State of Colorado

Department of Health Care Policy & Financing

Office of Medical Assistance

Quality Improvement Section

FY2005 COMPLIANCE MONITORING REPORT *for* MANAGEMENT TEAM SOLUTIONS

January 2005

I. History, Purpose and Origin of Medicaid Managed Care Entity Site Review

As part of the Colorado Department of Health Care Policy & Financing's (the Department's) overall effort and commitment to ensure quality of care and access to services for Medicaid members, the Department developed and implemented an annual site review process in 1999. The objective of the site review is to evaluate all managed care entities (MCEs) that contract with the Department for contractual and regulatory compliance. The Balanced Budget Act of 1997 specified additional requirements for MCEs. These requirements were incorporated into all FY03-04 MCE contracts. The Department began monitoring MCEs for the new requirements in addition to the existing requirements during the FY03-04 site review schedule.

Each site review involves the development of a monitoring tool. Development of the tool begins at the Department, where areas of contract compliance are selected and general questions are drafted. The draft tool is distributed to various areas within the Department for feedback. Once approved, the final tool is then distributed to the MCEs and a site review schedule is determined. In FY03-04, the Department follows the External Quality Review Monitoring Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans Protocol (Final Version 1.0, February 11, 2003) to monitor for federal compliance. A monitoring tool was developed by the Department that incorporated questions from the protocol and from the current contract.

The site review process (as outlined in II.H.4.b.of the contract between the Department and the MCE), consists of a desk review and a site visit to the MCE. Sixty (60) days prior to the site review, the Department requests documentation from the MCE in order to determine contractual and regulatory compliance. The MCE is required to submit materials (in electronic format) within thirty (30) days after receiving the desk review request. The materials submitted by the MCE are reviewed by the site review team for the presence or absence of evidence to demonstrate compliance within the documents. The evaluation of materials submitted during the desk review (document review) allow for development of additional interview questions and further clarification during the interview sessions conducted on site.

Document review is an important part of determining compliance. A greater understanding of the document content can be determined by interviewing MCE personnel as part of the site review. Interviews are also an effective method in order to determine the degree of compliance with the requirements. Interviews provide clarification, by revealing the extent to which what is documented is actually implemented. Interviews also provide an opportunity to explore any issues that were not fully addressed in documents, and also provide a better understanding of the MCEs' performance. A broad overview of the preliminary site review findings are presented to MCE at the conclusion of the site review.

Thirty (30) days after the site review, the Compliance Monitoring Report is sent to the MCE for their review and to comment on any inaccuracies in the initial report. The MCE has thirty (30) days to respond to the Department. Comments from the MCE are reviewed and corrections may be made to the final report. The Final Compliance Monitoring Report indicates areas that require the MCE to produce a Corrective Action Plan (CAP). The CAP is developed by the MCE and submitted for approval to the Department within thirty (30) days of the final report. The CAP

shall be specific and include timeframes for completion. The Department monitors the MCE's CAP objectives and timeframes.

II. Site Review Protocol

On February 1, 2004, the Department entered into a contract with Management Team Solutions (MTS) to serve as a Primary Care Case Manager (PCCM). This is the first site review of MTS. This evaluation is designed to determine MTS's compliance with various contractual and regulatory requirements and to review individual MCE member records for evidence of case management and care coordination. This report documents the results of the FY04-05 compliance monitoring for MTS. The report provides findings for MTS regarding its performance in complying with the 13 evaluation standards, the elements of the record review and evaluation and feedback acquired throughout the interview sessions for each evaluation standard.

The 13 evaluation standards are derived from the requirements as set forth in the contract agreement between the Department and MTS, Colorado Regulations 10 CCR 2505-10, 8.000 et seq. and the requirements as specified by the Centers for Medicare & Medicaid Services (CMS) regulations. These requirements are outlined under the CMS Protocols for External Quality Review of Medicaid Managed Care Organizations and Prepaid Inpatient Health Plans (Final Protocol Version 1.0 February 11, 2003).

The 13 standards include: Subcontracts and Delegation, Provider Issues, Marketing, Advance Directives, Practice Guidelines, Member Rights and Responsibilities, Access and Availability, Utilization Review, Continuity of Care, Quality Assessment and Performance Improvement (QAPI) Documentation, Quality Assurance Program, Covered Services and Coordination with Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

III. Site Review Findings

The findings for this annual site review were determined following a desk review of documents submitted to the Department prior to the site review, and observations, interviews with key MTS staff and record reviews conducted during the site visit. The site review team assigned MTS a finding for each element and aggregately, for each standard. Details regarding MTS's compliance with the evaluation standards, including the findings MTS received for each of the elements in each standard, can be found in Section V of this report.

For the evaluation tool standard, the individual elements of each standard were rated "Met," "Partially Met," "Not Met," or "Not Applicable." A summary finding for each evaluation tool standard was then determined by adding the number of compliant elements MTS received out of the number of applicable elements.

For the record reviews, each record review area was evaluated based on the total number of MTS's compliant elements out of the applicable elements for each individual record reviewed.

A finding for each record review area was determined based on the percentage of MTS's compliant points out of applicable points.

IV. Conclusions

MTS received two (2) "Met" findings, one (1) "Partially Met" finding and seven (7) "Not Met" findings out of ten (10) total applicable evaluation tool standards. Three (3) evaluation tool standards were Not Applicable (N/A).

30 of the "Total Compliant Elements" received a "Not Met" out of a total 30 applicable elements for the Chart Review. The Chart Review Summary is located within Standard IX: Coordination and Continuity of Care.

Details of the findings are provided, by standard element, in Section V. Specific strengths and opportunities identified for each standard are provided within each particular section. MTS is required to submit a CAP for any standard elements receiving a finding of *Partially Met* or *Not Met*. The CAP(s) will be submitted to the Department for review and approval prior to implementation. The CAP(s) should identify the areas of noncompliance, the proposed changes to achieve compliance, the individual(s) responsible and the timeline for completion of the proposed changes.

V. Evaluation Overview

This section of the report describes the strengths and opportunities for improvement for each of the 13 standards included in the Department's FY04-05 PCCM Evaluation Tool. The evaluation tool was used to conduct a site review of MTS from November 29-December 2, 2004.

Standard I: Subcontracts and Delegation

Staff Present at Site Review:
MTS: Rita DeHerrera, Sue Takaki and Molly Thorson.

Department: Craig Gurule, Sandra DeSanto-Mortensen and Maureen Wallner (Lead).

Department Summary of Review:
Currently, MTS does not subcontract or delegate any activity.

Score for this Area:
Not Applicable

Corrective Action Plan and Timeframe:
None

Area of Opportunity:
None

Standard II: Provider Issues

Staff Present at Site Review:
MTS: Molly Thorson, Sue Takaki and Rita DeHerrera.

Department: Craig Gurule, Sandra DeSanto-Mortensen, Sue Tripathi and Maureen Wallner (Lead).

Department Summary of Review:
There are currently 26 primary care providers (PCPs) in the MTS network. The MTS provider agreement does not contain sufficient detail regarding the specific responsibilities of the provider. The agreement also does not contain sufficient provisions for imposing sanctions if the providers' performance is inadequate.

MTS is required to monitor covered services rendered by providers for quality, appropriateness, and patient outcomes. No policies and procedures are in place to document that this level of monitoring is occurring. No details were provided outlining the process regarding CAPs for providers who fail to perform.

MTS states that it's Utilization Management/Quality Improvement (UM/QI) Committee will review any quality of care concerns. The revised MTS (November 2004) Utilization Management and Quality Improvement Policy and Procedures Manual reflect some procedures for how quality concerns will be handled but the procedures in this manual have not been implemented. MTS provided a list of physicians that may be utilized for quality of care reviews; however, there is no detail in the manual about the process or confidentiality of findings. To date, MTS states that the committee has not received any quality concerns about physicians.

MTS is aware of the Client Overutilization Program managed by the Department and has specific procedures listed in the manual about how overutilization will be identified, tracked and addressed. MTS is also aware that county departments of social services handle member fraud allegations and specific procedures are listed in the manual for referring these members.

MTS states it is currently collecting information regarding a durable medical equipment (DME) provider for allegations of possible fraud. During the interview session, MTS indicated that once this information is collected it would be submitted to the UM/QI Committee for review. MTS did not report this instance of possible fraud to the Department within ten (10) business days as is contractually required.

MTS attested in writing to not knowingly having any prohibited relationships and that documentation was provided to the Department's Managed Care Section at the beginning of the contract. A copy was provided for review during the site review as well. The Department performs credentialing for MTS's physician population.

Score for this Area:
Not Met

Corrective Action Plan and Timeframe:
Final Corrective Action(s) shall be developed by the Contractor and approved by the Department.

At a minimum, the Corrective Action(s) shall address:

1. Amending the provider agreement to broaden MTS's authority, such as imposing sanctions for inadequate provider performance, requiring corrective actions plans and allowing for monitoring of covered services.
2. Developing comprehensive policy and procedures to reflect specific activities to be implemented for provider oversight and monitoring as required in the contract.
3. Ensuring fraud and abuse notification adheres to contractual and regulatory requirements.

Standard III: Marketing

Staff Present at Site Review:
MTS: Rita DeHerrera, Sue Takaki and Molly Thorson.

Department: Craig Gurule, Sandra DeSanto-Mortensen, and Maureen Wallner (Lead).

Department Summary of Review:
MTS does not participate in any marketing activities to any members. MTS refers members to the Primary Care Physician Program Member handbook (distributed by the Department's enrollment broker) for information regarding rights and responsibilities, advance directives, complaints and grievances, etc.

Score for this Area:
Not Applicable

Corrective Action Plan and Timeframe:
None

Area of Opportunity:
None

Standard IV: Advance Directive

Staff Present at Site Review:
MTS: Rita DeHerrera, Sue Takaki and Molly Thorson.

Department: Craig Gurule (Lead), Sandra DeSanto-Mortensen, Sue Tripathi, and Maureen Wallner.

Department Summary of Review:
Advance directives are currently contractually required however; this requirement will not be included in the FY06 contract. Therefore, MTS will not be evaluated on this standard/requirement.

Score for This Area:
Not Applicable

Corrective Action Plan and Timeframe:
None

Area of Opportunity:
None

Standard V: Practice Guidelines

Staff Present at Site Review:
MTS: Rita DeHerrera, Carolyn Hants and Molly Thorson.

Department: Craig Gurule, Sandra DeSanto-Mortensen (Lead), Sue Tripathi and Maureen Wallner.

Department Summary of Review:
MTS' focus is on "utilization guidelines" rather than "clinical practice guidelines." As outlined in the current contract, practice guidelines related to perinatal, prenatal and postpartum care for women; persons with special needs; and well child care are required.

Practice guidelines were identified as a standard to be met in the MTS provider manual. Practice guidelines are outlined as a quality initiative in the MTS quality improvement (QI) plan. The QI plan and provider manual describe that provider training on guidelines will be performed at the time a provider joins MTS and additional training will be provided which will be customized specific to provider data utilization outcomes. The program manager is responsible for physician training. There was no documentation available that guidelines had been discussed with or disseminated to providers.

Utilization data profiles are individualized for each provider and given at the time of a meeting with the program manager. Sample profiles provided to the Department at the time of site review were on the topics of emergency department visits and childhood immunizations. There was no documentation available that highlighted practice guidelines or data profiles on perinatal care, well child visits or persons with special health care needs.

The UM/QI Committee is responsible for guideline selection and adoption. Guidelines adopted by the Committee focus only on utilization guidelines and do not include practice guidelines. There is no documentation available that practice guidelines on perinatal care, well childcare or persons with special health care needs have been brought to the UM/QI Committee for review and or adoption. MTS did identify at a UM/QI meeting the desire to manage adult diabetics as it was felt to be prevalent in the population. There was no documentation or evidence presented at the time of site review that population data was used to make this decision. Therefore, it is unclear if population demographics are used to identify health needs in the population before guidelines are selected and adopted.

Score for This Area:
Not Met.

Corrective Action Plan and Timeframe: Final Corrective Action(s) shall be determined by the Contractor and approved by the Department. At a minimum, the Corrective Action(s) shall address:

1. Implementation and documentation of practice guideline selection and adoption process regarding perinatal, prenatal and postpartum care for women; persons with special needs and well child care.
2. Documentation of practice guideline dissemination to the provider population.

Standard VI: Member Rights and Responsibilities

Staff Present at Site Review:
MTS: Rita DeHerrera, Sue Takaki and Molly Thorson.

Department: Craig Gurule (Lead), Sandra DeSanto-Mortensen, Maureen Wallner and Sue Tripathi.

Department Summary of Review:
Desk review and site review documentation submitted by MTS refer to "Medicaid Department Policy on Member Rights and Responsibilities". However, the Department does not have a policy on member rights and responsibilities. MTS is contractually required to "establish and maintain written policies and procedures regarding the rights and responsibilities of Members that incorporate the rights and responsibilities identified by the Department in this contract." MTS is also required to ensure that its staff and affiliated providers take member rights into account when furnishing services to members. There is no evidence that MTS staff and providers have received training and are monitored regarding their responsibility concerning member's rights.

The potential exists for inconsistent member referrals to interpretative services. Documentation provided by MTS indicates they are developing "a partnership with Mountain Centers for Interpretation & Translation". Additional information regarding the implementation or final outcome of this partnership was not included. However, the member handbook distributed by the Department's enrollment broker references The Language Line for translation services. The documentation submitted by MTS and referenced by MTS providers make providers aware of The Language Line as a resource for translation services.

A copy of policies on members' rights and responsibilities is required to be distributed to providers by MTS. The provider manual developed by MTS which outlines the members' rights and responsibilities is scheduled for distribution to providers pending the results of the site review.

Score for This Area:
Not Met

Corrective Action Plan and Timeframe:
Final Corrective Action(s) shall be determined by the Contractor and approved by the Department. At a minimum, the Corrective Action(s) shall address:

1. Distributing a description of the members' rights and responsibilities to MTS staff and providers.
2. Developing and implementing a process to ensure member rights are taken into account when furnishing services to members.
3. Developing a procedure for member referrals to interpretation services that clearly define services/resources to be used.

Standard VII: Access and Availability- Service Delivery

Staff Present at Site Review:
MTS: Rita DeHerrera, Dr. Grace Nweke and Molly Thorson.

Department: Craig Gurule (Lead), Sandra DeSanto-Mortensen, Sue Tripathi and Maureen Wallner.

Department Summary of Review:
MTS utilizes existing Medicaid providers or recruits providers to participate in the Medicaid program. At the time of the site review, 26 providers have contracted with MTS.

MTS is contractually required to ensure members have access to appropriate services on a 24-hour per day basis and written polices and procedures on how this will be achieved. Monitoring access and availability requirements are not contractually required in the MTS provider agreements or referenced in material currently distributed to providers. In addition, policies and procedures outlining the monitoring of access and availability requirements have not been developed.

No evidence was provided to demonstrate that MTS ensures reasonable proximity of providers to members to prevent unreasonable barriers to access. Requirements regarding 24-hour availability of services, scheduling guidelines and wait times are specified in the contract between MTS and the Department; and although a monitoring system has been referenced in the documents, no evidence exists that the monitoring system has been implemented.

Score for this Area:
Not Met

Corrective Action Plan and Timeframe:
Final Corrective Action(s) shall be developed by the Contractor and approved by the Department.

At a minimum, the Corrective Action(s) shall address:

1. Updating provider agreement to specify monitoring access and availability requirements.

2. Developing a process to ensure reasonable proximity of providers to members, including identifying any potential barriers to access and monitoring of access requirements.

Standard VIII: Utilization Review

Staff Present at Site Review:
MTS: Carolyn Haunts and Molly Thorson.

Department: Craig Gurule, Sandra DeSanto-Mortensen and Maureen Wallner (Lead).

Department Summary of Review:
MTS conducts prospective, concurrent and retrospective reviews. Milliman and Robertson utilization criteria are applied to these reviews. Self-imposed timeframes of three (3) business days have been established for completion of these reviews. The revised Management Team Solutions Medicaid ASO Standards for Utilization Management and Quality Improvement Policy and Procedures Manual (November 2004) lists policies and procedures for how reviews will be completed.

MTS states that all reviews that result in a denial of services, with the exception of overlapping service dates, are referred to the Medical Director for review. The Contract requires any denial of service shall be made by a health care professional who has appropriate clinical expertise in treating the member's condition. Although a list of the available specialists was provided during the site review, documentation presented did not specify criteria necessary for MTS to consult with specialist. There was no documentation submitted outlining the peer review process.

Prospective Review
MTS performs prospective review for all Medicaid procedures, equipment and services that currently require review as well as all elective procedures.

Concurrent Review
MTS performs concurrent review for all admissions through the Emergency Department (ED) when the hospital notifies MTS. While this review method reflects good case management, the value of reviewing these cases on a daily basis and providing ongoing authorizations may only be beneficial for inpatient stays that are close to exceeding the maximum allowable days since these claims are paid by Diagnosis Related Group (DRG).

Retrospective Review
MTS performs retrospective review on a case by case basis and on cases that it did not conduct a prospective review. MTS relies on referrals from outside parties or initiates reviews based on high utilizers. High utilizers are defined by MTS as those member's who utilize a high volume of service and/or who exceed typical expenditures for their population. MTS states that case management is started at this point for appropriate members.

Several issues exist with the operational aspects of the utilization review program. MTS currently submits prospective review denials to Affiliated Computer Services (ACS), the Department's fiscal agent. MTS sends out a denial notice to the provider. ACS also sends out a denial notice to the member and the provider. This duplication is unnecessary and could result in communication errors. Additionally, different appeal rights are sent to the member and providers and can create confusion. MTS notifies providers of prospective review approvals via

fax or phone call. All prospective review approvals also must be sent to ACS. This is necessary to ensure that correct unit amounts and partially approved requests are data entered into the Medicaid Management Information System (MMIS) and are reflective of MTS's utilization review determination. The MMIS system is the claims payment system operated by ACS. MTS states they review all denials they have issued in the MMIS to ensure that providers have not billed or been paid for services that were not authorized.

The appeals process is experiencing difficulty since denial notices are sent out from both MTS and ACS. MTS' denial notice allows for submission of additional information as does the ACS notice. However, members and/or providers may be confused as to where to send additional information if they receive both notices. Additionally, MTS may not receive additional information if it is sent only to ACS and therefore may not be in compliance with the appeal rules. The appeal process should be streamlined by identifying which agency should send out notices and where additional information should be sent.

Score for this Area:
Met

Corrective Action Plan and Timeframe:
None

Area of Opportunity:

1. MTS should develop a comprehensive utilization review program including policies and procedures for conducting retrospective review on an ongoing basis and incorporate strategies for identifying target populations, services or claim types.

2. MTS should further develop concurrent and retrospective review methodologies to include processes for identifying when members are close to exceeding maximum allowed inpatient days and conducting retrospective review on an ongoing basis and incorporating strategies for identifying target populations, services or claim types.
3. Develop mechanisms to detect underutilization through better defined case management processes to support a comprehensive utilization management program.
4. Further develop the appeals process by discussing responsibilities with the Department and implementing necessary requirements.

Standard IX: Coordination and Continuity of Care

Staff Present at Site Review:
MTS: Rita DeHerrera, Carolyn Hants, Dr. Grace Nweke and Molly Thorson.

Department: Craig Gurule, Sandra DeSanto-Mortensen (Lead), Sue Tripathi and Maureen Wallner.

Department Summary of Review:
Documentation submitted by MTS outlines the responsibilities of MTS PCPs, which include providing case management and care coordination to members. Within the scope of case management, MTS requires the PCP to: indicate any significant illness or past medical conditions, identify past medical history, address any unresolved problems from previous office visits, maintain the rationale and results from any consultation requested, maintain advance directives, assess the member for any barriers to receiving health care, maintain an outcome-oriented treatment plan for members with chronic needs, involve the member and/or family in formulating the treatment plan and document any communication between the member's PCP and additional providers.

Members who utilize a high level of services are identified by MTS as high-risk members. MTS recognizes special needs members may be eligible for waiver programs and have initiated a review process to identify them. The process involves identifying members through excessive DME utilization. There was no process in place to screen members who were not high utilizers or a process to screen current and new members that may be special needs and or high-risk.

The focus of case management is over utilization of DME and ED. MTS states any identified cases for case management are brought to the UM/QI committee. A case review form was recently implemented by MTS to assist the UM/QI Coordinator in tracking referrals. There was documentation of cases being discussed at the QI/UM Committee with recommendations made for Social Worker evaluation.

Members who visit the ED are reviewed by the UM Coordinator on a weekly basis. Data is used to track for inappropriate utilization. Letters are sent to members if they were seen in the ED for conditions that could be treated in an ambulatory setting. For example, a member with four ED visits and no office visits was sent a letter from MTS identifying this person for inappropriate ED utilization. Criteria used by MTS to determine inappropriate utilization of services was not made available.

Chart Review: MTS provides care coordination and case management when members over utilize services or receive services that require a pre-authorization. Therefore, the initial chart request from the Department focused on over utilization and pre-authorization in order to review charts that would be likely to demonstrate care coordination and case management. At the time of the site review, it was determined these charts were not useful for evaluation of care coordination and case management and a request was made for additional records.

The Department requested ten (10) charts from MTS providers with dates of services February 1,

2004 to September 30, 2004; at least ten (10) billed office visits and or two (2) or more ED visits. These new charts were copies of clinic and office visits selected and deemed sufficient by MTS for review.

On two (2) separate occasions, the Department requested complete member charts to illustrate the manner in which MTS PCPs provide care coordination and case management. Of the ten charts reviewed, none demonstrated care coordination/case management. The criteria used by the Department to review charts are based upon criteria as outlined in documentation submitted by MTS. This criteria is listed in the following table:

Table X: Care Coordination/Case Management Chart Review Summary

Chart #, initials' dates of service reviewed	Criteria 1: Assessment of member for case mgmt/ care coordination	Criteria 2: Development of treatment plan	Criteria 3: Coordination with other service providers and agencies	Place of Service	# Office Visits during contract	# ED Visits	Was Chart Compliance Met?
1. MS 060104 to 112204	No evidence of assessment	No	No	Southwest Clinic	10	0	**No**
2. RC 010604 to 101804	No evidence of assessment	No	No	Southwest Clinic	12	0	**No**
3. JC 031504 to 102804	No evidence of assessment	No	No	Southwest Clinic	11	0	**No**
4. RR 010504 to 100504	No evidence of assessment	No	No	Southwest Clinic	10	0	**No**
5. MC 022304 to 111704	No evidence of assessment	No	No	Southwest Clinic	10	0	**No**
6. DC 011404 to 102904	No evidence of assessment	No	No	Southwest Clinic	10	0	**No**
7. LC 021104 to 110504	No evidence of assessment	No	No	Southwest Clinic	10	0	**No**
8. CA 010204 to 102704	No evidence of assessment	No	No	Private practice	11	0	**No**

Chart #, initials' dates of service reviewed	Criteria 1: Assessment of member for case mgmt/ care coordination	Criteria 2: Development of treatment plan	Criteria 3: Coordination with other service providers and agencies	Place of Service	# Office Visits during contract	# ED Visits	Was Chart Compliance Met?
9. TL 061604 to 102804	No evidence of assessment	No	No	Private practice	1	4	**No**
10. TB 122303 to 111704	No evidence of assessment	No	No	Private practice	29	*Unable to determine	**No**

*Per the office notes, only one ED visit was documented, yet notes refer to frequent ED utilization.

In addition, the above-mentioned ten (10) charts were also used to evaluate PCP case management using four (4) out of a possible ten (10) MTS-developed criteria as outlined in documentation submitted by MTS. The four (4) criteria selected by the Department were determined based upon the information provided within each chart.

- Outcome-oriented treatment plans for members with chronic health needs was not evident in any of the charts.
- Unresolved problems expressed by members from previous office visits were addressed by providers in six (6) of the ten (10) charts reviewed.
- Assessment performed of barriers to optimal health care (i.e. financial, support system, communication, literacy, disabilities, psychiatric and or risk behavior) was not evident in any of the charts.
- There was no evidence of member and/or family involvement in formulating the treatment plan in any of the charts provided.

The charts reviewed by the Department did not illustrate any care coordination or case management. The records do demonstrate frequent office visit utilization; however MTS does not evaluate frequent office utilization with regard to care coordination or case management. ED utilization was not evaluated, due to incomplete records during the site review.

Two Social Work consultations were made available at the time of the review. The referrals were identified by the UM Coordinator using the case review form. Both members were discussed at the UM/QI Committee and recommended for Social Work evaluation as both members were identified as over utilizing DME. The consultation reports demonstrate the following:

- Date of consultant visit and date of report missing.
- Credentials of evaluator missing.
- Unable to determine if review of medical records performed prior to visit.
- It was noted one member was receiving additional services through Blue Sky program. However, there was no indication of services or actual coordination of services.

As reviewed, Social Work consultations do not demonstrate an effective case management/care coordination effort as there was no evaluation of potential needs: financial, support system, communication, literacy, psychiatric and or risk behavior or referral to community services.

Score for This Area: Not Met.

Corrective Action Plan and Timeframe: Final Corrective Action(s) shall be developed by the Contractor and approved by the Department.

At a minimum, the Corrective Action(s) shall address:

1. Monitoring of PCP Case Management requirements as outlined in the MTS documentation provided.

2. Providing evidence of care coordination/case management activities through documentation such as meeting minutes, discussions with providers and or consultants, and ensure documentation exists that demonstrates activities.

Standard X: QAPI Documentation
Standard XI: Quality Assessment and Performance Improvement Program

Staff Present at Site Review:
MTS: Rita DeHerrera, Carolyn Hants, Sue Takaki and Molly Thorson.

Department: Craig Gurule, Sandra DeSanto-Mortensen (Lead), Sue Tripathi and Maureen Wallner.

Department Summary of Review:
Documents submitted outline policies and procedures regarding organizational activities MTS is currently performing or will be performing to meet QI requirements. Organizational responsibilities of QI are under the direction of the QI/UM Committee. Members include MTS administrators and staffs, both the pediatric and internal medicine medical directors, and the consulting registered nurse and social worker. There was documented evidence of committee meetings but meetings focused mainly on utilization versus quality initiatives. Providers are required to follow MTS QI/UM requirements as outlined in the UM & QI Policy and Procedure Manual but there is no documented evidence that providers are aware of and adhere to these standards.

The Quality Plan is dated February 2004 to September 2005. It was previously agreed between the Department and MTS that the program impact and analysis report will be due June 30, 2005. The Quality Plan appropriately references the State Quality Work Plan.

MTS is not currently performing Performance Improvement Projects (PIP). Staff present at this meeting described the intent to perform an adult diabetes study but documentation surrounding topic selection, applicability to MTS population or approval by the committee to perform the study was not available. A diabetic medical assessment tool is currently in development but there is no documentation about how this project ties into quality PIPs. An area identified in the MTS Quality Plan was to study members with special health care needs. There was no information available regarding the QI/UM committee's decision and discussion of the topic selection and no documented evidence in QI/UM meeting minutes that the PIP had been performed.

Member satisfaction is being assessed by MTS. Surveys performed by MTS are intended to identify areas of member satisfaction and dissatisfaction. The Program Manager is responsible for the project. Surveys are randomly done at the Southwest Clinic throughout the year. Results have not been tabulated to date. Actions are taken on surveys that indicate dissatisfaction. A number of completed surveys were provided to the Department at the time of site review. An evaluation of the completed surveys identified the following:

- Forms are missing dates; two different versions of the survey were submitted. It is unclear as to which survey was distributed.
- There was no documented evidence presented that the survey was approved by MTS QI/UM Committee.
- Neither survey adheres to the 6th grade reading level requirement.

- It was not evident how the results of the survey are used or if the results are distributed.
- There is not documentation outlining the survey process.

A survey in which a provider treated a member poorly was discussed at the site review and MTS did follow up on this particular survey. There have been no additional corrective actions resulting from a negative survey.

There was not any criteria outlining which quality of care (QOC) cases are being reviewed internally through the UM/QI committee and which cases are referred to the appropriate medical director.

Score for This Area: Not Met.

Corrective Action Plan and Timeframe: Final Corrective Action(s) shall be developed by the Health Plan and approved by the Department.

At a minimum, the Corrective Action(s) shall address:

1. Documentation of all QI/UM meetings in the form of meeting minutes.

2. Documentation of approval of the MTS member satisfaction survey at a QI/UM meeting.

3. Documentation describing the process of how PIPs will be selected and implemented.

Area of Opportunity:

1. Documentation specifying how surveys will be developed and performed.

Standard XII: Covered Services

Staff Present at Site Review:
MTS: Rita DeHerrera, Sue Takaki and Molly Thorson.

Department: Craig Gurule (Lead), Sandra DeSanto-Mortensen, Sue Tripathi and Maureen Wallner.

Department Summary of Review:
MTS generates hospital inpatient/outpatient, emergency department visit, claims and pharmacy reports. These reports are used in conjunction with member satisfaction surveys in evaluating the amount, duration and scope of covered services as required in the contract. Additional emphasis is directed at potential overutilization of emergency room visits and the costs associated with inappropriate pharmacy utilization.

Coordination between local area hospitals exists concerning emergency room information regarding MTS members. Reports are developed and evaluated to ensure appropriate use of emergency room services. Information obtained from emergency room reports are used to educate members regarding emergency room alternatives for non-urgent medical services. Provider offices also receive this information to encourage members to access non-urgent medical services when appropriate. Provider offices are made aware of "locations for after-hour and weekend clinics accepting same day appointments and/or walk-in patients".

PCP telephone review templates were submitted, but have not been implemented or distributed in order to gather information. Several areas of the covered services requirements (i.e. monitoring access to emergency services) stated in the contract are impacted as a result of a lack of data from proposed surveys and reviews.

Score for this Area: Partially Met

Corrective Action Plan and Timeframe:
Final Corrective Action(s) shall be developed by the Contractor and approved by the Department.

At a minimum, the Corrective Action(s) shall address:

1. Develop, implement and distribute telephone reviews. Compile data, analyze and evaluate information on regular basis. Disseminate review results to providers.

Standard XIII: Coordination with Early & Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Staff Present at Site Review:
MTS: Rita DeHerrera, Carolyn Hants, Sue Takaki and Molly Thorson.

Department: Craig Gurule, Sandra DeSanto-Mortensen (Lead), Sue Tripathi and Maureen Wallner.

Department Summary of Review:
Documents submitted outline policy and procedures regarding organizational activities MTS to be performed for EPSDT. Responsibilities for EPSDT are under the program manager.

EPSDT is being monitored as a part of the organization's QI plan under well child care. MTS has documentation of active participation in community partnerships that include working with the Pueblo City/County Health Department and the Colorado Immunization Program. MTS utilizes educational materials from these organizations for distribution to their providers. There is documented evidence of provider education regarding EPSDT including distribution of education materials to providers and furnishing immunization profiles to physicians.

In order to track utilization, MTS performs individual provider profiles of immunizations for children in the practice. The Practice Manager uses this as a talking point with providers when she meets with them.

Score for This Area: Met.

Corrective Action Plan and Timeframe: Not applicable.

VI. Documents Submitted by the Contractor

Standard I: Subcontracts and Delegation

Documentation Provided for Desk Review:

- Utilization Management and Quality Improvement Policy and Procedures Manual, Feb/2004 & Oct/2004
- Provider Manual for Prior Authorization and Referral Policies and Procedures
- Provider Letter to Participate in UM/QI Program
- Provider Newsletter
- Provider Visit/Phone Teaching Log
- Notification of Provider Breakfast/Lunch Meetings
- Provider Office Criteria Request Form
- Referral Information and Care Coordination Form
- Reviewer/Criteria Review Tool
- Board Certified Physician Reviewer Consultation List
- Patient Satisfaction Survey
- Emergency Room Review Form
- Emergency Room Member Information Letter
- Affirmative Statement Regarding Incentives

Documents Submitted at Time of Site Review:

- Revised Utilization Management and Quality Improvement Policy and Procedures Manual, Feb/2004 & Nov 2004
- Revised Provider Manual for Policies and Procedures
- Sample of Monthly PCP Visit Log
- Quarterly PCP MTS meeting agendas
- PCP Pre-contract Evaluation agenda
- Affirmative Statement Regarding Incentives
- Participating Provider Agreements
- Addendum to Participating Provider Agreements and Revised Provider Manual
- UM/QI Process Flow Chart
- Care Coordination/Case Management Process Flow Chart
- UM/QI Program Organizational Structure Flow Chart
- Revised MTS Referral Information and Care Coordination Form
- Prior Authorization Request Form
- Long Term Home Health, Private Duty Nursing, EPSDT Extraordinary Home Health Prior Authorization Form
- Case Review Form
- Medicaid Patient Clinic Information Sheet
- Revised Patient Satisfaction Survey

Standard II: Provider Issues

Documentation Provided for Desk Review:

- Utilization Management and Quality Improvement Policy and Procedures Manual
- Provider Manual for Prior Authorization and Referral Policies and Procedures
- Provider Letter to Participate in UM/QI Program
- Provider Newsletter
- Provider Visit/Phone Teaching Log
- Notification of Provider Breakfast/Lunch Meetings
- Provider Office Criteria Request Form
- Referral Information and Care Coordination Form
- Reviewer/Criteria Review Tool
- Board Certified Physician Reviewer Consultation List
- Patient Satisfaction Survey
- Emergency Room Review Form
- Emergency Room Member Information Letter
- Affirmative Statement Regarding Incentives

Documents Submitted at Time of Site Review:

- Revised Utilization Management and Quality Improvement Policy and Procedures Manual
- Revised Provider Manual for Policies and Procedures
- Sample of Monthly PCP Visit Log
- Quarterly PCP MTS meeting agendas
- PCP Pre-contract Evaluation agenda
- Affirmative Statement Regarding Incentives
- Participating Provider Agreements
- Addendum to Participating Provider Agreements and Revised Provider Manual
- UM/QI Process Flow Chart
- Care Coordination/Case Management Process Flow Chart
- UM/QI Program Organizational Structure Flow Chart
- Revised MTS Referral Information and Care Coordination Form
- Prior Authorization Request Form
- Long Term Home Health, Private Duty Nursing, EPSDT Extraordinary Home Health Prior Authorization Form
- Case Review Form
- Medicaid Patient Clinic Information Sheet
- Revised Patient Satisfaction Survey

Standard III: Marketing

Documentation Provided for Desk Review:

- Utilization Management and Quality Improvement Policy and Procedures Manual
- Provider Manual for Prior Authorization and Referral Policies and Procedures
- Provider Letter to Participate in UM/QI Program
- Provider Newsletter

- Provider Visit/Phone Teaching Log
- Notification of Provider Breakfast/Lunch Meetings
- Provider Office Criteria Request Form
- Referral Information and Care Coordination Form
- Reviewer/Criteria Review Tool
- Board Certified Physician Reviewer Consultation List
- Patient Satisfaction Survey
- Emergency Room Review Form
- Emergency Room Member Information Letter
- Affirmative Statement Regarding Incentives

Documents Submitted at Time of Site Review:
- Revised Utilization Management and Quality Improvement Policy and Procedures Manual
- Revised Provider Manual for Policies and Procedures
- Sample of Monthly PCP Visit Log
- Quarterly PCP MTS meeting agendas
- PCP Pre-contract Evaluation agenda
- Affirmative Statement Regarding Incentives
- Participating Provider Agreements
- Addendum to Participating Provider Agreements and Revised Provider Manual
- UM/QI Process Flow Chart
- Care Coordination/Case Management Process Flow Chart
- UM/QI Program Organizational Structure Flow Chart
- Revised MTS Referral Information and Care Coordination Form
- Prior Authorization Request Form
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- Case Review Form
- Medicaid Patient Clinic Information Sheet
- Revised Patient Satisfaction Survey

Standard IV: Advance Directives

Documentation Provided for Desk Review:
- UM & QI Policy and Procedure Manual, October 2004
- Circle of Life Education Programs
- PCP Office Orientation Template

Additional Documentation Provided at Time of Site Review:
- Provider Manual Policies & Procedures Feb/2004 & Nov/2004
- ASO/PCP Requirements

Standard V: Practice Guidelines

Documentation Provided for Desk Review:

- UM & QI Policy and Procedure Manual, October 2004;
- QI Plan for period February 2004 through September 2005.

Additional Documentation Provided at Time of Site Review:

- Provider Manual, November 2004;
- UM & QI Policy and Procedure Manual, November 2004;
- Documents reviewed at time of site review include the following materials:
    - PCPP Physician Manual, March 2001
    - Centers for Disease Control and Prevention, print of website, October 2004
    - Milliman and Robertson Care Guidelines, In-Patient and Surgical Care, 8th Ed., Part 1 of 3
    - Colorado Medicaid Bulletins
    - Colorado Medical Assistance Program, Specialty Manuals, 2004

Standard VI: Member Rights and Responsibilities

Documentation Provided for Desk Review:

- UM & QI Policy and Procedure Manual, October 2004
- PCP Office Orientation Template

Additional Documentation Provided at Time of Site Review:

- Provider Manual Policies & Procedures Feb/2004 & Nov/2004
- ASO/PCP Requirements
- UM & QI Policy and Procedure Manual, November 2004

Standard VII: Access and Availability- Service Delivery

Documentation Provided for Desk Review:

- Utilization Management and Quality Improvement Policy and Procedures Manual
- Provider Manual for Prior Authorization and Referral Policies and Procedures
- Provider Letter to Participate in UM/QI Program
- Provider Newsletter
- Provider Visit/Phone Teaching Log
- Notification of Provider Breakfast/Lunch Meetings
- Provider Office Criteria Request Form
- Referral Information and Care Coordination Form
- Reviewer/Criteria Review Tool
- Board Certified Physician Reviewer Consultation List
- Patient Satisfaction Survey
- Emergency Room Review Form
- Emergency Room Member Information Letter
- Affirmative Statement Regarding Incentives

Additional Documentation Provided at Time of Site Review:

- Revised Utilization Management and Quality Improvement Policy and Procedures Manual
- Revised Provider Manual for Policies and Procedures
- Sample of Monthly PCP Visit Log
- Quarterly PCP MTS meeting agendas
- PCP Pre-contract Evaluation agenda
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- Long Term Home Health, Private Duty Nursing, EPSDT Extraordinary Home Health Prior Authorization Form
- Case Review Form
- Medicaid Patient Clinic Information Sheet
- Revised Patient Satisfaction Survey

Standard VIII: Utilization Review

Documentation Provided for Desk Review:

- Utilization Management and Quality Improvement Policy and Procedures Manual
- Provider Manual for Prior Authorization and Referral Policies and Procedures
- Provider Letter to Participate in UM/QI Program
- Provider Newsletter
- Provider Visit/Phone Teaching Log
- Notification of Provider Breakfast/Lunch Meetings
- Provider Office Criteria Request Form
- Referral Information and Care Coordination Form
- Reviewer/Criteria Review Tool
- Board Certified Physician Reviewer Consultation List
- Patient Satisfaction Survey
- Emergency Room Review Form
- Emergency Room Member Information Letter
- Affirmative Statement Regarding Incentives

Documents Submitted at Time of Site Review:

- Revised Utilization Management and Quality Improvement Policy and Procedures Manual
- Revised Provider Manual for Policies and Procedures
- Sample of Monthly PCP Visit Log

- Quarterly PCP MTS meeting agendas
- PCP Pre-contract Evaluation agenda
- Affirmative Statement Regarding Incentives
- Participating Provider Agreements
- Addendum to Participating Provider Agreements and Revised Provider Manual
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- Case Review Form
- Medicaid Patient Clinic Information Sheet
- Revised Patient Satisfaction Survey

Standard IX: Coordination and Continuity of Care

Documentation Provided for Desk Review:

- UM & QI Policy and Procedure Manual, October 2004;
- QI Plan for period February 2004 through September 2005.
- Management Team Solutions ASO/PCP Requirements (no date);

Additional Documentation Provided at Time of Site Review:

- Provider Manual, November 2004;
- UM & QI Policy and Procedure Manual, November 2004;
- MTS Case Review Form (no date);
- MTS Policy for Member Referral for Waiver Programs (no date);
- Documents reviewed at time of site review include the following materials:
    - 10 charts from MTS providers with utilization parameters of: dates of services February 1, 2004 to present; at least 10 billed office visits and or 2 or more emergency department visits.

Standard X: QAPI Documentation
Standard XI: Quality Assessment and Performance Improvement Program

Documentation Provided for Desk Review:

- UM & QI Policy and Procedure Manual, October 2004;
- QI Plan for period February 2004 through September 2005.

Additional Documentation Provided at Time of Site Review:

- Provider Manual, November 2004;
- UM & QI Policy and Procedure Manual, November 2004;
- MTS Health Care Unit Medical Assessment Protocol on Diabetes (no date);
- PCP/ASO Patient Satisfaction Survey (no date);

    - 10 surveys were reviewed
- PCP/MTS ASO Patient Satisfaction Survey (no date);
- QI/QA Cases for October and November 2005.

Standard XII: Covered Services

Documentation Provided for Desk Review:

- Utilization Management and Quality Improvement Policy and Procedures Manual, Feb/2004 & Oct/2004
- Provider Manual for Prior Authorization and Referral Policies and Procedures
- Provider Letter to Participate in UM/QI Program
- Provider Newsletter
- Provider Visit/Phone Teaching Log
- Notification of Provider Breakfast/Lunch Meetings
- Provider Office Criteria Request Form
- Referral Information and Care Coordination Form
- Reviewer/Criteria Review Tool
- Board Certified Physician Reviewer Consultation List
- Patient Satisfaction Survey
- Emergency Room Review Form
- Emergency Room Member Information Letter
- Affirmative Statement Regarding Incentives

Additional Documentation Provided at Time of Site Review:

- Revised Utilization Management and Quality Improvement Policy and Procedures Manual, Feb/2004 & Nov 2004
- Revised Provider Manual for Policies and Procedures
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- Medicaid Patient Clinic Information Sheet
- Revised Patient Satisfaction Survey

Standard XIII: Coordination with Early & Periodic Screening, Diagnosis and Treatment (EPSDT) Program

Documentation Provided for Desk Review:

- UM & QI Policy and Procedure Manual, October 2004;
- QI Plan for period February 2004 through September 2005.

Additional Documentation Provided at Time of Site Review:

- Provider Manual, November 2004;
- UM & QI Policy and Procedure Manual, November 2004;
- Documents reviewed at time of site review include the following materials:
    - File folder of outreach materials developed locally.
    - Articles from local newspaper describing MTS participation and efforts.
    - Immunization Registry information