff members reported that the majority of grievances are filed via the telephone. During the on-site interview, DHMC staff members reported that the initial call comes to the Member Services department, and if the call is about a grievance, it is transferred to a grievance and appeal coordinator who then investigates and works with the member to resolve the issue. Staff members also reported that, during the review period, the grievance and appeal team met with each of the DHMC clinic managers for training regarding forwarding grievances to the grievance and appeal team for investigation and processing. In this manner, staff members reported, grievances expressed to clinic staff are captured for reporting and trending. DHMC staff members also described monthly meetings with the director to whom all the clinic managers report, to address any issues with reporting grievances. DHMC staff members stated that the volume of grievances received tends to vary seasonally, but that the average number of grievances received during the review period tended to be about 40 per quarter.

Required Actions:



Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
7. Members have 30 calendar days from the date of the incident to file a grievance. 42CFR438.402(b)(2) State Rule: 8.209.5.A	 Member Handbook – page 21, "What is a Grievance?" DHMC_Prov_Manual_P40-45.pdf, "Grievances (Complaints)" CHOICE_MBR803.pdf – page 3, Procedure A.2. Description of Process: Members are made aware that they may file grievances up to 30 calendar days from the date of the incident through the Member Handbook. The Provider Manual includes language that specifies members must file grievances within 30 calendar days from the date of the incident. CHOICE_MBR803 explains that DHMC shall accept grievances up to 30 calendar days from the date of the grievance. 	Met □ Partially Met □ Not Met □ N/A
	C will accept grievances within 30 days of the incident. Members were ders were informed of the 30-calendar-day filing time frame via the pro	
8. The Contractor sends written acknowledgement of each grievance within two working days of receipt. 42CFR438.406(a)(2) State Rule: 8.209.5.B	 Member Handbook – page 21, "After You File a Grievance" DHMC_Prov_Manual_P40-45.pdf, "After Filing a Grievance" CHOICE_MBR803.pdf – page 3, Procedure B.1. Description of Process: The Member Handbook informs members that DHMC will send a written acknowledgement of each grievance within 2 working days of receipt. Providers are also informed of this acknowledgement in the Provider Manual. CHOICE_MBR803 specifies that DHMC must send a written acknowledgment of each grievance within 2 working days of receipt. 	



Standard VI—Grievance System				
Requirement	Evidence as Submitted by Health Plan	Score		
Findings: The Grievance Process policy included the provision that DHMC sends a grievance acknowledgement letter within two working days of receipt of the grievance. DHMC provided a grievance acknowledgement letter template. Members were informed via the member handbook of the grievance process, including the process to send acknowledgement letters within two working days of the receipt of the grievance. Providers were informed of the grievance acknowledgement process via the provider manual. During the on-site interview, DHMC staff members reported that timeliness of grievance processing, such as timeliness of letters sent, was tracked manually by the grievance and appeal team, and that DHMC has been working toward acquiring a new database that incorporates electronic tracking and alerts.				
Required Actions:				
 None. 9. The Contractor must dispose of each grievance and provide notice of the disposition in writing as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the health plan receives the grievance. 42CFR438.408(b)(1) and (d)(1) State Rule: 8.209.5.D.1, 8.209.5.F 	 Member Handbook – page 21, "After you File a Grievance" DHMC_Prov_Manual_P40-45.pdf, "After Filing a Grievance" CHOICE_MBR803.pdf – page 4, Procedure D.1. Description of Process: The Member Handbook informs members, and the Provider Manual informs providers, that grievance dispositions shall be made as quickly as the member's health condition requires, not to exceed 15 working days from the day DHMC receives a grievance. CHOICE_MBR803 explains to DHMC employees the 15 working day requirement for disposition of grievances. 			
Findings: The Grievance Process policy included the provision that DHMC sends a grievance resolution letter within 15 working days of receipt of the grievance. DHMC provided a grievance resolution letter template for review. Members were informed via the member handbook of the grievance process, including the process to send resolution letters within 15 working days of the receipt of the grievance. Providers were informed of the grievance resolution process via the provider manual. During the on-site interview, DHMC staff members reported that timeliness of grievance processing, such as timeliness resolution notifications sent was tracked manually, and that DHMC has been working toward acquiring a new database that incorporates electronic tracking and alerts.				
Required Actions: None.				



Standard VI—Grievance System				
Requirement	Evidence as Submitted by Health Plan	Score		
10. The written notice of grievance resolution includes:	Member Handbook – page 21, "After you File a Grievance"	Met		
 The results of the disposition/resolution process. The date it was completed. 	DHMC_Prov_Manual_P40-45.pdf , "After Filing a Grievance"	☐ Partially Met ☐ Not Met ☐ N/A		
State Rule: 8.209.5.G	• CHOICE_MBR803.pdf – page 4, Procedure D.2.	∐ N/A		
	Description of Process: Members are informed of the contents of the grievance resolution in the Member Handbook. Similarly, providers are made aware of the grievance resolution content requirements in the Provider Manual. CHOICE_MBR803 explains to DHMC employees that the grievance resolution notice includes the results of the resolution process and the date it was completed.			
Findings: The Grievance Process policy indicated that the grievance resolution/disposition letter explains the resolution and the date it was completed. DHMC provided a grievance disposition template letter. The grievance resolution template letter included fields for the outcome of the grievance and the date the resolution process was completed. The template also included the address for the Department and informed the member that he or she may send a letter to the Department if he or she is not happy with the resolution of the grievance.				
Required Actions:				
None.				
11. Members may file an appeal within 30 calendar days from the date of the notice of action. 42CFR438.402(b)(2) State Rule: 8.209.4.B	 Member Handbook – page 22, "How to File an Appeal" DHMC_Prov_Manual_P40-45.pdf, "How to File an Appeal" CHOICE_UMG1002.pdf – page 14, Procedure 4.B.1 			
Findings:				
* *	mbers may file an appeal within 30 calendar days of the date of the no			
Members were informed of the 30-calendar-day filing time fra	me via the member handbook and the notice of action process. During	the on-site		

The UR Determinations policy included the provision that members may file an appeal within 30 calendar days of the date of the notice of action. Members were informed of the 30-calendar-day filing time frame via the member handbook and the notice of action process. During the on-site interview, DHMC staff members confirmed that the attachment "What is an Appeal?" was included in notice of action letters. The handout included the filing time frame for appeals. Staff members stated that, effective July 2011, the attachments were in the system such that when notice of action letters were printed, the attachment printed with the letter for sending. Appeals reviewed on-site were all prior to the effective date of this process. Providers were notified of the 30-calendar-day filing time frame via the provider manual. During the interview, staff members also stated that appeals were typically initiated by the provider, following which the grievance and appeal team would contact the member to ensure that written consent or a DCR form was in place, then move forward with the appeal process.



Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
Required Actions: None.		
12. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution).	 Member Handbook – page 22, "How to File an Appeal" DHMC_Prov_Manual_P40-45.pdf, "To appeal an action the Member/DCR may:", first bullet CHOICE_UMG1002.pdf – page 14, Procedure 4.C.1. 	
42CFR438.402(b)(3)(ii) State Rule: 8.209.4.F	Description of Process: Members are informed that they are allowed to file appeals orally or in writing through the Member Handbook. Similarly, providers are made aware of this through the Provider Manual. CHOICE_MBR803 explains to DHMC employees that appeals may be accepted orally or in writing and that an oral request must be followed by a written and signed request, unless the request is for an expedited resolution.	
resolution, verbal appeals must be followed by a written, signer requesting that the member return the letter, signed to serve as writing, or that the member may call member services to reque action letter (via the attachment explaining the appeals process)	eals may be filed verbally or in writing, and, unless the member requered appeal. The policy described DHMC's process of describing the methe written appeal. The member handbook informed members that appears the appears were also informed of the filing requirements. During the on-site interview, staff members reported that the revise ecords reviewed on-site included written requests, some of which had	ember's appeal and peals may be filed in via the notice of d templates and the
None.		



Requirement	Evidence as Submitted by Health Plan	Score
13. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms required, putting oral requests for a State fair hearing into writing, and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. 42CFR438.406(a)(1) State Rule: 8.209.4.C	 Member Handbook – Page 21, "If you Need Help Filing a Grievance" Page 23, "Getting Help Filing an Appeal" Page 24, "State Fair Hearing", last paragraph DHMC_Prov_Manual_P40-45.pdf, "If Member Needs Help Filing a Grievance" DHMC_Prov_Manual_P40-45.pdf, "Getting Help Filing an Appeal" CHOICE_UMG1002.pdf – page 14, Procedure 4.B.2.c (1) Description of Process: DHMC informs members in the Member Handbook of the assistance available to them in completing any forms required through the grievance system. Providers are also informed of this in the Provider Manual. CHOICE_UMG1002 specifies that DHMC must provide reasonable assistance to members in completing forms or provide any other help through the grievance system. 	Met Partially Met Not Met N/A
assistance with forms, interpreter services, and toll-free telepho handbook offered assistance with filing grievances and appeals	included the provision that DHMC will provide any reasonable assist one numbers and that DHMC provides adequate TTY/TTD capability. Is and with requesting a State fair hearing, and listed the TTY/TTD number provider manual that assistance was available for filing grievances	The member mber in the



Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
14. The Contractor sends the member a written acknowledgement of each appeal within two working days of receipt, unless the member or the designated client representative (DCR) requests an expedited resolution. 42CFR438.406(a)(2) State Rule: 8.209.4.D	 Member Handbook – page 23, "After You File an Appeal" DHMC_Prov_Manual_P40-45.pdf, "After Filing an Appeal" CHOICE_UMG1002.pdf – page 15, Procedure 4.E.1. Description of Process: DHMC explains to members in the Member Handbook that appeal acknowledgements will be sent to members unless it is for an expedited resolution. Providers are also made aware of this in the Provider Manual. CHOICE_UMG1002 explains to DHMC employees that a written acknowledgement of appeal is required unless it is for an expedited resolution. 	Met Partially Met Not Met N/A
	MC sends a written acknowledgement to the member within two busined that acknowledgement letters were sent within the required time fra	
 The Contractor's appeal process must provide: That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date). The member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents considered during the appeals process. That included as parties to the appeal are: 	 Member Handbook – page 23, "After You File an Appeal" DHMC_Prov_Manual_P40-45.pdf, "To appeal an action the Member/DCR may:" DHMC_Prov_Manual_P40-45.pdf, "Appeal Decisions" (second paragraph) CHOICE_UMG1002.pdf - Page 14, Procedure 4.C.2 Page 15, Procedures 4.F.2-4 	Met Partially Met Not Met N/A



Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
 The member and his or her representative; or The legal representative of a deceased member's estate. 		
State Rule: 8.209.4.G, 8.209.4.H, 8.209.4.I		
person or in writing. The policy also included the provision that appeal information attachment to the notice of action letter information the appeal process. The handbook also informed metadditional information is short. The UR Determinations policy	w members to examine documents associated with the appeal, and to put the date of the oral appeal shall be used as the filing date. The members of the right to provide information, as well as the right embers that, for expedited appeals, the time available to review records described parties to the appeal, as required. HSAG reviewed appeals of the right to the appeals record review also included examples of the iew.	oer handbook and the t to review the case s or provide during the on-site
 16. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal. For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. 	 Member Handbook – page 23, "After You File an Appeal" (fourth paragraph) DHMC_Prov_Manual_P40-45.pdf, "Appeal Decisions" CHOICE_UMG1002.pdf – Page 15, Procedure 4.F.5 Page 16, Procedure 4.H.1 Description of Process: The Member Handbook informs members of when they will receive written notice of disposition on each appeal. The Provider Manual informs providers of when members will receive written notice of disposition on each appeal. CHOICE_UMG1002 explains the same time frames to DHMC employees. 	Met □ Partially Met □ Not Met □ N/A



Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
for expedited appeals. The policy also included the provision for review demonstrated that the resolution letters were sent within	esolution time frame for standard appeals and the three-working-day report reasonable effort to provide oral notice for expedited appeals. The on the required time frame in all cases reviewed. During the on-site intendited cases. In one case reviewed verbal notice was provided, although	on-site appeals record rview, staff members
 The written notice of appeal resolution must include: The results of the resolution process and the date it was completed. For appeals not resolved wholly in favor of the member: The right to request a State fair hearing and how to do so, The right to request to receive benefits while the hearing is pending, and how to make the request, and That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action. 42CFR438.408(e) State Rule: 8.209.4.M 	 Member Handbook – page 23, "After You File an Appeal" (last paragraph) DHMC_Prov_Manual_P40-45.pdf, "Appeal Decisions" (fourth paragraph) CHOICE_UMG1002.pdf – page 16, Procedure 4.H.2 and 4.H.2.a Description of Process: Members are informed of the contents of the written appeal resolution in the Member Handbook. Providers are informed of the contents of the written appeal resolution in the Provider Manual. CHOICE_UMG1002 lists the contents of the written appeal resolution. 	Met Partially Met Not Met N/A
letters included fields to add the results of the resolution proces appeal resolution letters. The attachment, "What is a State Fair time frame.	le the required content in the appeal resolution letters. The appeal reso as and the date it was completed. DHMC had developed an attachment Hearing?" included information about requesting a State fair hearing,	to be sent with
Required Actions: None		



Requirement	Evidence as Submitted by Health Plan	Score
 18. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: Were not involved in any previous level of review or decision-making, and who, Have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: An appeal of a denial that is based on lack of medical necessity. A grievance regarding the denial of expedited resolution of an appeal. A grievance or appeal that involves clinical issues. 42CFR438.406(a)(3)(ii) State Rule: 8.209.4.E, 8.209.5.C Findings:	 Member Handbook – Page 21, "After You File a Grievance" Page 23, "After You File an Appeal" DHMC_Prov_Manual_P40-45.pdf, "Appeal Decisions" CHOICE_MBR803.pdf – page 2, Policy E. CHOICE_UMG1002.pdf – page 15, Procedure 4.F.1 Description of Process: Members are informed that individuals who make decisions on grievances and appeals are individuals who were not involved in previous review and who have the clinical expertise to make decisions on such grievances and appeals. Providers are notified of the same information in the Provider Manual, and CHOICE_UMG1002 also lists this information. 	Met □ Partially Met □ Not Met □ N/A

The Grievance Process policy and the UR Determinations policy both stated that grievance or appeal resolution decisions are made by individuals who were not involved in any previous level of review or decision-making and have appropriate clinical expertise. The Grievance section of the member handbook stated that the "people who decide the grievance will not be the same people the member is filing the grievance about," and will have appropriate medical training. The appeal section of the member handbook stated that if the member appeals and the reason for the action was "lack of medical necessity," the people who decide the appeal will not be the same people who were involved with the action and will have appropriate medical training. Providers were informed of these processes via the provider manual. The on-site record review included only non-clinical administrative appeals (non-covered benefit, and out of network question); however, demonstrated that individuals who reviewed the appeal had not been involved with the original denial decision.

Required Actions:



Requirement	Evidence as Submitted by Health Plan	Score
 19. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: The member requests the extension; or The Contractor shows that there is need for additional information and how the delay is in the member's interest. If the Contractor extends the time frames, it must—for any extension not requested by the member—give the member written notice of the reason for the delay. 42CFR438.408(c) State Rule: 8.209.4.K, 8.209.5.E 	 Member Handbook – Page 21, "After you File a Grievance" Page 23, "Extending Appeal Timeframes" DHMC_Prov_Manual_P40-45.pdf, "Appeal Timeframe Extensions" CHOICE_MBR803.pdf – page 4, Procedure D.4.b. CHOICE_UMG1002.pdf – page 16, Procedure 4.G.1 Description of Process: Members are informed in the Member Handbook that either DHMC or the member can extend the time frame to make decisions on grievances or appeals. Providers are made aware of the same information in the Provider Manual, and CHOICE_MBR803 and CHOICE_UMG1002 also list this information. 	Met Partially Met Not Met N/A
policy) may be extended by up to 14 calendar days if the member member. The member handbook informed members that DHM could ask for additional time for grievances or appeals. Both pot to the member for extensions not requested by the member or I	policy included the provision that resolution of grievances or appeals ber requests the extension or DHMC indicated that it would be in the IC could ask for more time to review grievances or appeals and that the olicies included the provision that prior written notice of the reason for DCR. DHMC provided both a grievance and an appeal resolution time esses via the provider manual. There were no appeal cases reviewed or	best interest of the ne member or DCR or delay would be se frame extension

Required Actions:

None.

extension of the resolution time frame.



Requirement	Evidence as Submitted by Health Plan	Score
20. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action. 42CFR438.402(b)(2)(ii) State Rule: 8.209.4.N	 Member Handbook – page 23, "State Fair Hearing" DHMC_Prov_Manual_P40-45.pdf, "State Fair Hearing" CHOICE_UMG1002.pdf – page 16, Procedures 5.A and 5.B Description of Process: The Member Handbook informs members that they do not have to exhaust the appeal process of DHMC, and that they may request a State fair hearing as well, or instead, at any time within 30 calendar days from the notice of action letter. Providers are made 	Met Partially Met Not Met N/A
	aware of this same information in the Provider Manual, and CHOICE_UMG1002 also explains this information.	
days from the date of the notice of action, and that members no	mbers may request a State fair hearing at any time during the appeal, beed not exhaust DHMC's appeal process prior to requesting a State fair a State fair hearing at any time within 30 calendar days after the notical.	r hearing. Members



Requirement	Evidence as Submitted by Health Plan	Score
 21. The Contractor maintains an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes: The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. If the Contractor denies a request for expedited resolution of an appeal, it must: Transfer the appeal to the time frame for standard resolution, and Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow up within two calendar days with a written notice. 	 Member Handbook – page 22, "Filing an Expedited (Quick) Appeal" DHMC_Prov_Manual_P40-45.pdf, "Filing an Expedited (Quick) Appeal" (first and third paragraphs) CHOICE_UMG1002.pdf – page 14, Procedure 4.D.1 Description of Process: The Member Handbook explains the expedited review process for appeals, including the information required (left) that members are to be aware of during the expedited review process. The Provider Manual also explains the expedited review process for appeals. CHOICE_UMG1002 contains the same information. 	Met Partially Met Not Met Not Met N/A
State Rule: 8.209.4.PR		
notice to deny the expedited process. The member handbook d	eview process, which included the required components. DHMC provescribed the expedited ("Quick") appeal review process in a manner the described the expedited review process. Providers were notified of the	hat was easily



Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
 22. The Contractor provides for continuation of benefits while the health plan-level appeal and the State fair hearing are pending if: The member or the provider files timely*—defined as on or before the later of the following: Within ten days of the Contractor mailing the notice of action. The intended effective date of the proposed action. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. The services were ordered by an authorized provider. The original period covered by the original authorization has not expired. The member requests extension of benefits. * This definition of timely filing only applies for this scenario—i.e. when	 Member Handbook – page 24, "Continuation of Benefits During an Appeal or State Fair Hearing" DHMC_Prov_Manual_P40-45.pdf, "Continuation of Benefits during an Appeal or State Fair Hearing" CHOICE_UMG1002.pdf – page 17, Procedure 5.A 	Met Partially Met Not Met Not Met N/A
* This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.		
42CFR438.420(a) and (b) State Rule: 8.209.4.S		
Findings:	,	
	ion for continuation of previously authorized services during the appearance of the services during the services during the appearance of the services during the services d	
	as for continuing previously authorized services during an appeal or St	
	MC staff members reported that there were no services that DHMC at	
	he authorized services through the end of the authorized period. Pharm medication from the formulary and providing advance notice to member 1.	

Required Actions:

None.

that time.



Required Actions:

None.

Requirement	Evidence as Submitted by Health Plan	Score
 23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: The member withdraws the appeal. Ten days pass after the Contractor mails the notice providing the resolution (that is against the member) of the appeal, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. A State fair hearing office issues a hearing decision adverse to the member. The time period or service limits of a previously authorized service has been met. 42CFR438.420(c) State Rule: 8.209.4.T 	 Member Handbook – page 24, "Continuation of Benefits during an Appeal or State Fair Hearing" DHMC_Prov_Manual_P40-45.pdf, "Continuation of Benefits During an Appeal or State Fair Hearing" CHOICE_UMG1002.pdf – page 17, Procedure 6.B 	
	inuation of previously authorized services during the appeal or the Stantinued services. The member handbook clearly described the duration	



Requirement	Evidence as Submitted by Health Plan	Score
 24. Effectuation of Appeal Resolution: If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. 42CFR438.420(d), 42CFR438.424	 Member Handbook – page 24, "Continuation of Benefits During an Appeal or State Fair Hearing" DHMC_Prov_Manual_P40-45.pdf, "Instances when the Member may have to pay for continuation of benefits" and "Effectuation of Appeal Resolutions" CHOICE_UMG1002.pdf – page 18, Procedure 6.C.1 page 18, Procedure 6.D.1 and 2 	Met □ Partially Met □ Not Met □ N/A

Required Actions:



Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
25. The Contractor maintains records of all grievances and appeals and submits quarterly reports to the Department.	Letters from HCPF_re DHMC Compliance Reports_FY11 Q3 FY12 Q1.pdf – entire document	
42CFR438.416 State Rule: 8.209.3.C	Description of Process: Letters from HCPF_re DHMC Compliance Reports_FY11 Q3 - FY12 Q1.pdf is a collection of letters from HCPF regarding prior DHMC Network Adequacy Report Submissions. DHMC submits, among other documentation, a report of the previous reporting quarter's appeals and grievances to HCPF on a quarterly basis. HCPF provides feedback in the form of a written letter.	□ N/A
had been sent to the Department during CY 2011, and copies of for documentation of grievances and appeals. Staff members rethe report for the Department each quarter.	ports to the Department. On-site, DHMC staff members also provided of screen prints of the grievance and appeals databases that demonstrate ported that the information within the grievance and appeals database	ed the fields captured
Required Actions: None.		
 26. The Contractor must provide the information about the grievance system specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. The information includes: The member's right to file grievances and appeals. The requirements and time frames for filing grievances and appeals. The right to a State fair hearing: The method for obtaining a State fair hearing. The rules that govern representation at the State fair hearing. The availability of assistance in the filing processes. The toll-free numbers the member may use to file a grievance or an appeal by telephone. The fact that, when requested by the member: 	DHMC_Prov_Manual_P40-45.pdf , "Grievances, Denials, and State Fair Hearings"	



Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
 Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member. The member's right to have a provider file a grievance or an appeal on behalf of the member, with the member's written consent. 		
42CFR438.414 State Rule: 8.209.3.B		

Findings:

The provider manual included thorough and accurate information about the grievance system and DHMC's processes. During the on-site interview, DHMC staff members stated that when the provider manual information changed (for example when the filing time frame for grievances and appeals changed) all contracted providers were sent a new hard copy of the manual, and the manual was replaced on the intranet.

Required Actions:

Results	for Standard VI–	-Grievai	nce Sy	/stem			
Total	Met	=	<u>26</u>	X	1.00	=	<u>26</u>
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Applicable	=	0	X	NA	=	<u>NA</u>
Total Ap	plicable		<u>26</u>	Total	Score	=	<u>26</u>

Total Score ÷ Total Applicable	=	100%
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Standard VII—Provider Participation and Program Integrity			
Requirement	Evidence as Submitted by Health Plan	Score	
1. The Contractor has written policies and procedures for the	• CHOICE_CTS 302 (Section 1B and 1C)	Met	
selection and retention of providers.	• DHMC_Prov_Manual_P51-53.pdf	Partially Met	
	CHOICE_CRE101 Credentialing and Recredentialing of	Not Met	
The Contractor has adopted NCQA credentialing and	Practitioners (see PURPOSE statement page 3)	□ N/A	
recredentialing standards and guidelines for provider	CHOICE_CRE101 ATT B DHHA Medical Staff Bylaws.pdf		
selection.	(see Article III page 6 & Article XVII Section 1 page 34		
	POLICY)		
42CFR438.214(a)			
DH Contract: II.F.1.a and c	Description of Process:		
RMHP Contract: II.G.1.a and c	Independent Direct Practitioners are chosen through DHMC		
	Contracts Dept and credentialed according to NCQA standards by		
	the DHMC Credentialing Coordinator.		
	DHHA practitioners are chosen by Department needs (DHHA is a		
	closed campus) and credentialed according to JC & NCQA		
	standards by the DHHA Medical Staff Office.		

Findings:

The Provider Selection and Retention policy stated that the Denver Health Managed Care (DHMC) credentialing program complies with the NCQA standards for initial credentialing and recredentialing of participating providers. The Credentialing and Recredentialing of Practitioners policy described the process for credentialing of physician and non-physician providers who have an independent relationship with DHMC (i.e., the contracted provider network). The policy stated that the credentialing of practitioners who are employed or contracted by Denver Health and Hospital Authority (DHHA), which includes the Denver Health clinics, is the responsibility of the DHHA medical staff office. The policy stated that the DHMC quality improvement department, medical director, and credentialing subcommittee are responsible for the oversight of all DHMC practitioner credentialing. The policy included a non-discrimination statement and described the practitioner rights to review and correct information and appeal credentialing decisions. The policy described the procedures for processing credentialing decisions by the medical director and credentialing subcommittee, with oversight from the Medical Management Committee. The policy outlined the criteria for initial credentialing and described primary source verification of licensure, DEA certification, education, board certifications, work history, professional liability history, and practitioner sanctions. The policy stated that recredentialing was performed every 36 months and included re-verification of initial credentialing information, as well as review of any quality of care or performance concerns. The policy stated that DHMC conducted ongoing monitoring of Medicare/Medicaid sanctions through OIG, licensure sanctions through State Boards, member complaints, and provider adverse events.

The DHHA Medical Staff Bylaws (applicable to employed DHHA providers) outlined similar criteria, primary source verification, and decision processes for credentialing and recredentialing (every 24 months) of DHHA practitioners. The Assessment of Organizational Providers policy outlined the criteria for



Standard VII—Provider Participation and Program Integ	arity	
	Evidence as Submitted by Health Plan	Score
Requirement the assessment of provider facilities/agencies with whom DHMC	C contracts, which included the standards consistent with NCQA guid	
•	entialing process, including a statement of non-discrimination and a c	
elements of practitioner criteria which are verified via the creden		description of the
elements of practitioner effects which are verified via the effects	maning process.	
During the on-site interview, staff members stated that all Denve	er Health (DH) system practitioners, including those employed in the	DH clinic network are
	in the medical staff bylaws, and that the DHMC QI department cond	
	s. Staff members stated that there are approximately 40 independent	
network who are contracted to meet specific specialty needs with	nin the network. Staff members stated that the DHMC and DHHA cre	edentialing offices
coordinate credentialing activities and information.		
Required Actions:		
None.		
	 CHOICE_CRE102 Practitioner Office Site Quality (see pg 2, PROCEDURES A.4 & Site Audit Tool #D) CHOICE_CRE104 Assessment of Organizational Providers (see Initial Assessment, Reassessment, and Ongoing Monitoring, & Assessment Application/Attestation) Denver HealthchoiceQIEvalFY11_20111010.pdf (see pages 6-24) CHOICE_CTS301.pdf MOU DH Managed Care- DH Office of Integrity for Auditing Svcs MCD Choice2012.pdf – entire document CHOICE_QIM1306.pdf – entire document Description of Process: Credentialing: DHMC will perform a site visit to a practitioner's office when the compliant threshold is met as outline in CRE102, which includes Medical Record Requirements. DHMC initially, and on an ongoing basis, assesses Facilities it contracts with for services to members, to assure compliance with DHMC's Organizational Provider standards which are based on 	Met □ Partially Met □ Not Met □ N/A



Standard VII—Provider Participation and Program Integrity		
Requirement	Evidence as Submitted by Health Plan	Score
	The annual Quality Improvement Impact Analysis (refer to pages 6-24) contains an evaluation of clinical quality of care as well as service related activities to measure outcomes and appropriateness of care. The evaluation uses the following for measurement: HEDIS, Performance Improvement Projects, Health Outcomes Programs, and CAHPS. The report contains an analysis and action plan for the next measurement timeframe that addresses opportunities for improvement. HEDIS measures are used to satisfy the CMS validation of performance measure protocol requirements. Annually, a set of HEDIS measures is selected to measure quality, timeliness and access to care. Some of these HEDIS measures would include subcontracted services. CHOICE_QIM1306, Medical Records Standards and Audits, outlines the standards of medical record maintenance for DHMC medical records.	

Findings:

The Assessment of Organizational Providers policy stated that DHMC would not contract with a provider organization that was not accredited by an acceptable accrediting body (listed) or State/CMS certified for meeting standards related to policies and procedures, quality assurance, patient safety, adequacy of medical record keeping, and the process for credentialing or screening of staff. The Contracting for Medical Services policy described the role/responsibility of DHHA to monitor covered services rendered by DHHA contracted providers for quality, appropriateness, and patient outcomes. The policy described the role of the DH Managed Care department to monitor providers for compliance with medical record requirements and data reporting, and taking corrective action as required. The Practitioner Office Site Quality policy outlined the process and criteria for on-site assessment of the quality of a practitioner office, including evaluation of physical accessibility, appearance, and safety, as well as adequacy of medical record keeping. The Medical Records Standards and Audits policy outlined the medical record documentation standards and defined that DHMC would conduct annual audits to evaluate PCP compliance. The Medicaid Provider Contract template stated that the provider agrees to comply with DHHA policies and procedures, the quality improvement program, the provider manual, peer review policies, utilization management, member appeals, credentialing requirements, claims and referral procedures, health care standards, and all applicable laws.

The DHMC Quality Improvement Impact Analysis reported on the outcomes of the 2010/2011 Quality Improvement Program. The report included summary data, analysis of results, and actions taken related to the following QI activities:

- Population outcome focus studies
- HEDIS clinical quality measures, with trending and comparison of results to performance thresholds



Standard VII—Provider Participation and Program Integ	grity	
Requirement	Evidence as Submitted by Health Plan	Score
the Medical Management Committee (MCC) for all managed can subcommittee report to the MCC. Staff members stated that the N During on-site review, HSAG staff members reviewed reports re	nat all monitoring activities related to quality and appropriateness are re lines of business, and that numerous QI subcommittees, as well as MCC reports results to the DHHA Board of Directors through the DI lated to grievances, quality of care concerns, annual HEDIS perform tandards evaluations. MMC meeting minutes documented that these liewed and actions were recommended.	the credentialing HHA executive staff. ance measures,
None.		
 3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: Discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. 	 CHOICE_CTS302 (Section 1E (i) and (ii)) CHOICE_CRE101 Credentialing and Recredentialing of Practitioners (see POLICY statement page 1 & Nondiscriminatory credentialing and recredentialing page 4) CHOICE_CRE101 ATT B DHHA Medical Staff Bylaws.pdf (see Article XVII Section 2 page 34 & Section 4, 4.2 page 40) 	
### 42CFR438.12(a)(1) and (2) ####################################		

The Provider Selection and Retention policy included the verbatim anti-discrimination statements specified above. The Credentialing and Recredentialing of Practitioners policy stated that credentialing decisions are not based solely on applicant's race, ethnic/national identity, age, sexual orientation, or the type of procedure or patient the practitioner specializes in, and that this information would not be in the practitioner's credentialing file. (The policy stated that practitioners may be included in the network for the purpose of meeting certain demographic or specialty/cultural needs.) The policy stated that DHMC



Standard VII—Provider Participation and Program Inte	egrity	
Requirement	Evidence as Submitted by Health Plan	Score
discrimination for annual review by the Credentialing Subcomm and nondiscrimination statement. The DHMC Provider Manual discrimination. The DHHA Medical Staff Bylaws stated that dec made without regard to race, sex, national origin, color, religion,	of recently credentialed practitioners and track any practitioner comp nittee. The policy stated that each Credentialing Committee member s described the credentialing and recredentialing process, including a s cisions regarding appointment and reappointment to the DHHA medi- , age, military status, sexual orientation, marital status or the types of citioner complaints alleging discrimination would be evaluated throu	igned a confidentiality tatement of non- cal staff would be procedures or patients
recently credentialed to ensure that there continues to be diversit	entialing department reviews a periodic report of the DHMC provider ty of culture, nationality, gender, age, and other factors represented in rovider relations if they feel they are being discriminated against, and the been no complaints of provider discrimination.	the network. In
 4. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. Any information the member needs in order to decide among all relevant treatment options. The risks, benefits, and consequences of treatment or non-treatment. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. 	 Member Handbook – page 8, "You and Your Provider" MEDICAID_CONTRACT_PG_6_7.pdf (ARTICLE 3.6,3.8 3.9) DHMC_Prov_Manual_P7-8.pdf, last paragraph on page 7 	
42CFR438.102(a) DH Contract: IV.C.7 RMHP Contract: IV.B.10		



Standard VII—Provider Participation and Program Inte	grity	
Requirement	Evidence as Submitted by Health Plan	Score
advising or advocating on behalf of the member related to the m of treatment options, or the member's right to participate in deci all times provide covered services to members in a manner cons the provider from expressing disagreement with a medical decis information to adult members regarding their right to refuse trea	ment that DHMC does not prohibit or otherwise restrict a health care ember's health status or treatment options, information on risks, bene sions or refuse treatment. The Medicaid Provider contract specified the istent with sound professional judgment and practice, that the agreemion, medical policy or medical criteria of DHHA, and that providers with the triphical transfer advance directives. The DHMC Provider Manual lawful scope of their practice and would not prohibit providers from a he right of the provider to advocate for the member.	efits, or consequences hat the provider shall at the nent does not prohibit would provide al informed providers
Required Actions: None.		
 5. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: To the State. To members before and during enrollment. To members within 90 days after adopting the policy with respect to any particular service. 42CFR438.102(b) DH Contract: NONE RMHP Contract: NONE 	 CHOICE_CONTRACT_PG_7_8.pdf (ARTICLE 3.13 (h)) DHMC_Prov_Manual_P7-8.pdf, "Moral or Religious Objections" 	Met Partially Met Not Met NI N/A
Findings: The DHMC Provider Manual informed the provider of the responsible provider may have to providing services, and that DHMC we staff members reported that that the DHMC organization does not providers had reported objections during the audit period.	onsibility to notify DHMC (contact number listed) of any moral or reliquid notify members and the State of the provider's objections. Durin ot object to providing any service on moral or religious grounds and t	g the on-site interview,
Required Actions: None.		



Standard VII—Provider Participation and Program Inte	egrity	
Requirement	Evidence as Submitted by Health Plan	Score
6. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either section 1128 or 1128 A of the Social Security Act. (This requirement also requires a policy.) 42CFR438.214(d) DH Contract: (Amendment 3) II.F.5.m RMHP Contract: (Amendment 2) II.G.4.m	 CHOICE_CONTRACT_PG_6_7_8.pdf (ARTICLE 3.9, 3.12, 3.13 (c, e, h)) CHOICE_CONTRACT_PG_14.pdf (ARTICLE 9.16) CHOICE_CRE101 Credentialing and Recredentialing of Practitioners (pages 7 & 8) CHOICE_CRE101 ATT B DHHA Medical Staff Bylaws.pdf (see Article XVII Section 4, b.8 page 36, Verification sources page 38, & Section 15 page 49) CHOICE_CRE104 Assessment of Organizational Providers (see page 2 & 4) Description of Process: Practitioners and Organizational Providers are queried against the OIG & EPLS prior to credentialing, at the time of recredentialing, and on an ongoing basis between credentialing cycles. 	
Findings:		

The Provider Selection and Retention policy stated that DHMC would not contract with any provider or individual that is excluded from participation in federal health care programs under section 1128 and 1128A of the Social Security Act. The Medicaid Provider Contract stated that the provider was responsible to notify DHHA within 10 days if the provider becomes subject to any federal government agency action, including sanctions, exclusion or disbarment, or termination of his or her national provider number. The DHMC Credentialing and Recredentialing of Practitioners policy stated that the initial credentialing and recredentialing process included verification of any practitioner sanctions through the NPDB, OIG, EPLS, and State licensing databases, and that monthly screening of OIG and State licensing board sanctions was performed for all licensed health care professionals. The DHHA Medical Staff Bylaws outlined the elements considered in the DHHA physician credentialing application process, including verification of Medicare and Medicaid sanctions, and specified that ongoing monitoring of providers consisted of monthly review of federal program sanctions, limitations on licensure, and complaints. The Assessment of Organizational Providers policy stated that each contracted organizational provider attests to having a process in place to perform ongoing monitoring of its employees and licensed independent practitioners in accordance with CMS and State regulations, including monthly query of the OIG.

During the on-site interview, staff members confirmed that a monthly screen of all active practitioners in the network is run against the OIG, EPLS, NPBD, and State licensing board databases, and provided a sample monthly summary report. In addition, staff members stated that all providers who are employees of Denver Health are screened through Human Resources within DHHA. Staff members reported that positive identification of a provider in any database is investigated and the provider is terminated from the network. Staff members confirmed that there had been no Medicaid Choice providers terminated within the audit period.

Rea	uire	ed A	ctions:	
			CULOID	٠



Standard VII—Provider Participation and Program Inte	grity	
Requirement	Evidence as Submitted by Health Plan	Score
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, or owner (owning 5 percent or more of the Contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549.	 CHOICE_CONTRACT_PG_14.pdf (ARTICLE 9.16) CHOICE_CTS302.pdf (Section 1H) Description of Process: See policy CHOICE CTS 302 	
42CFR438.610		
DH Contract: (Amendment 3) II.F.5.m		
RMHP Contract: (Amendment 2) II.G.4.m		<u> </u>
excluded from participating in federal program procurement or in that any director, officer, principal or employee of the provider in	would not contract with a provider or individual who is debarred, sus non-procurement activities. The Medicaid Provider Contract stated the is not currently excluded, debarred, or otherwise ineligible to participal equired that the provider must notify DHHA if any of these individual	at the provider ensures ate in State or federal
	The state of the s	

The Provider Selection and Retention policy stated that DHMC would not contract with a provider or individual who is debarred, suspended or otherwise excluded from participating in federal program procurement or non-procurement activities. The Medicaid Provider Contract stated that the provider ensures that any director, officer, principal or employee of the provider is not currently excluded, debarred, or otherwise ineligible to participate in State or federal procurement or non-procurement programs. The contract also required that the provider must notify DHHA if any of these individuals become debarred during the term of the agreement. The Assessment of Organizational Providers policy stated that DHMC requires that each contracted organizational provider attest to having a process in place to perform ongoing monitoring of its employees and licensed independent practitioners in accordance with CMS and State regulations. The DHHA Investigative Reports policy stated that DHHA employees, trainees, contractors, interns, and volunteers are screened upon employment against a variety of background check databases, including the GSA and OIG lists of Excluded Individuals/Entities, and may be screened "for cause" thereafter. The policy stated that DH would not hire and may terminate existing employees based on matches in the investigative reports. During the on-site interview, staff members confirmed that all DHHA employees, which included the majority of the DHMC provider network, are screened by DHHA Human Resources upon employment. Staff members provided a sample report of a background check against the OIG list of excluded individuals.

Required Actions:	
None.	



Standard VII—Provider Participation and Program Integrity		
Requirement	Evidence as Submitted by Health Plan	Score
8. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.	 CHOICE_CRE101 Credentialing and Recredentialing of Practitioners (see PROCEDURE, Practitioner Rights D #III page 4) 	
42CFR438.12(a)(1) DH Contract: II.F.11 RMHP Contract: II.G.10	Description of Process: DHMC has a formal process for practitioner's to appeal a negative credentialing decision based on issues of quality	
denied participation in the network. The Credentialing and Recre Quality of Care Issues policy (within the DHHA medical staff by including reasons for the action, and the provider's right to apper inclusion in the network contained the reason for the decision and stated that unsolicited applications to join the network were infred DHHA nor DHMC had denied provider participation in the network	would issue a written notice with the reason for the decision to any predentialing of Practitioners policy and the Practitioner Rights and No ylaws) addressed the written notification of a provider regarding any al the action. The DHMC template letter for informing providers of and a description of the provider appeal rights. During the on-site interequent due to the employed provider model of DHHA. Staff members work during the audit period.	tification Based on credentialing decision, denied application for view, staff members
Required Actions: None.		
 9. The Contractor's provider incentive plans meet the following requirements: No specific payment can be made directly or indirectly under a provider incentive plan to a provider as an inducement to reduce or limit medically necessary services furnished to a member. The Contractor shall disclose to the Department or any member or member's designated client representative, at the Department's request, information on any provider incentive plan. The Contractor shall ensure that agreements containing physician incentives comply with 42 CFR Section 438.6. 42CFR438.6(h) DH Contract: II.F.3 RMHP: NONE 	 Member Handbook – page 6, "Physician Incentive Plans" CHOICE CTS301.pdf (SECTION B (3)) 	Met Partially Met Not Met Not Met



Standard VII—Provider Participation and Program Integ	grity	
Requirement	Evidence as Submitted by Health Plan	Score
inducement to reduce medically necessary services furnished to a information about provider incentives plans. The Utilization Revideny or limit medically necessary services. The member handbook	er incentive must comply with 42CFR438.6 and cannot be made dire a member. The policy stated that DHMC would disclose to HCPF and riew Determinations policy stated that compensation for UM did not ook stated that DHMC does not use physician incentive plans to "pay nembers confirmed that there is no incentive plan for practitioners.	d the member any provide incentives to
 arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards. The designation of a compliance officer and a compliance committee that are accountable to senior management. Effective training and education for the compliance officer and the Contractor's existing and new employees for reporting violations. Effective lines of communication between the compliance officer and the Contractor's employees. 	 The following documents address the administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse: MCD_CompliancePlan 2011.pdf; Code of Conduct 2011.pdf; CHOICE_ADM101.pdf; CHOICE_ADM104.pdf; F&A_Training Final.pptx; Federal and State Laws Training.pptx; MOU DH Managed Care- DH Office of Integrity for Auditing Svcs MCD Choice2012.pdf; CHOICE_MIS502.pdf. For the Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards refer to CHOICE_ADM101.pdf; Code of Conduct 2011.pdf - page 3; 2011.pdf; MCD_CompliancePlan 2011.pdf -page 8. For the designation of a compliance officer and a compliance committee that are accountable to senior management refer to MCD_CompliancePlan 2011.pdf -pages 3, 4, 12 For the Effective training and education for the compliance officer and the Contractor's existing and new employees for reporting violations refer to CHOICE_ADM101.pdf; CHOICE_ADM104.pdf; F&A_Training Final.pptx; MCD_CompliancePlan 2011.pdf -pages 4& 5. For the Effective lines of communication between the compliance officer and the Contractor's employees refer to MCD_CompliancePlan 2011.pdf -pages 1, 7; 	Met □ Partially Met □ Not Met □ N/A



Standard VII—Provider Participation and Program Integrity		
Requirement	Evidence as Submitted by Health Plan	Score
	 CHOICE_ADM104.pdf; F&A_Training Final.pptx slide 19. For Enforcement of standards through well-publicized disciplinary guidelines refer to MCD_CompliancePlan 2011.pdf –pages 8, 10; Code of Conduct 2011.pdf – page 23. For the Provisions for internal monitoring and auditing refer to CHOICE_ADM104.pdf, section B9; MOU DH Managed Care- DH Office of Integrity for Auditing Svcs MCD Choice2012.pdf For the Provisions for prompt response to detected offenses and for development of corrective action initiatives refer to Section C of CHOICE_ADM104.pdf 	

Findings:

The DHMC Corporate Compliance Program description, DHHA Integrity Program Overview/Code of Conduct, and numerous compliance policies documented DHMC's and DHHA's intent to comply with all laws and regulations related to ethical business practices, privacy and confidentiality, and fraud and abuse. The compliance program description stated that DHMC would partner with the DHHA Office of Integrity regarding compliance. The DHMC Corporate Compliance Program description named the Compliance Officer (CO) and described the responsibilities of the CO and compliance committee, who are accountable to the DHMC Executive Director and Board of Directors. The program description also addressed employee training by the DHHA Office of Integrity related to the code of conduct, fraud and abuse, auditing of claims, and other compliance issues. The program description described background investigations to determine whether prospective employees and contractors had been suspended or debarred and outlined multiple avenues for internal reporting of suspected fraud or compliance issues. The program description defined staff disciplinary actions for violations of compliance standards, as well as investigation and reporting of potential fraud to appropriate authorities. The DHHA Integrity Program Overview included an introductory statement by the CEO, identified the Chief Integrity Officer (with contact information), described the ethical framework of DHHA, outlined the components of the Code of Conduct (patient rights, confidentiality, business ethics, conflict of interest, workplace conduct, etc.), and described implementation processes, including reporting, investigation, corrective action, disciplinary actions, internal auditing, and training.

The Memorandum of Understanding (MOU) between DHMC and the DHHA Integrity Office stated that the integrity office would provide an internal auditor to annually review and evaluate DHMC's compliance with internal controls, information system controls, fraud detection and deterrence, claims processing, adjudication, and medical record testing. During the on-site interview, staff members stated that goals and the specific focus of the monitoring activities were determined annually and provided sample reports of a claims verification audit and a focused study. The Fraud, Waste and Abuse policy described employee F&A training (annually and upon employment), internal lines of reporting, and non-retaliation/whistle-blower protections. The Federal and State Laws online training and Fraud & Abuse Awareness online training provided an overview of specific laws and internal procedures related to compliance and fraud and abuse. During on-site review, staff members demonstrated the online employee training system, which must be completed by



Standard VII—Provider Participation and Program Integrity		
Requirement	Evidence as Submitted by Health Plan	Score
every employee of DHMC annually. Staff members stated that of	completion is tracked electronically. Staff members also stated that de	epartment directors
were responsible for assuring employee completion and that hur	man resources oversees organization-wide compliance by department	S.
Required Actions:		
None.		
 The Contractor's Compliance program includes the following: Approval of the Compliance plan by the Contractor's CEO and Compliance Officer. Submission of the compliance plan to the Department for review. Provisions for monitoring members for improper prescriptions for controlled substances, inappropriate emergency care, or card-sharing. Effective processes to screen all provider claims collectively and individually for potential fraud, waste, or abuse. Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste, and abuse. Effective mechanisms to identify and report suspected instances of upcoding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided. Effective processes for reporting fraud, which include:	 Approval of the Compliance plan by the Contractor's CEO and Compliance Officer is addressed on page 4 of the MCD_CompliancePlan.pdf For the Submission of the compliance plan to the Department for review refer to MCD_CompliancePlan.pdf - the updated Compliance Plan document that is included with this requirement. For the Provisions for monitoring members for improper prescriptions for controlled substances and inappropriate emergency care refer to Section B4 & B5 of CHOICE_ADM104.pdf For the Provisions for monitoring members for for card-sharing refer to Section B6 of CHOICE_ADM104.pdf and to the following documents: P-2.070 Two Patient Identifiers and Patient Identification Bands.pdf; PR-1.2 Verification of Identity and Address at Registration.pdf; PR-5.150 Med ID Theft-Prevention Detection and Mitigation.pdf For the Effective processes to screen all provider claims collectively and individually for potential fraud, waste, or abuse refer to Section B3 of CHOICE_ADM104.pdf For the Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste, and abuse refer to CHOICE_ADM104.pdf For the Effective mechanisms to identify and report suspected instances of upcoding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided refer to 	Met □ Partially Met □ Not Met □ N/A



Standard VII—Provider Participation and Program Integrity						
Requirement	Evidence as Submitted by Health Plan	Score				
the Contractor shall continue to investigate and submit a final report within 15 business days (further extension may be approved by the contract manager). The Contractor reports known, confirmed intentional incidents of fraud and abuse to the Contract Manager and to the appropriate law enforcement agency, including the Colorado Medicaid Fraud Control Unit. **DH Contract: II.F.5** RMHP Contract: II.G.4**	 CHOICE_ADM113.pdf; CHOICE_ADM104.pdf - section B3 and MOU DH Managed Care- DH Office of Integrity for Auditing Svcs MCD Choice2012.pdf The Effective processes for reporting fraud is outlined in Section C of CHOICE_ADM104.pdf. 					

Findings:

The Corporate Compliance Program description stated that the program was subject to approval by the DHMC Executive Director and Compliance Officer, and Denver Health Medical Plans' Board of Directors minutes documented approval of the current compliance plan. During the on-site interview, the Department contract manager confirmed that the DHMC Compliance Plan was previously submitted to the Department. The Fraud, Waste and Abuse policy outlined processes for detecting fraud, which included:

- Staff reporting of suspected fraud and abuse
- Claims adjudication edits for screening for suspicious claims
- Roles of the DHMC medical director and DHHA credentialing department regarding practitioner credentialing concerns
- Monitoring of controlled substances by the pharmacy benefit manager
- Managing frequent ED visits
- Prevention of card-sharing by members
- Timely reporting of fraud to appropriate authorities, including the Department

The Medicaid Recipient Verification Procedure outlined the process for member verification of services received to identify potential cases of fraud. The Memorandum of Understanding (MOU) between DHMC and the DHHA Integrity Office addressed the responsibility of the integrity office to conduct medical record verification of DHMC claims annually. The annual audit report from the Office of Integrity included detailed analysis of a sample of claims against medical record documentation and included recommendations for improvement.

During the on-site interview, staff members stated that claims detail was analyzed weekly for identification of duplicate submissions or other outliers, and that an updated electronic fraud and abuse-oriented claims auditing system would be implemented in coming weeks. Staff members also described routine QI auditing of medical records for compliance with medical record completeness and accuracy. Staff members described the process for screening of



Standard VII—Provider Participation and Program Integrity				
Requirement	Evidence as Submitted by Health Plan	Score		
potential member prescription fraud was identified, investigated a documentation tracking system for the identification, investigated	sions to prevent members from narcotics shopping. Staff members reported, and reported to HCPF during the audit period. Staff members reportation, and timely reporting of suspected fraud had been delayed due to attine review of compliance policies and procedures, as well as audit a	ted that development of turnover in the CO		
 12. The Contractor's compliance program includes written policies for employees, requiring all employees to be informed of and detailing compliance with: The False Claims Act 31 USC 3729, et seq. Administrative remedies for false claims and statements. State laws relating to civil or criminal penalties for false claims and statements, if any. Whistleblower protection under such laws. DH Contract: II.F.5 RMHP Contract: II.G.4	 The requirements for all employees to be informed of and detailing compliance with: The False Claims Act 31 USC 3729, et seq. is addressed in CHOICE_ADM104.pdf & F&A_Training Final.pptx The Administrative remedies for false claims and statements is addressed in CHOICE_ADM104.pdf; CHOICE_ADM101.pdf and F&A_Training Final.pptx. State laws relating to civil or criminal penalties for false claims and statements, if any are outlined in F&A_Training Final.pptx (slides 12 & 8) Whistleblower protection under such laws is outlined in the MCD_CompliancePlan 2011.pdf –page 8; in Section B1c of CHOICE_ADM104.pdf; F&A_Training Final.pptx (slide 11). 			
Findings: The Fraud, Waste, and Abuse policy included a description of the False Claims Act and Whistleblower protection. The Corporate Compliance Plan described DHMC's intent to comply with the Health Insurance Portability and Accountability Act (HIPAA), the False Claims Act, the Fraud Enforcement and Recovery Act, Anti-Kickback Statutes, the Medicare Modernization Act, the Beneficiary Inducement Statute, the Deficit Reduction Act, the Identity				
Theft and Red Flag Rules, and the Whistleblower Employee Protection Act. The Fraud & Abuse Awareness power point, utilized in annual employee compliance training, reviewed the False Claims Act and other laws, as well as administrative remedies and potential legal penalties related to false claims. Required Actions: None.				



Standard VII—Provider Participation and Program Integrity					
Requirement	Evidence as Submitted by Health Plan	Score			
 13. The Contractor provides that Medicaid members are not held liable for: The Contractor's debts in the event of the Contractor's insolvency. Covered services provided to the member for which the State does not pay the Contractor. Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contract, referral, or other arrangement. Payments for covered services furnished under a contractual, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. 	 CHOICE_CONTRACT_PG_9_10_11.pdf (ARTICLE 4.4, 5.1) MOU DH Managed Care- DH Office of Integrity for Auditing Svcs MCD Choice2012.pdf 				
member in any event, including nonpayment by DHHA, DHHA DHMC Provider Manual stated that members shall not be held to During the on-site interview, staff members stated that there have	not charge members any fees for covered services and will not seek a insolvency or breach of contract, or termination of DHHA's contract financially liable for any of the circumstances as outlined 42CFR 438. We been very few instances of providers billing members for covered surding billing. In addition, staff members described the process of sendat the services had been provided and not billed to the member.	t with the State. The .106. (specified).			
None					



Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	<u>13</u>	Χ	1.00	=	<u>13</u>
	Partially Met	=	<u>0</u>	Χ	.00	=	<u>0</u>
	Not Met	=	<u>0</u>	Χ	.00	=	<u>0</u>
	Not Applicable	=	<u>0</u>	Χ	NA	=	<u>0</u>
Total Applicable = $\underline{13}$ Total Score = $\underline{13}$							

Total Score + Total Applicable	=	<u>100%</u>
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Standard IX—Subcontracts and Delegation		
Requirement	Evidence as Submitted by Health Plan	Score
The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. 42CFR438.230(a)(1) Contract: II.G.1 RMHP Contract: II.H.1	 P&P CHOICE_CRE105 Delegation of Credentialing Activities (See POLICY statement page 1 &RESPONSIBILITY DHMC's #b page 2) CHOICE_CTS305.pdf – page 1, "Responsibility" Description of Process: P&P CHOICE_CRE105 describes the process and responsibilities for any entities DHMC has delegated credentialing agreements with, and that DHMC is ultimately responsible for all credentialing activities. 	Met Partially Met Not Met N/A
agreement shall release DHMC of any responsibility for performance. The Delegation of Credentialing Activities policing retain full authority and responsibility for oversight of delegations.	ne Delegation/Subcontracting policy) included the provision that be branched the duties required by the DHMC managed care contractly (the Delegation of Credentialing policy) included the provision and recredentialing activities, as did the delegating performed by DHMC demonstrated DHMC's intent to maintain	act with the that DHMC shall on agreements with
Before any delegation, the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated. ### 42CFR438.230(b)(1) Contract: II.G.1 RMHP Contract: II.H.1	 P&P CHOICE_CRE105 Delegation of Credentialing Activities (see PROCEDURES A page 4.) CHOICE_CTS305.pdf – page 2, Procedure A.2. Description of Process: PROCEDURES A. in CRE105 outlines the predelegation and initial delegation activities for credentialing; a part of the process for assuring a provider is able to perform the activities being delegated. 	
Findings: The Delegation/Subcontracting policy included the process for activities could include: Request for information or request for proposal (RFP) On-site assessment	or predelegation evaluation of potential subcontractors. The prede	legation evaluation



Standard IX—Subcontracts and Delegation		
Requirement	Evidence as Submitted by Health Plan	Score
 Reference checks with the potential subcontractor's existing Financial solvency review Review of the delegate's applicable policies and procedure 		
 Predelegation evaluation activities could include: Review of potential delegate's credentialing program desc Review of current roster of credentialed practitioners Submission of DHMC credentialing policies and procedur Possible site visit Review of credentialing files 	•	
The Delegation of Credentialing policy also stated that if the d recredentialing, ongoing monitoring), a predelegation evaluati	lelegate is NCQA accredited in all three categories of credential on is not required.	ing (credentialing,
benefit management [PBM] organization). The predelegation of	t in January 2012, DHMC entered in to a new contract with Medevaluation for MedImpact included an RFP process with evaluation he DHHA Board of directors (as evidenced by Board of Directors)	tion by the applicable
Required Actions:		
None. The Contractor has written policies and precedures for	P&P CHOICE CRE105 Delegation of Credentialing	Met
3. The Contractor has written policies and procedures for the monitoring of subcontractor performance, monitors the subcontractor's performance on an ongoing basis, and subjects it to a formal review according to a periodic schedule established by the State, consistent with industry standard.	 P&P CHOICE_CRE105 Delegation of Credentialing Activities (See PROCEDURES B, Ongoing Delegation Activities page 4) Delegated Cred Audit tool.docx CHOICE_CTS305 – page 3, Procedure C. 	Partially Met Not Met N/A
42CFR438.230(b)(3) Contract: II.G.3 RMHP Contract: II.H.3	Description of Process: DHMC performs yearly audits on entities it has delegation agreements with using a standardized audit tool based on NCQA standards and the 8/30 file review	

rule.



Requirement Evidence as Submitted by Health Plan Score

Findings:

The Delegation/Subcontracting policy included the general provision for development of specific policies and procedures related to the tasks being monitored and included provisions for monitoring the delegate for compliance with the provisions of the specific delegation agreement. The Delegation of Credentialing policy described annual evaluation of the delegate's credentialing, recredentialing, and practitioner monitoring processes. The annual review included review of the delegate's policies, procedures, and Credentialing Committee meeting minutes. The policy also described the requirement for periodic reporting to DHMC. The Delegation of Credentialing policy also stated that if the delegate is NCQA accredited in all three categories of credentialing (credentialing, recredentialing, and ongoing monitoring), an annual evaluation is not required. Ongoing monitoring discussed and reviewed on-site for DHMC's delegates was as follows:

- DHHA Medical Staffing Office for credentialing and recredentialing:
 - Monthly reports of current, added, and terminated providers
 - Annual audit/review of policies and procedures against NCQA standards
 - Annual review of the delegate's Credentialing Committee meeting minutes
 - Annual review of the delegate's provider application content
 - Annual audit of credentialing and recredentialing records
- University Physicians Incorporated (UPI) for credentialing and recredentialing
 - Monthly reports of current, added, and terminated providers
 - Annual audit/review of policies and procedures against NCQA standards
 - Annual review of the delegate's Credentialing Committee meeting minutes
 - Annual review of the delegate's provider application content
 - Annual audit of credentialing and recredentialing records
- MedImpact for PBM services and pharmacy claims management
 - Annual review/revision of the Plan Oversight List, which was a DHHA internal document describing all monitoring and oversight activities, documents due from the PBM, and key indicators for the monitoring of the delegate's performance
 - DHHA provided a list of participants for the weekly joint operating teleconference
 - The Project log for MedImpact consisted of an electronic log (database) that documented issues arising from daily operations, or weekly teleconferences, the log assigned staff to address the issue and tracked actions needed and "open" and "completed" dates
 - The MedOptimize Reports Catalog provided examples of reports DHHA may access at any time related to key performance indicators
 - The MedFocus Report provided sample reports sent quarterly to DHHA for review; examples included Benefit/Cost Distribution, Claims Summaries, Utilization, and utilization by drug category

On-site, DHHA staff members also provided an example of the project log that demonstrated oversight and monitoring of DHHA's previous PBM, CVS/Caremark.

Required Actions:

None.



Standard IX—Subcontracts and Delegation		
Requirement	Evidence as Submitted by Health Plan	Score
4. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action. 42CFR438.230(b)(4) Contract: II.G.4 RMHP Contract: II.H.4	 For 2011, no deficiencies were identified during delegated credentialing audits which required corrective actions CHOICE_CTS305.pdf – page 2, Procedure B.3.c. Description of Process: DHMC performs yearly audits of entities with delegated credentialing agreements (DHHA & UPI). If any deficiencies are found requiring corrective actions, the entity is required to submit a plan to correct, which is reviewed and approved by DHMC, and implemented by delegated entity. 	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A
breach of performance in any of the delegated requirements. The failure to satisfy requirements of the delegated scope of work.	greements must include a provision for corrective action or sanct The Delegation of Credentialing policy included the provision for Review of annual credentialing audits performed by DHMC in 2 DHHA or UPI during the review period. The MedImpact projec ff, and track action needed to completion date.	corrective action for 2011 for DHHA and
5. There is a written agreement with each delegate. 42CFR438.230(b)(2) Contract: II.G.2 RMHP Contract: II.H.2	 CHOICE_CRE105 Delegation of Credentialing Activities CHOICE_CTS305.pdf – page 2, Procedure B.3. Description of Process: DHMC has two entities with which it has delegated credentialing arrangements: it has an official agreement with both entities which describes the responsibilities of each party. 	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A



Standard IX—Subcontracts and Delegation		
Requirement	Evidence as Submitted by Health Plan	Score
Findings: The Delegation of Credentialing policy included the provision delegation relationship. The Delegation/Subcontracting policy following signed Delegation Agreements or Contracts on site: DHMC/DHHA—an interagency MOU between DHMC (Staffing Office of DHHA for credentialing and recredential DHMC/UPI—for delegation of credentialing and recredential delegation of credentialing and recredential delegation of credential delegation of credential delegation of credential delegation delegat	n for DHMC to have a letter of agreement for each entity with why included a list of the required content for delegation agreements: the managed care division is a line of business within DHHA) and	. HSAG reviewed the d the Medical DHMC members
Required Actions:	ianagement, Filarmacy Ciannis Management, and Filarmacy Netw	OIK Management
 None. The written delegation agreement: Specifies the activities and reporting responsibilities delegated to the subcontractor. Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. Provides for access to all records by the Secretary of the U.S. Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. 	 CHOICE_CRE105 Delegation of Credentialing Activities CHOICE_CTS305.pdf – page 2, Procedure B.3.a, d, e. 	Met Partially Met Not Met Not A
attachment to the Delegation of Credentialing policy was a ter	nt for delegation agreements, which included all of the required complate agreement, which included tasks and standards for delegated dentialed, recredentialed, or terminated. The DHMC/DHHA MOU deltall of the required provisions.	ted credentialing



Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	<u>6</u>	Χ	1.00	=	<u>6</u>
	Partially Met	=	<u>0</u>	Χ	.00	=	<u>0</u>
	Not Met	=	<u>0</u>	Χ	.00	=	<u>0</u>
	Not Applicable	=	<u>0</u>	Χ	NA	=	<u>NA</u>
Total Ap	plicable	=	<u>6</u>	Total	Score	=	<u>6</u>

Total Score + Total Applicable	=	<u>100%</u>
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Appendix B. Appeals Record Review Tool for Denver Health Medicaid Choice

The completed record review tool follows this cover page.



Appendix B. Colorado Department of Health Care Policy & Financing FY 2011–2012 Appeals Record Review Tool for Denver Health Medicaid Choice

Review Period:	January 1, 2011–December 31, 2011
Date of Review:	February 14, 2012–February 16, 2012
Reviewer:	Barbara McConnell
Participating Health Plan Staff Member:	Rich French, Carola Webb

Part	icipating Hea	alth Plan St	aff Member:	f Member: Rich French, Carola Webb								
1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknow- ledgment Letter	Acknow- ledgment Within 2 Working Days	Decision- maker— Previous Level	Decision- maker— Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
1	*****	2/3/11	2/3/11	M⊠N□	M⊠ N□ U□	NA	Y□N⊠	Y□N⊠	2/11/11	$M \boxtimes N \square$	M⊠N□	M⊠N□
review followi	Comments: The acknowledgement letter was difficult to understand and included information that did not apply to the member. Acknowledgement letter templates had been revised during the review period to improve understandability. Staff members reported that the new templates were saved in the system for implementation in approximately July 2011. No appeals occurred following implementation of the new templates. The appeal was related to the request for weight loss medication, which is a noncovered medication under the Medicaid managed care contract. An individual with clinical expertise was not required to make this appeal decision.											
2	*****	2/21/11	2/21/11	M⊠N□	M⊠ N□ U□	NA	Y□N⊠	Y□N⊠	2/25/11	M⊠N□	M⊠N□	M⊠N□
Comn	Comments: The appeal was related to the request for weight loss medication, which is a noncovered medication under the Medicaid managed care contract. An individual with clinical expertise											

Comments: The appeal was related to the request for weight loss medication, which is a noncovered medication under the Medicaid managed care contract. An individual with clinical expertise was not required to make this appeal decision.

3 ****** 4/18/11 4/18/11 M⊠ N□ M⊠ N□ U□ NA Y□ N⊠ Y□ N⊠ 4/28/11 M⊠ N□ M⊠ N□ M□ N⊠

Comments: The appeal was related to an inpatient hospitalization at an out-of-network facility. The member had not known she was auto-enrolled by the State. The reason for the appeal decision was based on the State approving retroactive disenrollment from Denver Health to fee-for-service Medicaid. An individual with clinical expertise was not required to make this decision. The reason, as stated in the resolution notice to the member, stated the State's disenrollment decision without explaining to the member the implications for the member, and assurance that the member was not responsible for the cost of the services. DHMC should consider including further explanations in the reasons stated in the resolution notice to ensure understandability.

# Applicable Elements	3	3	0		3	3	3
# Compliant Elements	3	3	NA		3	3	2
Percent Compliant	100%	100%	NA		100%	100%	67%

Note: M = Met, N = Not met, U = Unknown, Y = Yes, N = No

Total # Applicable Elements	15
Total # Compliant Elements	14
Total Percent Compliant	93%



Appendix C. Site Review Participants for Denver Health Medicaid Choice

Table C-1 lists the participants in the FY 2011–2012 site review of **DHMC**.

Table C-1—HSAG Reviewers and Health Plan Participants				
HSAG Review Team	Title			
Barbara McConnell, MBA, OTR	Project Director			
Katherine Bartilotta, BSN	Project Manager			
Debra Harris	Compliance Auditor			
DHMC Participants	Title			
Ron Aguilar	Provider Relations			
David Brody	Managed Care Medical Director			
Sherry DiQuinzio	Credentialing			
Leann Donovan	Executive Director			
Rich French	Director, Member Services			
Laurie Goss	Director of Marketing for Managed Care			
Aygul Gumerova	Compliance Analyst			
Craig Gurule	Government Program Manager			
Scott Hoye	Senior Assistant General Counsel			
Taliah Lauf	Government Products Specialist			
Chryss MacGowan	Director, Pharmacy			
Deb Mitchum	Director of Case Management			
Tasha Oliver	Quality Improvement Intervention Manager			
Lorna Pate	Compliance Director			
Mary Pinkney	Director of Quality Improvement/Accreditation			
Sue Tripathi	Quality Improvement Manager			
Carola Webb	Customer Service Manager/Grievances and Appeals			
Pat Williams	Claims Manager			
Department Observers	Title			
Russell Kennedy	Quality and Compliance Specialist			
Valerie Baker-Easley	Contract Manager			
Teresa Craig	Contract Manager			



Appendix D. Corrective Action Plan Process for FY 2011–2012

for Denver Health Medicaid Choice

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

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



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

The template for the CAP follows.



Table D-2—FY 2011–2012 Corrective Action Plan for DHMC						
Standard #: Description						
Requirement Findings Required Actions						

Denver Health Medicaid Choice scored 100 percent on each of the four standards and does not have any corrective actions for FY 2011–2012.



Appendix E. Compliance Monitoring Review Activities

for Denver Health Medicaid Choice

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

	Table E-1—Compliance Monitoring Review Activities Performed
For this step,	HSAG completed the following activities:
Activity 1:	Planned for Monitoring Activities
	 Before the compliance monitoring review: HSAG and the Department held teleconferences to determine the content of the review. HSAG coordinated with the Department and the health plan to set the dates of the review. HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. HSAG staff attended the Medical Quality Improvement Committee (MQUIC) meetings to discuss the FY 2011–2012 compliance monitoring review process and answer questions as needed. HSAG assigned staff to the review team. Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the health plans were prepared for the compliance monitoring review.
Activity 2:	Obtained Background Information From the Department
	 HSAG used the BBA Medicaid managed care regulations and the health plan's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tool, and report template. HSAG submitted each of the above documents to the Department for its review and approval. HSAG submitted questions to the Department regarding State interpretation or implementation of specific managed care regulations or contract requirements. HSAG considered the Department's responses when determining compliance and analyzing findings.
Activity 3:	Reviewed Documents
	 Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the desk review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.



	Table E-1—Compliance Monitoring Review Activities Performed
For this step,	HSAG completed the following activities:
	 The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	Conducted Interviews
	 During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance.
Activity 5:	Collected Accessory Information
	 During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.) HSAG reviewed additional documents requested as a result of the on-site interviews.
Activity 6:	Analyzed and Compiled Findings
	 Following the on-site portion of the review, HSAG met with health plan staff to provide an overview of preliminary findings. HSAG used the FY 2011–2012 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. HSAG analyzed the findings and assigned scores. HSAG determined opportunities for improvement based on the review findings. HSAG determined actions required of the health plan to achieve full compliance with Medicaid managed care regulations and associated contract requirements.
Activity 7:	Reported Results to the Department
	 HSAG completed the FY 2011–2012 Site Review Report. HSAG submitted the site review report to the health plan and the Department for review and comment. HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. HSAG distributed the final report to the health plan and the Department.