COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2022–2023 Compliance Review Report

for

Rocky Mountain Health Plans

Region 1

May 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposal 2017000265, the Department of Healthcare Policy & Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service primary care providers and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). 42 CFR requires PCCM entities and PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PCCM entities and PIHPs to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2022–2023 compliance review activities for **Rocky Mountain Health Plans** (**RMHP**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2022–2023 compliance monitoring review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2021–2022 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record review tools. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process that the RAE will be required to complete for FY 2022–2023 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1] Appendix F includes the compliance monitoring report for **RMHP Prime**.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 27, 2023. At the start of FY 2022–2023 compliance review, CMS had not finalized the 2023 CMS EQR Protocol 3; therefore, the 2019 CMS EQR Protocol 3 was used for the period under review.

Summary of Compliance Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

Table 1-1 presents the scores for **RMHP RAE 1** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	32	32	30	2	0	0	94%
II. Adequate Capacity and Availability of Services	13	13	12	1	0	0	92%
VI. Grievance and Appeal Systems	35	35	33	2	0	0	94%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**86**	**86**	**81**	**5**	**0**	**0**	**94%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

Table 1-2 presents the scores for **RMHP RAE 1** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	100	70	67	3	30	96%
Grievances	60	52	52	0	8	100%
Appeals	60	58	54	4	0	93%
Totals	**220**	**180**	**173**	**7**	**38**	**96%**

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

Standard I—Coverage and Authorization of Services

Evidence of Compliance and Strengths

The **RMHP** utilization management (UM) department ensured services were sufficient in amount, duration, and scope through the use of standardized review tools and clear policies and procedures. Oversight of denial decisions was evident in **RMHP** reports, committee meeting minutes, and delegate monitoring of Advanced Medical Reviews (AMR), which is contracted for specialty cases. Inter-rater reliability testing for **RMHP** was well above the goal of 80 percent, at 97 percent reliability or higher overall. While many UM requests are submitted through the provider portal, American Society of Addiction Medicine (ASAM) requests were not fully integrated at the time of the review and required faxes or secure email; however, the UM department reported an overall 98 to 99 percent timeliness of processing authorization requests, and the ASAM procedures that occurred outside the portal do not appear to be a barrier.

A portion of the sample notice of adverse benefit determination (NABD) letters included retrospective claims denials which required member notification. While the NABD letter was not based on the Department's template, for retrospective claims denials, the letters contained the minimum required information. Other NABDs related to medical necessity, administrative denials, and out-of-network requests followed the Department's NABD template.

Documentation within the denial samples demonstrated extensive outreach to the provider when additional information or clarification is needed. Most files included at least two outreaches and some files included 10 or more documented efforts. Some NABDs included clear recommendations for the member to obtain the recommended alternative level of care and listed available providers in the area, including contact information. HSAG recognizes this as a best practice.

Lastly, **RMHP** accurately defined emergency services and poststablilization in accordance with State and federal requirements. The claims production manager described how these service codes are set up in the claims system to pass through or be immediately approved upon the manual review process. Monitoring included annual review of trends with pended claims and internal audits. No major findings were noted during the review period and staff members confirmed that the service codes and locations are fairly easy to spot as the combinations are common and can be easily manually adjudicated.

Opportunities for Improvement and Recommendations

Many of the NABDs reviewed included acronyms or clinical terminology that could be explained in a more member friendly manner. HSAG recommends additional internal review and plain language explanations whenever possible.

Required Actions

While preparing the denial samples, **RMHP** identified an issue related to member claims denial notices. Staff members described that a glitch in the member letter file did not trigger the next step to notify the support services team, which processes and mails the member letters. As a result of the corrupt file, **RMHP** estimates that roughly 2,000 member letters were not mailed. Upon discovery of the issue, these member letters were processed in early February 2023, and the letters included a timeline to file an appeal 60 days from the date of the delayed written notice. Staff members reported that roughly 20 to 30 members have contacted **RMHP** with questions. Staff members described actions taken to prevent this from occurring again, such as additional information technology, UM, and support services communication and monitoring. However, due to the large-scale issue, **RMHP** must show evidence of this long-term update and ongoing monitoring as part of the CAP process.

Additionally, **RMHP** must update its language related to authorization timelines in the *UM Program Description* to clarify that the time frame starts at the time of the request.

Standard II—Adequate Capacity and Availability of Services

Evidence of Compliance and Strengths

During the interview, staff members described ongoing efforts to continue expanding the **RMHP** network, which includes seeking Behavioral Health Administration funding whenever possible. Leadership noted a significant network gain with the provider, Integrated Insights Therapy, that serves the Delta, Gunnison, and Montrose regions. **RMHP** provided support to this provider in order to scale and grow into new offices in western Montrose. One significant loss during the review period was a youth substance use disorder (SUD) provider, which has resulted in SUD gaps in time and distance standards statewide that are not unique to **RMHP**.

Regarding women's specialist services, staff members described how members are documented in the system, and customer service representatives have a robust reference guide to help answer member's benefits questions, even referencing the claims adjudication system, if needed. Staff members also reported that provider advocates have a geographic focus and can help members find specialists. Regarding second opinions, staff members again confirmed that all inquiries are tracked, and care management is assigned for additional support if follow-up is needed.

UM representatives described how out-of-network requests, when approved, are processed promptly between UM and the provider networking team. The director of care management also discussed how care management staff members stay involved, as needed, to inform members about any updates to the out-of-network request.

Appointment timeliness standards were accurately captured in the provider manual and most relevant policies. Monitoring efforts included provider self-monitoring and member surveys. However, member survey responses were notably low. The director of care management described additional monitoring

through emergency department data. Other staff members from network operations added that a new format of member surveying is currently being considered. **RMHP** submitted thorough documentation of the leadership team reviewing appointment timeliness reports and trends at the committee level, raising any access complaints from the grievance department, and the executive leadership team described making personal efforts to follow up with providers and initiating CAPs.

RMHP's cultural competency trainings, outreach, and initiatives submitted in documentation and described by staff members were extensive and specifically targeted to its membership. Staff members discussed a focus on social determinants of health and increasing assessments. Data analysis has pointed specifically to the importance of member needs surrounding housing and transportation as a key focus for its members.

Submitted documentation described Latinx community outreach and support for the deaf and hard of hearing population, including grants. Trainings developed and facilitated by **RMHP**'s practice transformation team included the following: implicit bias; health equity; connecting across cultures; cultural humility; the basics of lesbian, gay, bisexual, transgender, and queer (LGBTQ) affirming care; caring for patients with brain injury; and cultural competency related to Americans with Disabilities Act, among others. **RMHP** described the ABIDE (Ambassadors for Belonging, Inclusion, Diversity, and Equity) employee advisory council which was formed with the goal of connecting **RMHP** staff members to the community and encouraging diverse representation of members in **RMHP** initiatives. To encourage participation in its extensive cultural competency initiatives and ensuring that members feel comfortable accessing care, **RMHP** demonstrated a tiered value-based payment (VBP) initiative that has been expanded to encourage psychosocial screeners, representation of diverse membership on patient and family advisory councils, and providers' enhanced ability to report on member satisfaction measures.

Opportunities for Improvement and Recommendations

Quarterly network reports indicated an opportunity to continue working with the Department to identify ways to improve compliance with time and distance standards for SUD general and pediatric treatment providers and for treatment facilities (i.e., ASAM levels of care 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM), psychiatric hospitals, and psychiatric units in acute care hospitals, which were marked as "not met" for time and distance compliance in quarter 1 of FY 2022–2023.

Required Actions

While the standards for timely access to care and services were accurately detailed in the *Network Plan*, the *Standards for Practitioner Office Sites* policy incorrectly stated that **RMHP** evaluates the availability of scheduling for urgent services between 24 and 48 hours and non-urgent care visits at 14 days, and did not include any exceptions for the American Academy of Pediatrics Bright Futures Periodicity Schedule related to well-care visits. **RMHP** must update *the Standards for Practitioner Office Sites* policy to include the correct standards for timely access to care related to urgent services

and non-urgent care visits, and should include the exceptions related to when well-care visits should be scheduled prior to one month.

Standard VI—Grievance and Appeal Systems

Evidence of Compliance and Strengths

RMHP has a thorough process in place to receive and accept grievances and appeals through its standard system, Macess. Documentation and evidence submitted included the *Provider Manual*, *Appeals Policy and Procedures*, *Non-discrimination Policy and Procedures*, *Grievance Policy and Procedures*, and multiple other documents that outline how staff members process grievances and appeals. Staff members reported the grievances and appeals department's organizational structure included a supervisor, managers, and five care coordinators that assisted members when filing a grievance or appeal. **RMHP** offered many opportunities for training internally to its staff members upon hire through SupportPoint. Training is conducted ongoing and biweekly so that new staff members understand the benefits.

Submitted documentation described how members received reasonable assistance such as staff member help in completing forms, offering auxiliary aids and other services upon request, and the opportunity to present evidence, testimony, and make legal factual arguments in person. Staff members described how they would assist the member by collecting information from the member and submitting it on behalf of the member for State fair hearing reviews, when the member had difficulties completing the submission on their own.

RMHP has a system in place to receive, log, and track a grievance request from the member at any time. **RMHP** submitted a full sample of 10 grievances that met 100 percent compliance for readability and timeliness of acknowledgment and resolution letters. HSAG reviewed **RMHP**'s documentation submission and noted that the term "grievance" was accurately defined within the policy and procedures and the *Provider Manual.*

Although the time frame to accept appeals from the member is 60 calendar days, **RMHP** reported accepting appeals beyond the 60 calendar day window, under certain circumstances. Staff members reported during the interview that if the member needed a service, they would assist the member in filing an appeal or start a new request for the alternative level of care recommended in the NABD.

Clinical decision makers who review appeals to decide whether to uphold or overturn denials are not involved in the initial denial decision. Staff members described an internal process in which the grievance and appeal coordinator sends an email with the name of the medical director who made the initial denial in the subject line so that other medical directors or other teammates with clinical expertise who were not previously involved may work on the appeal case. **RMHP** staff members reported that if clinical expertise for a specialty case was not available, **RMHP** would outsource to AMR. Additionally, the timeliness of mailing member letters was described by staff members to be very important to **RMHP** and associated metrics are tracked and trended.

Opportunities for Improvement and Recommendations

All opportunities for improvement HSAG identified resulted in a required action.

Required Actions

RMHP's *Appeals Policy and Procedure* accurately stated that a member can request an appeal verbally or in writing and a verbal request will be treated the same as a written request. However, the *UM Program Description,* page 17, stated that telephone notifications to initiate the standard appeals process must be followed up by a written confirmation from the member or provider. **RMHP** must remove in the *UM Program Description* any references that require a member to submit appeal information in writing.

RMHP had four sample appeal resolution letters that required the member to request continuation of benefits in writing. **RMHP** must remove language that continuation of benefits must be submitted "in writing," as it is not a requirement by the federal regulations or State contract.

Standard XII—Enrollment and Disenrollment

Evidence of Compliance and Strengths

RMHP submitted an *Enrollment and Disenrollment Policy and Procedure* that describes a process in which member enrollment is completed. Staff members described a thorough overview of how the enrollment process works beginning when the Electronic Data Interchange (EDI) 834 files are received from the Department daily, Monday through Friday, and are processed in the order of receipt, indicated by the timestamp displayed at the top of the file with no restriction. Additionally, staff members reported that there is a monthly validation completed on 834 files received, using the process of exchanging the Health Care Eligibility Benefit Inquiry and Response (270/271) information with the Department for reconciliations purposes.

RMHP does not discriminate according to staff members who described a process that **RMHP** begins working with the member and providing healthcare services promptly. If a member complained of an allegation of discrimination, **RMHP** would process the complaint through the appropriate channels and investigate the accusation; however, staff members were not aware of any instances of a member reporting accusations of discrimination during this reporting period or prior.

Although in the past **RMHP** has requested disenrollment of one member, staff members reported that only in the most extreme cases would they request a disenrollment of the member, and staff members would do what they can and take all avenues necessary to meet the member's needs. In these types of situations, the Department and **RMHP** would discuss this request. **RMHP** and the Department discuss member topics during a biweekly meeting.

Opportunities for Improvement and Recommendations

HSAG recommends that **RMHP** develop a mechanism to compare disenrollment files to member reported quality-of-care concerns for tracking and trending purposes.

Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2022–2023 Compliance Monitoring Activities

For the FY 2022–2023 compliance 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 performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was January 1, 2022, through December 31, 2022. HSAG conducted a desk review of materials submitted prior to the compliance review activities; a review of records, documents, and materials requested during the compliance review; and interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the RAE's administrative records related to denials, grievances, and appeals to evaluate implementation of federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of the denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all RAE denial, grievance, and appeal records that occurred between January 1, 2022, and December 31, 2022. For the record review, the RAE received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2022–2023 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT).

Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the RAE regarding:

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

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

FY 2021–2022 Corrective Action Methodology

As a follow-up to the FY 2021–2022 compliance review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE 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 RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP** until it completed each of the required actions from the FY 2021–2022 compliance monitoring review.

Summary of FY 2021–2022 Required Actions

For FY 2021–2022, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, and Standard XI—EPSDT.

Related to Standard V—Member Information Requirements, **RMHP** was required to complete two corrective actions as follows:

- Revise critical informational materials such as the *Getting Started Guide*, *Directory of Participating Providers*, formulary list, and member letter templates to include all required components of a tagline.
- Update its policy to include the language, "or 30 days prior to the effective date of the termination."

Summary of Corrective Action/Document Review

RMHP submitted a proposed CAP in June 2022. HSAG and the Department reviewed and approved the proposed plan and responded to **RMHP**. **RMHP** submitted the following final documents that included a complete tagline:

- *Combined_1557Notice_0MLIS_09302022 (Medicaid CHP+)*
- *Combined_1557Notice_0MLIS_09302022 (Medicaid CHP+) (Spanish)*
- *RAE Provider Directory_Sept 2022_ENG_V2*
- *RAE Provider Directory_Sept 2022_SPA_V2*
- *RAE-PRIME Getting Started Guide_MD11-GSG_V2*

- *Overturn Denial No Medical Review Template*
- *RAE Prime Denial Letter Adult Template*
- *RAE Prime Denial Letter Child Template*

The updated *Notification of Provider Terminations* policy was submitted in September 2022. The CAP was completed in October 2022.

Summary of Continued Required Actions

RMHP successfully completed the FY 2021–2022 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* RAE Contract: Exhibit B-8—14.6.2 Prime Contract: Exhibit M-10—14.1.1.1, 14.4.2	Note: Federal requirements only apply to MCOs and PIHPs (behavioral health services of RAEs) unless otherwise noted. **Both RAE and Prime:** *I_UM_UM Program Description_2022* Page 4, Section II, Paragraph 2: This describes that RMHP's UM Program is designed to ensure that medical services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the Plan. *I_UM_Preauthorization Policy & Procedure* Page 6, Section 6, Paragraph 6.18: This describes that as part of its procedure RMHP ensures that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *I_PNM_2021 RMHP Provider Manual* Page 97, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the Member. Further, RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* RAE Contract: Exhibit B-8—14.6.4 Prime Contract: Exhibit M-10—14.1.1.3, 14.4.4	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 7, Section 6, Paragraph 6.23.1: This states that RMHP does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the Member. *I_PNM_2021 RMHP Provider Manual* Page 97, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the Member. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. – For Utilization Management, provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used. *Note: The Contractor shall not deny or reduce the amount, duration, and scope of services provided under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as long as the service is supporting a*	**Both RAE and Prime:** *I_UM_Clinical Criteria for UM Decisions* Page 1, Paragraph 1.1 This describes that RMHP applies objective and evidence-based criteria when determining medical appropriateness (necessity) of health care services. *I_UM_Preauthorization Policy & Procedure* Page 8, Section 6.23.6 - 6.23.6.2 This describes that RMHP may place appropriate limits on services on the basis of criteria applied under the State (medical necessity) and for the purpose of utilization control, provided that the services furnished can reasonably be expected to achieve their purpose.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
member to maintain stability or level of functioning or making treatment progress. *42 CFR 438.210(a)(4)* RAE Contract: Exhibit B-8—14.6.2.1; 14.6.5; 14.6.5.2; 14.6.5.2.3 Prime Contract: Exhibit M-10—14.4.5	Page 8, Paragraph 6.23.6.4 Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. *I_UM_Preauthorization Policy & Procedure* Page 8, Paragraph 6.23.6.6 RMHP will not deny or reduce the amount, duration, and scope of services provided under EPSDT for RAE or RAE Prime Members as long as the service is supporting a member to maintain stability or level of functioning or making treatment progress. *I_PNM_2021 RMHP Provider Manual* Page 97, Paragraph 3: This states that RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan. Family Planning services are included in this in accordance with the State plan. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). • The Contractor shall only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or substance use disorder benefits, in any classification, in a manner comparable to and no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to the same NQTL in the same benefit classification of the members' medical/surgical benefits. *42 CFR 438.905* *HB19-1269: Section 3–10-16-104(3)(B)* RAE Contract: Exhibit B-8—14.6.5.2.1, 14.6.5.2.2 Prime MCO Contract: Exhibit M-10—Not Applicable	**RAE-specific:** *I_UM_Preauthorization Policy & Procedure* Page 8, Section 6, Paragraph 6.23.6.3: This states that for the purpose of utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive that the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members (whether or not the benefits are furnished by the same Contractor). *I_UM_Clinical Criteria for UM Decisions* Paragraph 3.2.4.2.1 - 3.2.4.2.2. This states that clinical criteria is clinically sound and based upon analysis of clear, professionally recognized, current clinical and medical/surgical and/or behavioral evidence of effectiveness, where available. Criteria used is compliant with all Federal and State regulations, including those relating to Mental Health Parity. Where regulations overlap, the stricter guidance shall apply.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet 1: *I_PNM_2021 RMHP BH Provider Manual* Page 9 "Mental Health Parity Reports (HCPF Website)," this section states that: The MHPAEA is designed to ensure that Medicaid managed care organizations and Medicaid alternative benefit plans providing mental health or substance use disorder (MH/SUD) benefits apply limitations on those benefits that are comparable to and no more stringent than those limitations imposed upon medical and surgical (M/S) benefits in the same classifications.	
5. The Contractor covers all medically necessary covered treatments for covered behavioral health (BH diagnoses), regardless of any co-occurring conditions. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered BH service. *HB19-1269: Section 12—25.5-5-402(3)(h-i)*	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 6, Section 6, Paragraph 6.19: This states that RMHP ensures that a diagnosis of an intellectual disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health service. *I_PNM_2021 RMHP BH Provider Manual* Page 35, bullets in the "Utilization Management Procedures" section: This describes Medical Necessity as defined by the Department, which includes intellectual or developmental disability, neurological or neurocognitive disorder, or a traumatic brain injury diagnosis is not precluded from receiving a covered BH service.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** *PRIME Member Handbook_July 2022* Page 12, "What does 'medically necessary' mean?; This describes that, as a HFC or RMHP PRIME member, medically necessary services are covered. Page 41, "Member Rights and Responsibilities"; "It is your right" describes that it is the Member's right to medically necessary services and the discussion to be presented in a manner appropriate to the condition and Member's ability to understand. Page 66, "Glossary - Covered Services"; This describes that Medically Necessary services are covered services. Page 70; "Glossary - Medically Necessary"; definition of Medically Necessary.	
6. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the MCO is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.	**Both RAE and Prime:** *I_UM_UM Program Description_2022* Page 4, Section I: This describes that RMHP's UM Program is designed to ensure quality medically necessary care is provided to Members with optimal outcomes and cost efficiency across the continuum of healthcare services and in accordance with regulatory and accreditation requirements. Page 14-15, Section X: This describes RMHP's use of nationally accepted	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. *Note: For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth at Section 8.076.1.8.b–g.* *The Contractor shall determine medical necessity under EPSDT for members ages 20 and under based on an individualized clinical review of a member's medical status and in consideration that the requested treatment can correct or ameliorate a diagnosed health condition.* *Note: The Contractor shall utilize the American Society of Addiction Medicine (ASAM) criteria to determine medical necessity for residential and inpatient substance use disorder treatment services. (RAE Only)* *42 CFR 438.210(a)(5)* RAE Contract: Exhibit B-8—14.6.5.1.1 Prime Contract: Exhibit M-10—7.7.5.3.6, 7.7.5.5.7 10 CCR 2505-10 8.280.4.E.2 10 CCR 2505-10 8.205.10.B.4.a	evidence-based guidelines that span the continuum of care, such as MCG Care Guidelines®, ASAM Criteria®, and other nationally recognized criteria established by organizations such as the American Academy of Obstetrics, Gynecology or Pediatrics. Use of these criteria ensures that RMHP provides services in accordance with professionally recognized standards for healthcare in the United States. *I_UM_Clinical Criteria for UM Decisions* Page 1, Section 3: This describes that RMHP applies written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services. Further this states that RMHP clinical policies are sound and based upon analysis of clear, professionally recognized evidence of effectiveness, and are financially responsible. *I_UM_Preauthorization Policy & Procedure* Page 1-2, Section 4, Paragraph 4.1: This provides the definition of "Medical Necessity" that complies with 42 CFR 438.210(a)(5). *I_PNM_2021 RMHP Provider Manual* Page 70, Paragraph 2, under "RMHP Prime, Rae and CHP+" section: This describes the full definition of medical necessity. *I_PNM_2021 RMHP Provider Manual* *Page 74, 2nd bullet:*	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Medically necessary treatments for conditions discovered by any screening or diagnostic procedure — even if they are not covered by Health First Colorado — may under certain circumstances be covered by RMHP as EPSDT exceptions. A provider can request an EPSDT exception by submitting a prior authorization request in accordance with the instructions in this manual. The request will be reviewed based on EPSDT and approved or denied. I_PNM_2022 Professional Services Contract Page 5, BB.- "Medically Necessary:" This describes the full definition of medical necessity. **RAE-specific: N/A** **Prime-specific: N/A**	
7. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* RAE Contract: Exhibit B-8—14.8.2 Prime Contract: Exhibit M-10—14.6.2	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 1, Section 1, Paragraph 1.1 Purpose: This policy addresses the processing of requests for initial and continuing authorization of services. *I_UM_UM Program Description_2022* Page 11, Section IX This describes that RMHP has a well-structured UM program with a continuum of processes to address requests for initial and continuing authorization of services. **RAE-specific: N/A** **Prime-specific:**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_eviCore_Delegation_Oversight_Summary_2022 Page 1, UM 1- Utilization Management Structure: This describes that eviCore has a well-structured UM program with policies that promote utilization decisions affecting the health care of Members in a fair, impartial and consistent manner.	
8. The Contractor and its subcontractors have mechanisms in place to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* RAE Contract: Exhibit B-8—14.8.2.6 Prime Contract: Exhibit M-10—14.6.2.6	**Both RAE and Prime:** *I_UM_Clinical Criteria for UM Decisions* Page 3, Section 3.3 This describes that RMHP applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Page 6, Section 3.7: This describes how RMHP annually assesses the consistency with which reviewers apply UM criteria in decision making and acts upon opportunities to improve consistency, if applicable. *I_UM_Preauthorization Policy & Procedure* Page 7, Section 6, Paragraph 6.23: This provides that the criteria for authorization decisions are applied consistently. **RAE-specific: N/A** **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2022*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2, UM 2: Clinical Criteria for Utilization Management Decisions: This demonstrates that eviCore uses evidence-based, objective criteria that are reviewed at least annually.	
9. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* RAE Contract: Exhibit B-8—14.8.2.5 Prime Contract: Exhibit M-10—14.6.2.5	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 13, Section 6, Paragraph 6.31.5: This describes that RMHP allows discussion with the attending physician, PCP or requesting physician to collect necessary information to make a preauthorization decision. Page 16, Section 6, Paragraph 6.33: This describes that RMHP allows a rendering provider to request a peer-to-peer review to discuss an adverse determination. **RAE-specific: N/A** **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2022* Page 2, UM 2: Clinical Criteria for Utilization Management Decisions: This demonstrates that the eviCore policies include assessment of the individual needs of the Member and consideration of the local delivery system. Input from outside physicians/practitioners with specific expertise is considered.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical or BH needs. The Contractor's utilization management program includes identification of the type of personnel responsible for each level of utilization management decision-making. *42 CFR 438.210(b)(3)* RAE Contract: Exhibit B-8—14.6.6, 14.8.2.4 Prime Contract: Exhibit M-10—14.4.6, 14.6.2.4	**Both RAE and Prime:** *I_UM_Appropriate Professionals for UM and Pharmacy* Page 3, Section 3.2: This describes the expertise required for the Chief Medical Officer (CMO), Medical and Behavioral Health Associate Medical Directors, and the Clinical Pharmacist. Pages 3-4, Section 3.3: This describes the process for practitioner review for medical, behavioral health, and pharmacy denials. Page 4, Section 3.4: This describes the process for use of board-certified consultants in instances where RMHP Clinical Pharmacists and Associate Medical Directors do not have clinical expertise in the areas for which services or pharmaceuticals are being requested. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 6.22: This describes that UM decisions are made by individuals with the knowledge and skills to evaluate working diagnoses and proposed treatment plans for the Member's medical or behavioral health needs. *I_UM_UM Program Description 2022* Page 6-10, Section V:	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This describes all roles in the UM Department and level of decision-making responsibility. **RAE-specific: N/A** **Prime-specific: N/A**	
11. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* RAE Contract: Exhibit B-8—8.6.1 Prime Contract: Exhibit M-10—8.7.13.5 10 CCR 2505-10 8.209.4.A.1	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 13-16, Section 6.32: This describes the procedures that RMHP has in place to notify Members and requesting providers of decisions to deny or modify service authorization requests, which may be completed orally or in writing. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: RMHP identified a large-scale issue where member letters related to retrospective claims denials were not mailed. This impacted three out of the 10 denial samples.		
Required Actions: RMHP must show evidence of this long-term update and ongoing monitoring as part of the CAP process.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* *Memo: HCPF FFS UM Policy Requirements for SUD Benefit—August 4, 2020* RAE Contract: Exhibit B-8—8.6.6, 8.6.8 Prime Contract: Exhibit M-10—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	**Both RAE and Prime:** **Bullet #1:** *I_UM_Timeliness of UM Decisions Policy and Procedure* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Turn Around Times, Notification, and Extension Requirements* This document is a grid of regulatory timeframes that RMHP follows for notification of authorization decisions. The grid indicates that RMHP provides notice of standard authorization decisions within 10 calendar days. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 6.31.1: This describes that RMHP follows regulatory timelines for UM decisions as outlined in the UM Turn Around Times, Notification, and Extension Requirements document. **Bullet #2:** *I_UM_Timeliness of UM Decisions Policy and Procedure* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_Turn Around Times, Notification, and Extension Requirements This document is a grid of regulatory time frames that RMHP follows for notification of expedited authorization decisions. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 6.31.3 This sets forth the process for issuing a notice for an authorization decision no later than 72 hours after receipt of the request for those instances when the Member's condition requires an expedited decision. **RAE-specific: N/A** **Prime-specific: N/A**	
13. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* RAE Contract: Exhibit B-8—8.6.6.1, 8.6.8.1 Prime Contract: Exhibit M-10—8.6.6.1, 8.6.8.1	**Both RAE and Prime:** *I_UM_Timeliness of UM Decisions* Page 4, Section 6.11 RMHP may extend the time frame for making a standard or expedited authorization decision by up to 14 additional calendar days if: The member or the provider requests an extension, or RMHP justifies a need for the additional information and how the extension is in the member's interest. *I_UM_Preauthorization Policy & Procedure* Page 13, Paragraph 6.31.9 Refers employees to the Timeliness of UM Decisions Policy and Procedure and the UM Turn-around-Time and Notification Requirements Grid for information on extensions.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_UM_Turn Around Times, Notification, and Extension Requirements Page 3 Outlines extension timeframes and requirements for RAE and RAE Prime. **RAE-specific: N/A** **Prime-specific: N/A**	
14. The notice of adverse benefit determination must be written in language easy to understand, available in State-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* RAE Contract: Exhibit B-8—8.6.1–8.6.1.4 Prime Contract: Exhibit M-10—8.6.1-8.6.1.4 10 CCR 2505-10 8.209.4.A.1	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 14, Paragraph 6.32.4.1 This describes that notification will be provided to a Member in writing in a manner calculated to be understood by the Member. Paragraph 6.32.4.2.2 Describes that the notice will be available in English and prevalent non-English languages spoken by Members throughout the State and available in alternative formats for persons with special needs. *I_UM_Medicaid Denial Letter BH_PH 5.2.22* *I_UM_Medicaid Denial Letter SUD 5.2.22* *I_UM_Redacted Sample CHP+ Denial Letter* These letter templates demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) **RAE-specific: N/A** **Prime-specific:**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_RX_Member denial letter_MD_PA_template *I_RX_Member denial letter_MD_QL_template* This pharmacy letter sample demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. Note: the 1557/MLIS notice is attached to these letters at mailing.	
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor or its subcontractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right (or member's designated representative) to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request.	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 14-15, Section 6.32.4.2.3 This describes the content of notices of action or adverse benefit determination and includes the entire list of regulatory requirements. *I_UM_Medicaid Denial Letter BH_PH 5.2.22* *I_UM_Medicaid Denial Letter SUD 5.2.22* These letter templates demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) **RAE-specific: N/A** **Prime-specific:** *I_RX_Member denial letter_MD_PA_template* *I_RX_Member denial letter_MD_QL_template* This pharmacy letter sample demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. Note: the 1557/MLIS notice is attached to these letters at mailing.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. • How each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services *(RAE only)*. *42 CFR 438.404(b)* *SB21-137: Section 10-25.5-5-424(3)* RAE Contract: Exhibit B-8—8.6.1.5–8.6.1.13 Prime Contract: Exhibit M-10—8.6.1.5-8.6.1.12 10 CCR 2505-10 8.209.4.A.2		
16. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service.	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 14, Section 6.32 This incorporates the circumstances in which notices of adverse benefit decisions are sent. *I_UM_UM Turn Around Times, Notification, and Extension Requirements* This document explains decision notification timeframes and extension timeframes. **Bullet #1:**	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* RAE Contract: Exhibit B-8—8.6.3.1, 8.6.5–8.6.8 Prime Contract: Exhibit M-10—8.6.3.1, 8.6.5-8.6.8 10 CCR 2505-10 8.209.4.A.3	*I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 6.4.1: This indicates RMHP must notify the Member at least 10 days before the date of action for termination, suspension, or reduction of previously authorized Medicaid/CHP+-covered services. **Bullet #2:** *I_UM_Preauthorization Policy & Procedure* Page 14, Paragraph 6.32.1: This indicates that RMHP provides notices of determination in compliance with regulatory timelines. *I_UM_UM Turn Around Times, Notification, and Extension Requirements* Page 2: This shows the notification requirement for retrospective determinations (denial of payment). **Bullet #3:** *I_UM_Preauthorization Policy & Procedure* Page 13, Paragraph 6.32.1: This indicates that RMHP provides notices of determination in compliance with regulatory timelines.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_Turn Around Times, Notification, and Extension Requirements Page 2: This shows notification for standard determinations is made within 10 calendar days. **Bullet #4:** *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 6.31.3: This indicates that RMHP will response to expedited service authorization requests within 72 hours of receipt. *I_UM_Turn Around Times, Notification, and Extension Requirements* Page 2: This shows notification for urgent preservice determinations is made within 72 hours. **Bullet #5:** *I_UM_Turn Around Times, Notification, and Extension Requirements* Page 3: This shows notification is sent once decision is made or no later than the expiration date of the extension.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet #6: *I_UM_Turn Around Times, Notification, and Extension Requirements* Page 1 This indicates that if no decision has been made within the allotted turnaround time, notification of appeal rights must be sent on the date the turnaround time expires." **RAE-specific: N/A** **Prime-specific: N/A**	
Findings: Three out of the 10 denial samples were not sent within timeliness standards, and the *UM Program Description* included incorrect authorization timelines on page 14 that miscommunicated the timeline from the time of the decision or after the time of verbal notification.		
Required Actions: RMHP must show evidence of its long-term update to ensure member letters are mailed and ongoing monitoring of denial notification timeliness as part of the CAP process. Additionally, RMHP must update its language related to authorization timelines in the *UM Program Description* to clarify that the time frame starts at the time of the request.		
17. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least 10 days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Contractor has factual information confirming the death of a member. – The Contractor receives a clear written statement signed by the member that the member no longer wishes services or gives information that requires termination or reduction	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 6.4.1: This describes that for reduction, suspension, or termination of previously authorized Health First Colorado RAE/Prime covered services, RMHP notifies the Member at least ten (10) days before the intended effective date of the proposed adverse benefit determination (action). **Bullet #1:** *I_UM_Preauthorization Policy & Procedure*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
of services and indicates that the member understands that this must be the result of supplying that information. – The member has been admitted to an institution where the member is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Contractor mail directed to the member indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* RAE Contract: Exhibit B-8—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.8 Prime Contract: Exhibit M-10—8.6.3.1-8.6.3.2, 8.6.4.1-8.6.4.8 10 CCR 2505-10 8.209.4.A.3(a)	Pages 3 Paragraphs 6.4.1.1 - 6.4.1.7: This describes the scenarios in which RMHP provides notice for reduction, suspension, or termination of a previously authorized Medicaid covered service on or before the intended effective date of the proposed adverse benefit determination. **Bullet #2:** *I_UM_Preauthorization Policy & Procedure* Page 4 Paragraph 6.4.2: This describes that if probable Member fraud has been verified, RMHP gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.404(c)(4)* RAE Contract: Exhibit B-8—8.6.6.2 Prime Contract: Exhibit M-10—8.6.6.2 10 CCR 2505-10 8.209.4.A.3 (c)(1*)*	**Both RAE and Prime:** *I_UM_Extension Letter Template* This is the template loaded into RMHP's authorization system to create extension letters. The template includes a notice of why the extension is needed and that a Member can file a grievance if they disagree with the extension. *I_UM_Timeliness of UM Decisions Policy and Procedure* Page 4, Paragraph 6.11.3.1.2: This states that if RMHP requires an extension, RMHP sends a written notice of the reason for the extension that includes the specific information required to complete the request as well as a notice that the member has the right to file a grievance if the Member disagrees with the need for the extension. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
19. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* RAE Contract: Exhibit B-8—14.8.7 Prime Contract: Exhibit M-10—14.6.6	**Both RAE and Prime:** *I_UM_Appropriate Professionals for UM and Pharmacy* Page 4, Section 3.5: This describes RMHP's Affirmative Statement about incentives. *I_UM_Program Description 2022* Page 4, Section II: This states that RMHP does not reward practitioners or other individuals for issuing denials of coverage or	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	care and offers no incentives for pharmacy or UM decision makers to encourage decisions that result in underutilization. **RAE-specific: N/A** **Prime-specific: N/A**	
20. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* RAE Contract: Exhibit B-8—2.1.36; 7.3.8.1.6.1 Prime Contract: Exhibit M-10—2.1.39, 7.3.8.1.6.1	**Both RAE and Prime:** *I_UM_UM Emergency Department Claim Review Policy* This policy describes that RMHP makes payment for all emergency department services without medical necessity review. *I_UM_Preauthorization Policy & Procedure* Page 2, Paragraph 4.6: This defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 6.6.1: This describes that RMHP will not deny treatment to	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *I_PNM_2021 RMHP Provider Manual* Page 88, "Definition of Emergent Care:" Includes the regulatory definition of "emergency medical condition." **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 16-17, "When to use the Emergency Room" This informs Members about when to use the emergency room, describing the circumstances contained in the regulatory definition of "emergency medical condition" (definition on page 66) – in plain language.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to deliver these services and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* RAE Contract: Exhibit B-8—2.1.37 Prime Contract: Exhibit M-10—2.1.40	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 2, Paragraph 4.5: This defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *I_PNM_2021 RMHP Provider Manual* Page 88, "Definition of Emergent Care:" Includes the regulatory definition of "emergency medical condition." This illustrates that emergency services means covered inpatient and outpatient services furnished by a provider qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Pages 20, Emergency Services: This defines emergency services for Members and informs that services for evaluation and stabilization are covered.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* RAE Contract: Exhibit B-8—2.1.82 Prime Contract: Exhibit M-10—2.1.85	**Both RAE and Prime:** *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* Page 2, Section 4 This contains the regulatory definition of post-stabilization care. *I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 4.7: This defines "post-stabilization care services" as defined as covered services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the Member's condition. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 20, Section – Emergency Services This explains that post-stabilization care to Members, including that these are covered services.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* RAE Contract: Exhibit B -8—14.5.6.2.2 Prime Contract: Exhibit M-10—14.2.1.2.1	**Both RAE and Prime:** *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (full manual available electronically onsite upon request) Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services, paragraph: "Emergent/Urgent Services" The claims manual states that RMHP always allows	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	(pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph 3.2: This describes that RMHP covers emergency department services by participating and non-participating practitioners and providers. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 6.6: This describe that preauthorization is not required in medically urgent/emergent situations. *I_UM_Program Description 2022* Page 13, 4th bullet from the top: This states that urgent and emergent services do not require prospective review and all emergency room claims are paid without review through the normal claims payment processes. *I_PNM_2021 RMHP Provider Manual* Page 28, "Access to Care" section, paragraph 2: This describes that RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider or when instructed by a representative of RMHP to seek emergency services. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* RAE Contract: Exhibit B-8—14.5.6.2.6 Prime Contract: Exhibit M-10—14.2.1.2.1.2	**Both RAE and Prime:** *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph 3.1: This describes that appropriateness of services is assumed based on Prudent Layperson definition. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 6.6.1 - 6.6.1.3 This describes that RMHP will not deny treatment to a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. RMHP will not deny treatment if a representative of RMHP instructed the Member to seek emergency services. *I_PNM_2021 RMHP Provider Manual* Page 88, "Definition of Emergent Care:" This defines emergent care and describes that RMHP will not deny payment for treatment obtained under the circumstances described in the regulation and contract.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 28, "Access to Care" section, paragraph 2: RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider or when instructed by a representative of RMHP to seek emergency services. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Pages 16-17, Section – When to use the emergency room: This informs Members about when to use the emergency room, explains the prudent layperson standard, and provides examples of when a person should go to the emergency room.	
25. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* RAE Contract: Exhibit B-8—14.5.6.2.8 Prime Contract: Exhibit M-10—14.2.1.4.1, 14.2.1.2.1.3	**Both RAE and Prime:** *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph 3.1: This states that RMHP makes payment for all emergency department services at a claim processer level without medical necessity review. Appropriateness of services is assumed based on Prudent Layperson definition. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraphs 6.6.3 - 6.6.4 This describes that RMHP will not limit what constitutes an emergency based on a list of diagnoses or symptoms. RMHP will not refuse to cover emergency services based upon failure of the	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	emergency room provider, hospital, or fiscal agent to notify the Member's primary care provider or RMHP of the Member's screening and treatment within 10 calendar days of presentation for emergency services. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (full manual available electronically onsite upon request) Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services, paragraph: "Emergent/Urgent Services" The claims manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. **RAE-specific: N/A** **Prime-specific: N/A**	
26. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* RAE Contract: Exhibit B-8—14.5.6.2.9 Prime Contract: Exhibit M-10—14.2.1.2.1.4	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 6.6.5: This describes that RMHP will not hold a Member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_CL_Emergency_Urgent Care_Claims Manual_Screenshot (full manual available electronically onsite upon request) Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services, paragraph: "Emergent/Urgent Services" The claims manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. **RAE-specific: N/A** **Prime-specific: N/A**	
27. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* RAE Contract: Exhibit B-8—14.5.6.2.10 Prime Contract: Exhibit M-10—14.2.1.2.1.5	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 4-5, Paragraph 6.6.6: This describes that RMHP allows the attending emergency physician, or the provider actually treating the Member, to be responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on RMHP who is responsible for coverage and payment. *I_PNM_2021 RMHP Provider Manual* Page 28, "Access to Care" section, paragraph 2: This describes that the attending emergency physician or provider actually treating the Member is responsible for determining when the	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member is sufficiently stabilized for transfer or discharge. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 20, Section – Emergency Services: This informs Members that the Member's doctor will decide when the Member receiving emergency services is ready for transfer or discharge.	
28. The Contractor is financially responsible for poststabilization care services that are prior authorized by an in-network provider or Contractor's representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(i)* RAE Contract: Exhibit B-8—14.5.6.2.11 Prime Contract: Exhibit M-10—14.2.1.2.1.6	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 6.7: This describes that RMHP is financially responsible for post-stabilization services that are prior authorized by an in-network provider or RMHP representative, regardless of whether they are provided within or outside of RMHP's network of providers. *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 1: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have been pre-approved (prior authorized) by RMHP or its representative. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(ii)* RAE Contract: Exhibit B-8—14.5.6.2.12 Prime Contract: Exhibit M-10—14.2.1.2.1.7	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 6.9: This describes that RMHP is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if: RMHP does not respond to a request for pre-approval within 1 hour. *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 2: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have not been pre-approved (prior authorized) by RMHP or its representative. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within one hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(2)(iii) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)* RAE Contract: Exhibit B-8—14.5.6.2.12 Prime Contract: Exhibit M-10—14.2.1.2.1.7.1-3	**Both RAE and Prime:** *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1-2, Section 3.0, Paragraph 3: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have not been pre-approved by RMHP or its representative under all of the circumstances set forth in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraphs 6.10 - 6.10.3 This describes that RMHP is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if: RMHP does not respond to a request for pre-approval within 1 hour, RMHP cannot be contacted, or RMHP's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, RMHP gives the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the Member until a plan provider is reached.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific: N/A**	
31. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* RAE Contract: Exhibit B-8—14.5.6.2.14 Prime Contract: Exhibit M-10—14.2.1.2.1.8	**Both RAE and Prime:** *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 3(c): This describes that RMHP's financial responsibility for post-stabilization services it has not pre-approved ends when any of the four situations occur as stated in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraphs 6.10.4 - 6.10.4.4: This describes that RMHP's financial responsibility for post-stabilization care services it has not pre-approved ends when: a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care, or the Member is discharged. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. If the member receives poststabilization care services from a provider outside the Contractor's network, the Contractor does not charge the member more than they would be charged if they had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* RAE Contract: Exhibit B-8—14.5.6.2.13 Prime Contract: Exhibit M-10—14.2.1.2.1.7.4	**Both RAE and Prime:** *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* Page 2, Section 6.0, Paragraph D: This describes that Member liability is limited to an amount no greater than what RMHP would charge the Member if he or she had obtained the services through RMHP. *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 6.8: This describes that if a Member receives post-stabilization services from a provider outside RMHP's network, RMHP does not charge the Member more than he or she would be charged if he or she had obtained services through an in-network provider. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 20, Section - Emergency Services: This describes that Member costs for post-stabilization care rendered by a non-RMHP provider will be no more than what the Member would have paid if treated by a RMHP provider.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard I—Coverage and Authorization of Services—RAE							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	30
				Total Score ÷ Total Applicable		=	94%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO maintains and monitors a network of providers that are supported by written agreements and is sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Family planning providers • Gerontologists • Internal medicine providers • Physician specialists *RAE Only* • Adult mental health providers • Pediatric mental health providers • Substance use disorder providers • Psychiatrists • Child psychiatrists • Psychiatric prescribers *42 CFR 438.206(b)(1)* RAE Contract: Exhibit B-8—9.3.1, 9.5.1.1, 9.5.1.3 Prime Contract: Exhibit M-10—9.1.1, 9.4.1.1, 9.4.3.2.1	**Both RAE and Prime:** *II_PNM_2022 Professional Services Agreement:* Written agreements for RAE Behavioral Health and PRIME Specialty providers. *II_PNM_2022 Physician Medical Services Agreement* Written agreements for RAE Behavioral Health and PRIME Specialy providers who are also MD and DO's. *PNM_2021 RMHP Provider Manual* Page 102, Provider Rights and Responsibilities- "Accommodations for People with Disabilities" section, paragraph 3: This describes that RMHP recommends that providers have a policy and/or procedure that documents how they ensure effective communication with Members with limited English proficiency. It also urges provider's offices and/or facilities to accommodate people with disabilities and/or special health care needs. *II_CI_R1_RM_NetworkMangPln_FY 22-23* Pages 36-38, Provider Type Counts: The Annual Network Management Strategic Plan is an annual contract deliverable to the Department that describes how the provider network is maintained,	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	monitored, and incentivized to provide adequate access to quality services for RAE and PRIME Members. Provider counts are shown on in the appendix on the pages noted. **RAE-specific:** *II_PNM_2022 RAE Provider Directory:* This illustrates providers who are able to serve Members with limited English proficiency as well as if they are handicap accessible with a H for handicap accessibility and abbreviations for the languages spoken. *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_R1* The Network Report is a quarterly contract deliverable to the Department for network adequacy reporting. This is the spreadsheet component of the report. See BH Summary tab. This includes the identified providers for this element. **Prime-specific:** *II_PNM_2022 PRIME Provider Directory:* This illustrates providers who are able to serve Members with limited English proficiency as well as if they are handicap accessible with a H for handicap accessibility and abbreviations for the languages spoken.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_MRM We report on PRIME specialists on the PH Summary tab. This includes the identified providers for this element.	
2. The Contractor ensures that its provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Specialists—adult and pediatric: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 24 and 25, "Prime/RAE Network Geographic and Time Standards": Informs providers of the RAE & Prime network time and distance standards. Page 23, "Prime, RAE, and CHP+ Network Availability Standards:" This informs providers of the RAE and Prime Member/Provider ratios. *II_PNM_Practioner Availability and Accessibility P&P*: This P&P describes how RMHP maintains an effective organizational process for monitoring network adequacy, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues. *II_PNM_Availability of Practitioners Analysis* Pages 10, 16-17, 22-23 This report shows the distance/drive time analysis per requirements regarding Primary Care Practitioners, Pediatric Primary Practitioners, OB/GYN, and Specialists for CHP+, RAE, and	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes *RAE Only* • Psychiatrists and psychiatric prescribers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B2—9.4.10.1)*	PRIME. Pages 24-26 This shows the distance/drive time analysis per requirements for BH Practitioners, Marriage and Family Therapy, Psychology, and Psychiatry. **RAE-specific:** *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_R1* The physical health tab on the Geo Access report evaluates the availability of physical health providers in the network by examining time and distance standards. Includes: Adult Primary Care Providers, Pediatric Primary Care Providers, Acute Care Hospitals, and OBGYN Providers. The behavioral health tab on the Geo Access report evaluates the availability of behavioral health providers in the network by examining time and distance standards. Includes: Adult Mental Health Providers, Pediatric Mental Health Providers, Adult Psych Prescriber Providers, Pediatric Psych Prescriber Providers, and Substance Use Disorder Providers **Prime-specific:** *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_MRM* The physical health tab on the Geo Access report evaluates the availability of physical health providers in the network by examining time and	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.206(a) RAE Contract: Exhibit B-8—9.4.7; 9.4.9 Prime Contract: Exhibit M-10—9.3.8	distance standards. Includes: Adult Primary Care Providers, Pediatric Primary Care Providers, OB/GYN Providers, Adult and Pediatric Specialists, and Pharmacies.	
3. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* RAE Contract: Exhibit B-8—9.2.7 Prime Contract: Exhibit M-10—9.2.8.3.2	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 71, first paragraph: This describes how RMHP provides female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services and is in addition to the Member's designated source of primary care if that source is not a women's health care specialist. *II_CM_Direct Access for OB GYN Care* Page 1, Policy, first bullet: Rocky Mountain provides for a covered woman to have "direct access" to a contracting obstetrician or gynecologist (OB/GYN) for her reproductive and gynecological care. This applies to reproductive health care and gynecological care for both the normal and abnormal processes of the female reproductive system, including medical and surgical management of disorders, pregnancy, childbirth, related preventive care and family planning services. *II_CI_R1_RM_NetworkMangPln_FY 22-23* Page 13, Women's Health: This describes direct access for women's health within the network. **RAE-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: *PRIME Member Handbook July 2022* Page 12, Care for pregnancy and other health care for women: This describes direct access within the network for women's health care.	
4. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* RAE Contract: Exhibit B-8—9.4.17 Prime Contract: Exhibit M-10—9.3.13	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 118, RMHP Prime, RAE, and CHP+ Members, "It is your right:" Bullet 12: This informs providers that Members can get a second opinion with no referral and at no cost to the Member. AND This shows that RMHP covers one second opinion per medical condition without a referral. *II_CM_Second Opinions_Out of Network Services* Page 1, 1.0 Purpose: RMHP provides for a second opinion from an in-network provider or arranges for the Member to obtain a second opinion outside the network. If RMHP is unable to provide a necessary and covered service to a Member in-network, RMHP must adequately and timely cover those services out-of-network for as long as RMHP is unable to provide the service **RAE-specific: N/A** **Prime-specific:**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	PRIME Member Handbook July 2022 Page 26 Second Opinion: This informs Members that second opinions are covered without copayment and explains how to obtain one. Page 39-40 Copayment Table: This informs Members that second opinions are covered without copayment.	
5. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* RAE Contract: Exhibit B-8—14.6.1 Prime Contract: Exhibit M-10—9.3.10.1	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 71, Out-of-Network/ Out -of-Plan Services: This informs providers of out-of-network/out-of-plan services available to Members in a timely manner at the in-network benefit level. *II_CM_Second Opinions_Out of Network Services* Page 2-3, Section 6.2: If the RMHP network is unable to provide necessary services covered under the Member's Evidence of Coverage (EOC), RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. RMHP will coordinate payment with the out of network practitioner to ensure that the cost to the Member is no greater than it would be if the services were furnished in-network. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 11, Section "Doctors that do not work with	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP": This describes that a Member may receive care, with permission from RMHP, with doctors who do not work with RMHP and that the Member will not have to pay extra for the care received.	
6. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* RAE Contract: Exhibit B-8—14.6.11.1 Prime Contract: Exhibit M-10—None	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 71, Out-of-Network/ Out -of-Plan Services: This informs providers that out-of-network/out-of-plan services are available to members at the in-network benefit level. *II_CM_Second Opinions_Out of Network Services* Page 2, section 6.2 "Services not available in network": RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. RMHP will coordinate payment with the out of network practitioner to ensure that the cost to the Member is no greater than it would be if the services were furnished in-network. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 11, Section "Doctors that do not work with RMHP": This describes that a Member may receive care, with permission from RMHP, with doctors who do not	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	work with RMHP and that the Member will not have to pay extra for the care received.	
7. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care *(RAE only):* – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *(RAE only)* *42 CFR 438.206(c)(1)(i)* RAE Contract: Exhibit B-8—9.4.13, 9.4.13.1-4, 9.4.13.5.1-2 Prime Contract: Exhibit M-10—9.3.9.1	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 26-27: This lists the RAE and Prime Appointment Wait Time Standards that demonstrate RMHP's guidelines and standards around emergency behavioral care, urgent care, non-urgent symptomatic care, well care visits within 30 days after the request, outpatient follow up appointments, and explains that Members will not be placed on waiting lists for initial routine services. AND This lists the RAE and PRIME appointment wait time requirements that include specifics for behavioral health services and explains that Members may not be placed on waiting lists for initial routine behavioral health Services. *II_PNM_Appointment Availability Analysis* This report describes RMHP access to service and wait time standards. It reviews how Member surveys are sent annually to ensure that appointment availability is sufficient. Page 15-16: This describes the results from the Member survey relating to the standards for timely access to care and services.	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_R1_RM_NetworkMangPln_FY 22-23 Pages 8-10 This describes Emergency BH care, urgent care and non-urgent care standards information. Page 10, BH Appointment Availability Grid: This describes that Members may not be placed on waiting lists for initial routine services. **RAE-specific: N/A** **Prime-specific: N/A**	
Findings: While the standards for timely access to care and services were accurately detailed in the *Network Plan*, the *Standards for Practitioner Office Sites* policy incorrectly stated that RMHP evaluates the availability of scheduling for urgent services between 24 and 48 hours and non-urgent care visits at 14 days and did not include any exceptions for the American Academy of Pediatrics Bright Futures Periodicity Schedule related to well-care visits.		
Required Actions: RMHP must update the *Standards for Practitioner Office Sites* policy to include the correct standards for timely access to care related to urgent services and non-urgent care visit and should include the exceptions related to when well-care visits should be scheduled prior to one month.		
8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday. • Extended hours on evenings and weekends, including access to clinical staff, not just an answering service or referral service. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)*	**Both RAE and Prime:** **Bullet 1:** *PNM_2021 RMHP Provider Manual* Page 70, "RMHP Prime, RAE, and CHP+": This informs providers that they may not limit their hours of operation in a manner which is less than is offered to Members of non-publicly-financed programs. Page 20, "Service Coverage" This section describes that RMHP highly recommends providers to have minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday, and for extended hour on evening	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—9.4.3–9.4.4 Prime Contract: Exhibit M-10—9.3.3-4	and weekends. *II_PNM_2022 Physician Medical Services Agreement* Page 6, Section A, Medical Services to Covered Persons: This states that providers arrange for the provision of medical services required by any Health Care Plan which is offered by RME to covered persons in the service area. (Due to the numerous lines of business we offer we must write the agreements in general terms to meet all contractual obligations.) Page 16, Section EE, Non-Discrimination- Publicly Financed Programs: This provider contract template describes that providers may not discriminate against any covered person enrolled in a publicly financed program, including limiting the hours of operation. **Bullet 2:** *II_PNM_RMHP Behavioral Health Provider Demographic Tool;* *II_PNM_RMHP PRIME_CHP Specialist Demographic Tool;* *II_PNM_RMHP PCMP_Demographic Tool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	directories and provide relevant information to Members. The questions asked on the tools include Appointment Availability questions for extended hours on evenings and weekends. Note: There are 3 versions of this tool: PCMP, BH Provider, and Specialist. *II_PNM_Provider Insider Plus NL_June 2022* Page 7, "Giving Eligible Members Instant Access to Care via CirrusMD": This includes news about CirrusMD, a tool that can be used by RAE, PRIME and CHP+ Members as an alternative to emergency department visits for after-hours urgent care. *II_CI_CirrusMD Webpage Screenshot* This document contains a link and screenshot of the CirrusMD for RMHP webpage on RMHP.org. CirrusMD can be used by Members as an alternative to emergency department visits for after-hours urgent care. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* RAE Contract: Exhibit B-8—9.4.6 Prime Contract: Exhibit M-10—9.3.7	**Both RAE and Prime:** *II_PNM_2022 Physician Medical Services Agreement* Page 16, Section BB- "24-Hour Coverage": This describes the requirement for providers to provide or arrange for 24-hour coverage for emergency medical services. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* RAE Contract: Exhibit B-8—9.4.14 Prime Contract: Exhibit M-10—9.1.14	**Both RAE and Prime:** *II_PNM_Appointment Availability Surveys P&P:* This P&P describes how RMHP maintains an effective organizational process for monitoring appointment scheduling and wait times, through the use of member surveys, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues if applicable. *II_PNM_Appointment Availability Analysis* Page 17-20, Appendix/Appendices: The Appointment Wait Time Surveys are sent annually to Members as a mechanism to ensure compliance with access by network providers, which includes behavioral health providers (prescribing and non-prescribing); primary care providers; and specialists (high-volume & high-impact).	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	PNM_2021 RMHP Provider Manual Page 20, Access to Care: This describes how RMHP maintains quality standards to identify, evaluate, and remedy problems relating to access of care. It also identifies RMHPs targets (goals) for Member/provider ratios, time and distance drive time standards as well as appointment wait time standards. *II_CQI_Annual Tier Assessment Process* *II_CQI_Tier Attestation Process; Page/Slide 11* *II_CQI_Tier Attestation Tree* These documents detail expectations of practices by Tier as it relates to Medicaid access within the PCMP offices. Higher Tier practices must be open to Medicaid. *II_CQI_2023 Project Charter* Page 1: The Value Based Contracting Review Committee (VBCRC) Charter details the aim, scope and general structure of the committee that evaluates practices in value-based contracts with RMHP for compliance with contractual expectations and requirements. This committee evaluates practices in Tiers 1, 2, & 3. *II_CQI_2022 VBCRC PROCESS* Page 2 – 4: This explains how the Value Based Contracting Review Committee (VBCRC) evaluates practices in	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	value based contracts with RMHP as it relates to contractual expectations and requirements. Specifically, this document details the frequency of review as well as how practices are notified if there is failure to comply with any requirements and a corrective action plan is implemented. *II_CQI_RAE PCMP Tiering & Attribution Analysis (not an evidence document)* This analysis demonstrates that 128/201 (63.68%) of RAE PCMPs and 51/64 (79.69%) of Prime PCMPs are evaluated within the VBCRC process for the Value Based Payment Tiering Program. This accounts for 81.01% of the attributed RAE Member population and 89.72% of the attributed Prime Member population. These Tier 1 & 2 practices must meet all the criteria required, which includes access standards, in order to participate in value-based payment programming. <u>RAE Practices:</u> · Tier 1 – 3: 128 (63.68%) · Total: 201 · RAE Tier 1 – 3 Attribution:153,985 (81.01%) · RAE Total Attribution: 190,077 <u>PRIME Practices:</u> · RAE Tier 1 – 3: 51 (79.69%) · Total: 64 · PRIME Attribution within a RAE Tier 1 – 3 practice: 17,040 (89.72%) · PRIME Total Population: 18,992	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific: N/A**	
11. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. and sex. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* RAE Contract: Exhibit B-8—7.2.1–7.2.6 Prime Contract: Exhibit M-10—7.2.1-5	**Both RAE and Prime:** **Bullet #1:** *II_PNM_RMHP Behavioral Health Provider Demographic Tool;* *II_PNM_RMHP Prime_CHP+ Specialist Demographic Tool;* *II_PNM_RMHP PCMP_Demographic Too*l: The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. The questions asked on the tools include Staff Training elements. Note: There are 3 versions of this tool: PCMP, BH Provider, and Specialist. **Bullet #2:** *PNM_2021 RMHP Provider Manual* Page 115-116: This describes cultural competency and provides direction to providers about where and how to complete cultural competency training. **Bullet #4:** *II_PNM_Provider Insider Plus NL_June 2022* Page 7, "Health Equity Education Highlights" The newsletter provides information about the	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Culturally and linguistically appropriate services (CLAS), a free resource for providers who may need language assistance services for deaf, hard of hearing or deafblind patients. *II_CQI_HE Report Exec Summary* Pages 4-5, This is an overview of the health equity report with identified opportunities for interventions on specific populations and pertains to all lines of business. This is for internal staff and provider training to promote the delivery of culturally competent services. The following documents illustrate that RMHP delivers services to Members in a culturally competent manner to all Members. *COMBINED_1557Notice_MLIS_2022 Mcaid_CHP+* RMHP's notice of nondiscrimination provides for meaningful access and effective communication and includes protections for those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. *II_CI_Cultural-DisabilityCompTrn_Screenshots_2023-2022* This screenshot lists the links to Cultural and Disability competency resources on the UHCPRovider.com and RMHP.org websites that	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providers can access for further training. *II_CM_UM_Communication Policy and Procedure* Page 1, section 3.1: This describes RMHP's commitment to meaningful and effective communication. *II_CM_Culturally Sensitive Services* Page 3, Section 5.0, Paragraph 1: This explains how RMHP facilitates culturally and linguistically appropriate care and outreach to members with diverse cultural and ethnic backgrounds for prevention, health education and treatment for diseases prevalent to those groups. *II_CM_UM_Communication Policy and Procedure* Page 1, Section 3.1 This describes RMHP's commitment to meaningful and effective communication. Page 2, Paragraph 3.1.3: This describes that RMHP ensures written materials that are critical to obtaining services are available in prevalent non-English languages. Pages 6-9, Section 6.7 through 6.12: This describes translation, interpreter, and auxiliary services that RMHP has available to communicate with members. *II_QI_RMHP 2021 Annual Culture and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Members and the actions RMHP takes to meet those needs. **Bullet #1** Page 5: Describes that written Member materials can be translated into any language requested and that RMHP keeps many materials such as the Getting Started Guide and Provider Directory on hand in Spanish. **Bullet #2** Page 10: Describes that Care Management staff participated in Bridges out of Poverty Bridges to Health and Healthcare training. Page 11: Describes disability competent care trainings for our provider network facilitated by the Colorado Commission for the Deaf, Hard of hearing and DeafBlind and the Mental Health Center of Denver. Page 11: Describes that RMHP offers provider resources for culturally responsive care through a variety of virtual learnings and on our website. **Bullet #3** Page 10: Describes work to improve access to healthcare and other important services for the deaf and hard of hearing. **Bullet #4** Page 5: Describes that RMHP contracts with a language services vendor, LanguageLine Solutions (LLS) that is available for all employees and providers (when needed) to use in assisting Members.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_QI_RMHP P&P Collection of REL & SOGI Data_draft **Bullet #3-5** This draft P&P describes the process for the collection of race, ethnicity, language, sexual orientation and gender identity data from Members in order to provide equitable access to health care. **RAE-specific: N/A** **Prime-specific: N/A**	
12. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* RAE Contract: Exhibit B-8—9.1.4.5, 9.1.7.1, 9.5.1.2 Prime Contract: Exhibit M-10—9.4.1.2	**Both RAE and Prime:** *II_PNM_RMHP Behavioral Health Provider Demographic Tool;* *II_PNM_RMHP PRIME_CHP+ Specialist Demographic Tool;* *II_PNM_RMHP PCMP_Demographic Tool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tools include a provider's ability to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical disabilities.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Specialist.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_PNM_Standards for Practitioner Office Sites: This P&P describes how RMHP maintains an effective organizational process for monitoring the quality and safety of clinical care and services provided to Members. **RAE-specific: N/A** **Prime-specific: N/A**	
13. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Adequacy Report is submitted to the State quarterly. *42 CFR 438.207(b)* RAE Contract: Exhibit B-8—9.5.1–9.5.4 Prime Contract: Exhibit M-10—9.4.2-3	**Both RAE and Prime:** *II_CI_R1_RM_NetworkMangPln_FY 22-23* This annual report provides an overview of RMHP's RAE and PRIME Provider Network Management Strategic Plan. It is submitted annually to the Department. **RAE-specific:** *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_R1 (MS Excel)* *II_CI_R1_NetworkRpt_Q1FY22-23 (MS Word)* This quarterly report contains 2 parts: a quantitative report in an Excel spreadsheet and a narrative report in a Word document. This comprehensive report provides Member/Provider ratios and time and distance reporting according to contract standards and is submitted to the Department quarterly. **Prime-specific:** *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_MRM (MS Excel)*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_RM_NetworkRpt_Q1FY22-23 (MS Word) This quarterly report contains 2 parts: a quantitative report in an Excel spreadsheet and a narrative report in a Word document. This comprehensive report provides Member/Provider ratios and time and distance reporting according to contract standards and is submitted to the Department quarterly.	

Results for Standard I—Standard II—Adequate Capacity and Availability of Services—RAE							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	92%

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an established internal grievance and appeal system in place for members, providers acting on their behalf, or designated member representatives. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* RAE Contract: Exhibit B-8—8.1 Prime Contract: Exhibit M-10—8.1 10 CCR 2505-10 8.209.1	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *VI_CS_MD - Uphold Denial Med Review* *VI_CS_MD - Uphold Denial No Med Review* *VI_CS_MD.CHP - Overturn Denial Med Review* *VI_CS_MD.CHP - Overturn Denial No Med Review* *VI_CS_Process for Accepting Appeal or Grievance* *VI_CS_MD.CHP - Designated Representative Request - Appeal* *VI_CS_MD.CHP - Designated Representative Request - Grievance* *COMBINED_1557Notice_MLIS_2022 Mcaid_CHP+ I_CS_Multilanguage and Notice of Nondiscrimination P&P* The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • 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, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities). *42 CFR 438.400(b)* RAE Contract: Exhibit B-8—2.1.3 Prime Contract: Exhibit M-10—2.1.3 10 CCR 2505-10 8.209.2.A	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 14, Subsection 2.7, Paragraph 2.7.1-2.7.7: This defines "Adverse Benefit Determination." Page 14 Section 2.7.6 addresses the circumstances of a resident of a rural area to exercise their right to obtain services outside the network due to various reasons. *VI_CL_Pend Codes* Page 2, "Steps to follow when information is not received" and Page 14 "Review" grid - New Code: RV60 item: "Unclean Claims" requiring additional information for adjudication are not denied to the member as an adverse benefit determination. The information needed is requested from the provider before a determination is made. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook_July 2022* Page 43, Section A. Appeal an Adverse Decision; This describes the example of the kinds of decisions a Member may appeal which includes when RMHP denies certain services.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* RAE Contract: Exhibit B-8—2.1.6 Prime Contract: Exhibit M-10—2.1.5 10 CCR 2505-10 8.209.2.B	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 14, Section 2.6 This defines "appeal" as a review by RMHP of an adverse benefit determination. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* RAE Contract: Exhibit B-8—2.1.46, 8.6.6.2 Prime Contract: Exhibit M-10—2.1.49, 8.6.6.2 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.(i)	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 13, Section 2.5: Definition of a Grievance *VI_CS_Grievance Policy and Procedure* Page 6, Section 4.1-4.1.1 - Definitions: In both documents, grievance is defined as a verbal or written expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to quality of care or services provided, aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by RMHP to make an authorization decision. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives acting on behalf of the member (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* RAE Contract: Exhibit B-8.5.1, 8.7.1, 8.7.15.1, 8.7.5 Prime Contract: Exhibit M-10—8.5.1, 8.5.3, 8.7.1, 8.7.15.1, 8.7.5	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 2.2: This indicates that a Member or their designated representative may file grievances. Page 2, Section 2.2.4: This states that RMHP must obtain authorization in writing from the Member or his/her designated client representative, including a treating health care professional, to represent his or her interests related to grievances. *VI_CS_Appeals Policy and Procedure* Page 2, Section1.1, Subsection 1.1.3: This indicates that procedures for authorized representatives to appeal on a Member's behalf are outlined in the "Designation of Representatives" Process. Page 10, Section 1.7: Subsection 1.7.1- 1.7.4: This states that the Member or their DCR may request a State Fair Hearing. *VI_CS_Process Designation of Representatives* Page 1, "Process" Section 3.0, Paragraph 2: This states that a Member, or a designated client representative acting on behalf of a Member with the Member's written consent, or the legal representative of a deceased Member's estate, may file a grievance,	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	a health plan-level appeal, and may request a State Fair Hearing. **RAE-specific: N/A** **Prime-specific: N/A**	
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities. *42 CFR 438.406(a)* RAE Contract: Exhibit B-8—8.3 Prime Contract: Exhibit M-10—8.3 10 CCR 2505-10 8.209.4.C	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 2, Section 1.1, Subsection 1.1.2: This explains how RMHP assists Members in completing any forms required, putting verbal requests, including requests for a State fair hearing, into writing and taking other procedural steps. *VI_CS_Grievance Policy and Procedure* Page 2, Section 2 - General Information, Subsection 2.2: This explains how RMHP assists Members with completing any forms or completing other procedural steps. *COMBINED_1557Notice_MLIS_2022 Mcaid_CHP+* Tagline and Notice of Nondiscrimination This document is sent with all significant Member communications, including with all appeals and grievances Member mailings. Page 1: The Notice of Nondiscrimination states that RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge, including auxiliary aids and services. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. 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 nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, 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. *42 CFR 438.406(b)(2)* RAE Contract: Exhibit B-8—8.5.4, 8.7.4 Prime Contract: Exhibit M-10—8.5.3, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 5, Section 1.4, Subsections 1.4.3 and paragraph 1.4.3.1 - 1.4.3.2: This describes the requirements for the grievances and appeals reviewers/decision-makers. The Medical Director and the clinical consultant must not have been involved in the initial decision or be the subordinate of the medical director involved in the initial review. The reviewer or consultant must have the appropriate clinical expertise in treating the Member's condition or disease. *VI_CS_Grievance Policy and Procedure* Page 5, Section 3 - Process, Subsection 3.1 - Standard Grievance/Compliant Process, 3.1. - 3.1.3.2.2: This indicates that RMHP ensures that individuals who make decisions on grievances are individuals who were not involved in any aspect of the circumstances or decision-making that led to the grievance nor a subordinate of any individual who was involved and have the appropriate clinical expertise in treating the Member's condition or disease. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* RAE Contract: Exhibit B-8—8.6.2 Prime Contract: Exhibit M-10—8.6.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Both RAE and Prime:** VI_CS_Appeals Policy and Procedure Page 5, Section 1.4, Subsections 1.4.3.4: This states that the individuals who make decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* RAE Contract: Exhibit B-8—8.5.3 Prime Contract: Exhibit M-10—8.5.3 10 CCR 2505-10 8.209.5.D	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 2., Subsection 2.1.: This lists the ways that RMHP accepts grievances, both orally and in writing. *VI_CS_Process for Accepting Appeal or Grievance* Pages 1 - 5: This describes the process that Customer Service Representatives follow to accept Member grievances orally by phone. *VI_CS_Complaints and Appeals Routing* Page 2, Section 6.0:	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This explains how Customer Service Representatives receive grievances by phone or email. **RAE-specific: N/A** **Prime-specific: N/A**	
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* RAE Contract: Exhibit B-8—8.5.3 Prime Contract: Exhibit M-10—8.5.3 10 CCR 2505-10 8.209.5.A	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 2., Subsection 2.2.: States that Members or their designated representative can file grievances at any time. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* RAE Contract: Exhibit B-8—8.1 Prime Contract: Exhibit M-10—8.1 10 CCR 2505-10 8.209.5.B	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 2., Subsection 2.2., Subsubsection 2.2.6.: General Information Paragraph V: This states that acknowledgment letters are sent to Members within two working days of receipt. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a);(b)(1); and (d)(1)* RAE Contract: Exhibit B-8—8.5.5, 7.2.7.3, 7.2.7.5 Prime Contract: Exhibit M-10—8.5.4, 7.2.7.3, 7.2.7.4, 7.2.7.5. 10 CCR 2505-10 8.209.5.D	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 5, Section 3 Subsection 3.1, Subsubsection 3.1.2.: This states that RMHP must respond to a grievance within 15 working days from the date of receipt, or as expeditiously as the Member's health condition requires. **Bullet #1** Page 3 Section 2., Subsubsection 2.2.7.1.: This describes that the reviewer's resolution must be in language that is easily understandable. It must provide a rationale in sufficient detail that may be easily understood by the Member. *VI_CS_MD - Grievance and Explanation Resolution* This template is used to provide notice to the Member of the disposition/resolution of their grievance. It is in a format and include standard language that can be easily understood by Members. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. *42 CFR 438.408(a)* RAE Contract: Exhibit B-8—8.5.8 Prime Contract: Exhibit M-10—8.1 10 CCR 2505-10 8.209.5.G	**Both RAE and Prime:** *VI_CS_MD - Grievance and Explanation Resolution* This template includes the disposition /resolution process and the date it was completed. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* RAE Contract: Exhibit B-8—8.1.1 Prime Contract: Exhibit M-10—8.1	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *VI_CS_MD - Uphold Denial Med Review* *VI_CS_MD - Uphold Denial No Med Review* *VI_CS_CHP - Uphold Denial Med Review* *VI_CS_CHP - Uphold Denial No Med Review* *VI_CS_Process for Accepting Appeal or Grievance* The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. The documents indicate that there is only one level of appeal with the health plan for RAE and PRIME Members. Members are provided clear instructions about how to request a State Fair Hearing (or State Review) after exhausting RMHP's appeal process, or	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	if RMHP fails to adhere to the required timeframes for processing appeals. **RAE-specific: N/A** **Prime-specific: N/A**	
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* RAE Contract: Exhibit B-8—8.7.5.1 Prime Contract: Exhibit M-10—8.7.5.1 10 CCR 2505 10 8.209.4.B	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* Page 1, Member Appeal Submission: This indicates the 60 calendar day time frame Members have to submit an appeal *VI_CS_Appeals Policy and Procedure* Page 2, Section 1.1, Subsection 1.1.4 This indicates that time frames for submitting appeals is in the "MD.CHP Timelines" grid **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* RAE Contract: Exhibit B-8—8.7.6 Prime Contract: Exhibit M-10—8.7.6, 8.7.7 10 CCR 2505-10 8.209.4.F	Inform health plan on-site that proposed federal rule changes include: Eliminate the requirement that an oral appeal must be followed by a written, signed appeal (must continue to treat oral appeals the same as written appeals). **Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 2, Section 1.1., Subsection 1.1.1: This indicates that appeals will be accepted by fax, e-mail, standard mail or verbally. Page 3-4, Section 1.2.: This explains how verbal appeals are acknowledged *VI_CS_Verbal Appeal Acknowledgment Template* This template explains to the Members what RMHP believes to be the reason for the appeal. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: RMHP's *Appeals Policy and Procedure* accurately stated that a member can request an appeal verbally or in writing and a verbal request will be treated the same as a written request. However, its *UM Program Description,* page 17, stated that telephone notifications to initiate the standard appeals process must be followed up by a written confirmation from the member or provider.		
Required Actions: RMHP must remove from the *UM Program Description* any references that require a member to submit appeal information in writing.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* RAE Contract: Exhibit B-8—8.1, 8.7.2 Prime Contract: Exhibit M-10—8.1, 8.7.3 10 CCR 2505-10 8.209. 4.D	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* This document indicates the two working day time frame to acknowledge receipt of a standard appeal. *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* These letter templates are used to provide written acknowledgement of verbal and written appeals and are sent within two working days of receipt of standard appeals. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* RAE Contract: Exhibit B-8—8.7.6, 8.7.7, 8.7.11 Prime Contract: Exhibit M-10—8.7.11 10 CCR 2505-10 8.209.4.I	**Both RAE and Prime:** *VI_CS_Process Designation of Representatives* Page 1, Section 3.0 Paragraph 2: This explains that the Member, the Member's designated representative or the legal representative of a deceased Member's estate are the parties to the appeal. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* RAE Contract: Exhibit B-8—8.7.8–8.7.10 Prime Contract: Exhibit M-10—8.7.8–8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 3, Section 1.2, Subsection 1.2.1.1.: This explains how RMHP gives Members an opportunity to submit further evidence, including in cases of expedited resolution where time is limited. Page 4, Section 1.2, Subsection 1.2.1.1.3.: This explains how RMHP gives Members an opportunity to receive a copy of the Member's case file free of charge and in advance of the appeal resolution time **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook_July 2022* Page 43-44, "Standard Review," describes that Members will receive information in their acknowledgement letter about how to access their appeal file and that they may provide more information about their appeal to RMHP either in person, or in writing.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. 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; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that:	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 7-8, Section 1.5: This describes the expedited review process. **Bullet #1** Page 8, Section 1.5, Subsection 1.5.2, Subsubsection 1.5.2.3:	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* RAE Contract: Exhibit B-8—8.7.14.2.1, 8.7.12 Prime Contract: Exhibit M-10—8.7.12, 8.7.14.2.1 10 CCR 2505-10 8.209.4.Q-R	This states that punitive action will not be taken against a provider for requesting an expedited appeal or supporting a Member's appeal. *II_PNM_2022 Physician Medical Services Agreement* Page 23, Section G, "Limitations on Adverse Actions": This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. *II_PNM_2022 Professional Services Agreement* Page 25, Section G, "Limitations on Adverse Actions": This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. *VI_PNM_2022 Hospital Services Agreement* Page 26, Section G, "Limitations on Adverse Actions": This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.410(c)* RAE Contract: Exhibit B-8—8.7.14.2.2 Prime Contract: Exhibit M-10—8.7.14.2.2 10 CCR 2505-10 8.209.4.S	**Both RAE and Prime:** **Bullet 1:** *VI_CS_Appeals Policy and Procedure* Page 7-8, Section 1.5, Subsection 1.5.2, Subsubsection 1.5.2.1: This describes that if RMHP denies a request for expedited resolution, it will transfer the appeal decision to the standard time frame and will make reasonable efforts to give the Member verbal notice followed by written notice of the denial within two calendar days. **Bullet 2:** *VI_CS_Appeals Policy and Procedure* Page 8, Section 1.5, Subsection 1.5.2, Subsubsection 1.5.2.4: This describes that the Member has the right to file a grievance if he or she disagrees with the decision not to expedite the appeal. *VI_CS_MD.CHP - No Expedited Appeal* This template provides the standard text contained in a notice that an appeal will not be expedited and demonstrates that the content is in a format and language that may be easily understood by the Member. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. 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. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* RAE Contract: Exhibit B-8—8.7.14.1. 7.2.7.3, 7.2.7.5 Prime Contract: Exhibit M-10—8.7.14.1.1, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	**Both RAE and Prime:** **Bullet 1:** *VI_CS_MD.CHP Timelines* This document provides timeframes for appeals process and decisions. **Bullet 2:** *VI_CS_Appeals Policy and Procedure* Page 7, Section 1.4, Subsection 1.4.4.3: This describes the content of appeal resolution letters, including that they must be in a format and language that is easily understood by the Member. *VI_CS_MD - Uphold Denial Med Review* *VI_CS_MD - Uphold Denial No Med Review* *VI_CS_MD.CHP - Overturn Denial Med Review* *VI_CS_MD.CHP - Overturn Denial No Med Review* These templates provides the standard text contained in a notice of appeal resolution and demonstrates that the content is in a format and language that may be easily understood by the Member. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours 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. *42 CFR 438.408(b)(3) and (d)(2)(ii)*	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* This document describes that the timeframe for resolving an expedited appeal is within 72 hours of receipt. *VI_CS_Appeals Policy and Procedure*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—8.7.14.2.3, 8.7.14.2.6 Prime Contract: Exhibit M-10—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	Page 7, Section 1.5, Subsection 1.5.2: This describes that RMHP will make reasonable efforts to provide oral notice to the Member of the expedited resolution. **RAE-specific: N/A** **Prime-specific: N/A**	
24. 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 (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* RAE Contract: Exhibit B-8—8.7.14.2, 8.7.14.2.4, 8.5.6 Prime Contract: Exhibit M-10—8.5.5, 8.7.14.2.2, 8.7.14.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 10, Section 1.6, Subsection 1.6.8: This explains the circumstances under which RMHP will extend the time frames for resolution of both expedited and standard appeals. *VI_CS_Grievance Policy and Procedure* Page 5, Subsection 3.1.3.5 This explains the circumstances under which RMHP will extend the time frame for resolution of a grievance. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* RAE Contract: Exhibit B-8—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 Prime Contract: Exhibit M-10—8.5.6, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 10, Section 1.6, Subsection 1.6.8: This explains that if RMHP extends the time frame, reasonable efforts will be made to give the Member prompt oral notice of the delay and the Member will be given written notice of the reason for the delay within two calendar days, informing the Member that they may file a grievance if they disagree with the decision. Further, this P&P explains that the appeal will be resolved as expeditiously as the Member's health condition requires and no later than the date the extension expires. *VI_CS_Grievance Policy and Procedure* *Page 5, Subsection 3.1.3.5* This explains the circumstances under which RMHP will extend the time frame for resolution of a grievance. *VI_CS_MD.CHP - Plan Needs Additional Time* This template illustrates the notices that the plan needs additional time to complete appeal and the Member's rights. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. 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 that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* RAE Contract: Exhibit B-8—8.7.14.3, 8.7.14.4 Prime Contract: Exhibit M-10—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 6, Section 1.4.4 - 1.4.13.3 This describes the information that must be included in the notice of appeal resolution. *VI_CS_MD - Uphold Denial Med Review* *VI_CS_MD - Uphold Denial No Med Review* This template illustrates that the notices of appeal resolution contain the required language **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: RMHP had four sample appeal resolution letters that required the member to request continuation of benefits in writing.		
Required Actions: RMHP must remove language that continuation of benefits must be submitted "in writing" as it is not a requirement by the federal regulations or State contract.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* RAE Contract: Exhibit B-8—8.7.15.1–8.7.15.2 Prime Contract: Exhibit M-10—8.7.15.1-2 10 CCR 2505-10 8.209.4.N and O	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 10, Section 1.7, Subsection 1.7.1.: This explains that the Member or their DCR may request a State fair hearing within 120 days from the date of the notice of resolution. The P&P also explains that a Member is deemed to have exhausted the appeal process and may request a State fair hearing/State Review if RMHP does not adhere to the notice and timing requirements. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook_July 2022* Page 44, paragraph 3: This informs Members they may request a State Fair Hearing within 120 calendar days from the date of the notice of resolution and that if RMHP does not adhere to the notice and timing requirements, the Member may request a State Review.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* RAE Contract: Exhibit B-8—8.7.15.3 Prime Contract: Exhibit M-10—8.7.15.3	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 10, Section 1.7, Subsection 1.7.4: This explains that RMHP, as well as the Member and his or her representative, participate in the State Fair Hearing/State Review. *VI_CS_Process Designation of Representatives* Page 1, Section 3, Paragraph 2: This explains that a representative of a deceased	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member's estate is considered a party to a State Fair Hearing/State Review. **RAE-specific: N/A** **Prime-specific: N/A**	
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • 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 an appeal in accordance with required time frames. ** 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. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)*	**Both RAE and Prime:** **Both RAE and PRIME:** *VI_CS_Appeals Policy and Procedure* Page 10, Section 1.8.3.: This describes the policy for continuation of benefits during the appeal process. *VI_CS_MD - Uphold Denial Med Review* *VI_CS_MD - Uphold Denial No Med Review* Page 3, How to Ask for your Services to Continue During a State Fair Hearing: This Member notice describes the continuation of benefits policy while RMHP appeal and State Fair Hearing are pending. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—8.7.13.1 Prime Contract: Exhibit M-10—8.7.13.1 10 CCR 2505-10 8.209.4.T		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* RAE Contract: Exhibit B-8—8.7.13.2 Prime Contract: Exhibit M-10—8.7.13.1.6 10 CCR 2505-10 8.209.4.U	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 11-12, Section 1.8, Subsection 1.8.6: This describes how long benefits are continued while an appeal or State Fair Hearing is pending and the events that must occur before benefits can be discontinued. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, 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. *42 CFR 438.420(d)*	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section 1.8, Subsection 1.8.7, Subsubsection 1.8.7.1.: This describes the Member's responsibility for the cost of continued services if the appeal decision is adverse to the Member. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—8.7.13.3 Prime Contract: Exhibit M-10—8.7.13.2 10 CCR 2505-10 8.209.4.V		
32. 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 as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* RAE Contract: Exhibit B-8—8.7.13.4 Prime Contract: Exhibit M-10—8.7.13.3 10 CCR 2505-10 8.209.4.W	**Both RAE and Prime:** **Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section 1.8, Subsection 1.8.7, Subsubsection 1.8.7.3.: This describes RMHP's responsibility for effectuating the State Fair Hearing decision if it reverses RMHP's decision to deny, limit or delay services that were not furnished while the appeal was pending. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
33. 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. *42 CFR 438.424(b)* RAE Contract: Exhibit B-8—8.7.13.5 Prime Contract: Exhibit M-10—8.7.13.4 10 CCR 2505-10 8.209.4.X	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section 1.8, Subsection 1.8.7, Subsubsection 1.8.7.2.: This describes that RMHP must pay for services when 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. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a *Grievance and Appeals* report including this information. *42 CFR 438.416* RAE Contract: Exhibit B-8—8.9.1–8.9.1.6 Prime Contract: Exhibit M-10—8.9.1-8.9.1.6 10 CCR 2505-10 8.209.3.C	**Both RAE and Prime:** **Both RAE and Prime:** **Bullet 1:** *VI_CS_Appeals Policy and Procedure* Page 2-3, Section 1.1, Subsection 1.1.7: This describes the records of appeals that RMHP maintains. *VI_CS_Grievance Policy and Procedure* Page 4-5, Section 2.2, subsection 2.2.13.: This describes the records of grievances that RMHP maintains. **Bullet 2:** *VI_CS_Appeals Policy and Procedure* Page 11, Section 1.9, Subsection 1.9.1 This describes the process for quarterly reporting that is completed and submitted to HCPF. **Bullet 2:** *VI_CI_R1_RM_GrieveAppealRpt_Q1-FY 2022-2023* This report, provides identified trends regarding timely response and completion of grievances and appeals, and any actions taken. Note: Grievance and Appeal approved template with Q1-FY22-23 data will be available via screenshare during interview. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system 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 after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – 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. *42 CFR 438.414* RAE Contract: Exhibit B-8—8.4 Prime Contract: Exhibit M-10—8.4 10 CCR 2505-10 8.209.3.B	**Both RAE and Prime:** *VI_PNM_2022 Physicians Medical Services Agreement* Page 13, Section U. "Expressing Disagreement": Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or requested in written form. *VI_PNM_2022 Physicians Medical Services Agreement* Page13, Section T. "Compliance, Cooperation and Participation in RME's Policies and Procedures": Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *VI_PNM_2022 Professional Services Agreement* Page 13, Section Q. "Expressing Disagreement": Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 13, Section P. "Compliance, Cooperation and Participation in RME's Policies and Procedures": Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VI_PNM_2022 Hospital Services Agreement Page 15, Section W. "Expressing Disagreement": Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 15, Section V. "Compliance, Cooperation, and Participation in RME's Policies and Procedures": Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *PNM_2021 RMHP Provider Manual* Page 57, "Appeal and Grievance Processes- Prime, RAE, CHP+" : This describes the Appeals and Grievances process for RAE & PRIME. **RAE-specific: N/A** **Prime-specific: N/A**	

Results for Standard VI—Grievance and Appeal Systems—RAE							
Total	Met	=	33	X	1.00	=	33
	Partially Met	=	2	X	.00	=	2
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	33
				Total Score ÷ Total Applicable		=	94%

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor agrees to accept individuals eligible for enrollment into its MCO in the order in which they are assigned without restriction and according to the enrollment policies and procedures. Members will be enrolled with the appropriate aid eligibility category and in the service area until the enrollment cap has been met. *42 CFR 438.3(d)(1)* RAE Contract: Exhibit B-8—6.6 Prime Contract: Exhibit M-10—6.6, 6.6.1	**Both RAE and Prime:** *XII_ProRec_Medicaid 834 Processing* RMHP processes the 834 EDI files in the order in which they are generated. RMHP does not have any rules setup in the 834 intake process that would restrict members from being loaded into the system of record. *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* This P&P describes the RMHP Enrollment and Disenrollment process. Page 2, 6.0 Procedure, RMHP Enrollment for Medicaid and CHP+ Members, paragraph 2: This describes that RMHP reports irregularities exceeding enrollment limits to the State. *XII_ProRec_Medicaid and CHP Enrollment Reporting* This P&P describes the analysis that RMHP performs monthly to identify any enrollment trends. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, national origin, ancestry, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability. *42 CFR 438.3(d)(3-4)*	**Both RAE and Prime:** *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* Page 2, 6.0 Procedure, bottom of page: This describes that RMHP does not discriminate against any members that are eligible for enrollment or enrolled in our programs for any reason.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—6.5 Prime Contract: Exhibit M-10—6.5	*PNM_2021 RMHP Provider Manual* Page 116, "Equal Opportunity Policy Statement": This describes that it is the policy of RMHP to provide equal opportunity and to prevent discrimination based on race, color, sex, national origin, age, or disability in admission or access to, or treatment or employment in, RMHP programs, health care plans, and activities to the extent required by applicable law. *XII_CM_Culturally Sensitive Services* Page 1, Policy & Procedure Section 3.0, Equal Opportunity Policy Statement: It is the policy of Rocky Mountain Health Plans (RMHP) to provide equal opportunity and to prevent discrimination based on race, color, national origin, sex, sexual orientation, gender identity, age, or disability in admission or access to, or treatment or employment in, RMHP programs, health care plans, and activities to the extent required by applicable law. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook_July 2022* -Member Rights & Responsibilities, pg. 41 -1557 Notice (CRN), PDF pg. 3 RMHP does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability. Members are notified of this policy through the Member Handbook.	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor may not request disenrollment of a member because of an adverse change in the member's health status or because the member's: • Utilization of medical services. • Diminished mental capacity. • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the member or to other members). *42 CFR 438.56(b)(2)* RAE Contract: Exhibit B-8—None Prime Contract: Exhibit M-10—6.13.2	**Both RAE and Prime:** *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* Page 4, 1st paragraph: This describes that RMHP will request disenrollment for a Member because of an adverse change in the Member's health status, utilization of services, diminished mental capacity, or behavior. *XII_CS_Disenrollment from RAE PRIME or CHP+* Section 4.0, Paragraph 1: This describes the process of review for potential disenrollment, due to when a Member is not allowing CS to assist, which may cause an interference with the Member's health and well-being. *XII_CM_CM 10 People with SHCN Policy* Page 2, Section 3 Bullet 7: Rocky Mountain care coordinators cannot request disenrollment of a Member due to an adverse change in the Member's health status or because of the Member's utilization of medical services, diminished mental capacity or due to uncooperative or disruptive behavior resulting from the Member's special needs (except when Member's continued enrollment seriously impairs the Contractor's ability to furnish services to the Member or to other Members). **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor may initiate disenrollment of any member's participation in the MCO upon one or more of the following grounds: • Uncooperative or disruptive behavior such that continued enrollment would seriously impair the Contractor's ability to furnish services to the member or poses physical threat to the provider, to other providers, contractor staff, or other members. • For cause, at any time under the following circumstances: – Admission of the member to any federal, state, or county governmental institution for treatment of mental illness, narcoticism or alcoholism, or a correctional institute. – Receipt of comprehensive health cover, other than Medicaid. – Enrollment in a Medicare MCO or capitated health plan other than such plan offered by the Contractor. – Ongoing pattern of failure on the part the member to keep scheduled appointments or meet any other member responsibilities. – The member has moved out of the Contractor's service area.	**Both RAE and Prime:** *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* Page 3, section "RMHP Disenrollment for Medicaid and CHP+ Members": This describes that RMHP may initiate disenrollment for the identified reasons. *XII_CS_Disenrollment from RAE PRIME or CHP+* Section 4.0, Paragraph 1: This describes the process of review for potential disenrollment, due to when a Member is not allowing CS to assist, which may cause an interference with the Member's health and well-being. *XII_CM_Disenrollment from RAE PRIME or CHP+* Page 1-2, Section 3.0 Policy: This describes that RMHP may initiate disenrollment of a Member's participation in the MCO upon one or more of the identified reasons. *PNM_2021 RMHP Provider Manual* Page 104, section "Circumstances that May Result in Member Dismissal" This describes that RMHP may initiate disenrollment of a Member due to Provider reported issues regarding Member behavior and/or responsibilities.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The Contractor does not (due to moral or religious objections) cover the service the member needs. – The member needs related services to be performed at the same time, not all related services are available from the Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk. – Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error. – Poor quality of care. – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs. – The member commits fraud or furnishes incorrect or incomplete information on applications, questionnaires, forms, or statements submitted as part of the member's enrollment. – Any other reason determined by the Department. *42 CFR 438.56(b)(1)* *42 CFR 436.56(d)(2)(i)-(v)*	*XII_CL_CoordofBenefitsProcessing_Medicaid Secondary P&P* Page 1, Section 6.0 The State of Colorado requires that a "third party" be responsible for the payment of claims before RMHP Medicaid. Benefits are to be exhausted by such third party before the claims are sent to RMHP for secondary consideration. Sometimes the "third party" is another commercial insurance through which the member has obtained coverage either as a dependent or as a subscriber. "Third Party" health benefits that are obtained through an employer group (active or as a retiree), individual plans or Tricare/Champus (Military Benefits) are considered primary to Medicaid. Medicaid is the payor of last resort. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—None Prime Contract: Exhibit M-10—6.13.1.1-7		
5. To initiate disenrollment of a member's participation with the MCO, the Contractor must provide the Department with documentation justifying the proposed disenrollment. *42 CFR 438.56(b)(3)* RAE Contract: Exhibit B-8—None Prime Contract: Exhibit M-10—6.13.1.7.4	**Both RAE and Prime:** *XII_ProRec_Member Change of Circumstance* This P&P describes the process to provide notification to the Department for the identified changes of circumstances for Members. *XII_CI_R1_RM_MmbrChange_MM_YY* This HCPF template is used to provide monthly reporting of a Member's change in circumstance. *XII_CS_Disenrollment from RAE PRIME or CHP+* Section 4.0, Paragraph 1: This describes the process of review for potential disenrollment (RAE/MCO reassignment) request by RMHP with HCPF. **RAE-specific: N/A** **Prime-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the Contractor's service area. – The Contractor does not (due to moral or religious objections) cover the service the member needs. – The member needs related services to be performed at the same time, not all related services are available from the Contractor's	**Both RAE and Prime:** *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* Page 4, 2nd paragraph: This describes that RMHP acknowledges that as Member may request disenrollment for cause or without cause at any time for the reasons identified. *XII_CS_Disenrollment from RAE PRIME or CHP+* Section 4.0 Paragraph 2 This describes how Customer Service assists members wanting to disenroll. **RAE-specific: N/A**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk. – Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error. – Poor quality of care. – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs. – The member enrolled with their provider and the provider leaves the Contractor. – The member is a resident of a long-term institutional care facility. – The member is enrolled into a Medicare managed care plan or Medicare capitated health plan other than the limited managed care capitation imitative offered by the Contractor and the Contractor cannot provide the member with reasonable access to a Medicare-approved provider or, if the member is enrolled in a Medicare managed care plan, and the Contractor cannot provide the member with providers participating in both plans.	**Prime-specific:** *PRIME Member Handbook_July 2022* Page 13-14, Section "*If you must leave Rocky Mountain Health Plans"* This describes that a Member may initiate disenrollment from RMHP for cause or without cause any time for the identified reasons.	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The member is in long-term community-based care. – The member is an Indian member and there is not timely access to an Indian Health Care Provider. • Without cause at the following times: – During the 90 days following the date of the member's initial passive enrollment. – At least once every 12 months thereafter. – Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity. – When the Department has imposed sanctions on the MCO (consistent with 42 CFR 438.702(a)(4). *42 CFR 438.56(2)(i)-(v)* RAE Contract: Exhibit B-8—6.10 Prime Contract: Exhibit M-10—6.13.4.1.1-12, 6.13.4.2.1-4		

Results for Standard XII—Enrollment and Disenrollment—RAE							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
			Total Score ÷ Total Applicable			=	100%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Denials Record Review
for
Rocky Mountain Health Plans RAE 1

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	March 7–8, 2023
Reviewer:	Crystal Brown
Participating MCE Staff Member(s):	Billie Bemis

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date of Initial Request [XX/XX/XXXX]	2/7/2022	5/24/2022	7/11/2022	8/16/2022	9/7/2022	9/16/2022	10/31/2022	10/19/2022	12/15/2022	12/2/2022					
Type of Denial: Termination (T), New Request (NR), Claim (CL)	NR	NR	NR	NR	CL	CL	NR	CL	NR	NR					
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	S	E	E	SUD	R	R	E	R	E	SUD					
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	2/8/2022	5/24/2022	7/11/2022	8/17/2022	10/1/2022	10/8/2022	11/1/2022	11/12/2022	12/16/2022	12/5/2022					
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	2/9/2022	5/25/2022	7/11/2022	8/17/2022	2/7/2023	2/7/2023	11/1/2022	2/7/2023	12/16/2022	12/5/2022					
Notice Sent to Provider and Member? [I.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Number of Hours or Days for Decision (H/D)	1 D	0 D	0 D	1 D	24 D	22 D	1 D	24 D	1 D	3 D					
Number of Hours or Days for Notice (H/D)	2 D	1 D	0 D	1 D	153 D	144 D	1 D	111 D	1 D	3 D					
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.12] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Notice Sent Within Required Time Frame? [I.17] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections Termination: 10 calendar days before the date of action	Met	Met	Met	Met	Not Met	Not Met	Met	Not Met	Met	Met					
Was Authorization Decision Timeline Extended? Yes or No	No	No	No	No	No	No	No	No	No	No					
If Extended, Extension Notification Sent to Member? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
If Extended, Extension Notification Includes Required Content? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
NABD Includes Required Content [I.15-16]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Authorization Decision Made by Qualified Clinician? [I.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
If Denied for Lack of Information, Was the Requesting Provider Contacted for Additional Information or Consulted (if applicable)? [I.9]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
Was the Decision Based on Established Authorization Criteria (i.e., not arbitrary)? [I.2]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Was Correspondence With the Member Easy to Understand? [I.14]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	7	7	7	7	7	7	7	7	7	7					
Compliant (Met) Elements	7	7	7	7	6	6	7	6	7	7					
Percent Compliant	100%	100%	100%	100%	86%	86%	100%	86%	100%	100%					
Overall Total Applicable Elements	**70**														
Overall Total Compliant Elements	**67**														
Overall Total Percent Compliant	**96%**														

Comments:
Files 5, 6, and 8: NABDs were not generated until 2/7/2023.

Yes and No = not scored—for informational purposes only
**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Grievances Record Review
for
Rocky Mountain Health Plans RAE 1

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	March 7–8, 2023
Reviewer:	Crystal Brown
Participating MCE Staff Member(s):	Rhonda Michaelson and Marci Wright O'Gara

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date Grievance Received [XX/XX/XXXX]	3/14/2022	5/9/2022	8/2/2022	8/26/2022	9/13/2022	9/19/2022	10/13/2022	11/9/2022	12/13/2022	12/30/2022					
Date of Acknowledgement Letter [XX/XX/XXXX]	3/16/2022	5/10/2022	8/4/2022	8/30/2022	9/15/2022	9/21/2022	10/17/2022	11/10/2022	12/14/2022	1/3/2023					
Days From Grievance Received to Acknowledgement	2	1	2	2	2	2	2	1	1	2					
Acknowledgement Letter Sent in 2 Working Days [VI.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Date of Written Notice [XX/XX/XXXX]	3/28/2022	5/27/2022	8/23/2022	8/30/2022	9/15/2022	10/8/2022	10/17/2022	11/10/2022	12/14/2022	1/3/2023					
# of Days to Notice	10	14	15	2	2	13	2	1	1	2					
Resolved and Notice Sent in Time Frame* [VI.12,24] Standard: 15 working days Extension: 15 working days + 14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker Not Involved in Grievance [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Appropriate Level of Expertise (If Clinical) [VI.7]	NA	NA	NA	NA	Met	NA	NA	NA	NA	Met					
Resolution Letter Includes Required Content [VI.13]**	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.12]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5	5	5	5	6	5	5	5	5	6					
Compliant (Met) Elements	5	5	5	5	6	5	5	5	5	6					
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
Overall Total Applicable Elements	**52**														
Overall Total Compliant Elements	**52**														
Overall Total Percent Compliant	**100%**														

Comments:

* Grievance timeline for resolution and notice sent is 15 working days (unless extended, then up to 14 calendar days).

**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Appeals Record Review
for
Rocky Mountain Health Plans RAE 1

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	March 7–8, 2023
Reviewer:	Crystal Brown
Participating MCE Staff Member(s):	Rhonda Michaelson and Marci Wright O'Gara

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date Appeal Received [XX/XX/XXXX]	3/1/2022	5/10/2022	7/12/2022	7/21/2022	9/12/2022	10/3/2022	10/20/2022	10/27/2022	11/11/2022	12/14/2022					
Date of Acknowledgement [XX/XX/XXXX]	3/3/2022	5/11/2022	7/13/2022	7/22/2022	9/14/2022	10/5/2022	10/21/2022	10/28/2022	11/14/2022	12/16/2022					
Days From Appeal Received to Acknowledgement	2	1	1	1	2	1	1	1	0	2					
Acknowledgement Sent Within 2 Working Days? [VI.17]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker Not Previous Level [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker—Clinical Expertise [VI.7]	NA	NA	Met	Met	Met	Met	Met	Met	Met	Met					
Expedited Appeal: Yes or No	No	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes					
Time Frame Extended: Yes or No	No	No	No	No	No	No	No	No	No	No					
Date Resolution Notice Sent [XX/XX/XXXX]	3/3/2022	5/23/2022	7/13/2022	7/22/2022	9/14/2022	10/17/2022	10/31/2022	10/28/2022	11/14/2022	12/16/2022					
Hours or Days From Appeal Filed to Resolution Notice Sent	2 D	9 D	1 D	1 D	2 D	9 D	7 D	1 D	0 D	2 D					
Notice Sent Within Time Frame*? [VI.22-25] Standard Resolution: 10 working days Expedited Resolution: 72 hours Time Frame Extended: +14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Includes Required Content [VI.26]**	Met	Met	Met	Met	Not Met	Not Met	Met	Not Met	Not Met	Met					
Resolution Letter Easy to Understand [VI.22]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5	5	6	6	6	6	6	6	6	6					
Compliant (Met) Elements	5	5	6	6	5	5	6	5	5	6					
Percent Compliant	100%	100%	100%	100%	83%	83%	100%	83%	83%	100%					
Overall Total Applicable Elements	**58**														
Overall Total Compliant Elements	**54**														
Overall Total Percent Compliant	**93%**														

Comments:
Files 5, 6, 8, and 9 included language in the appeal resolution letters that said continuation of benefits request must be in writing. Continuation of benefits requests are not required in writing.

*__Appeal resolution letter time frame__ does not exceed 10 working days from the day the MCE receives the appeal (unless expedited—72 hours; or unless extended—+14 calendar days).

**__Appeal resolution letter required content__ includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request (does not apply to CHP+).

**** = Redacted Member ID

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2022–2023 compliance review of **RMHP**.

Table C-1—HSAG Reviewers and RMHP and Department Participants

HSAG Review Team	Title
Sarah Lambie	Senior Project Manager
Crystal Brown	Project Manager I
RMHP Participants	**Title**
Alyssa Rose	Chief Compliance Officer
Ashley Murphy	Manager, Behavioral Health Utilization Management
Billie Bemis	Director of Utilization Management
Braden Neptune	Director of Business Analysis, Member Enrollment and Billing and Program Reconciliation
Christy Hunt	Manager, Claim Production
Cynthia Mattingley	Manager, Quality and Accreditation
Dale Renzi	Vice President of Network Strategies and Operations
David Mok-Lamme	Vice President of Data Systems and Strategy, Health Information Technology and Data Director
David White	Compliance Analyst, United Health Care (UHC) Audit Management
Diana Lopas	Quality Auditor and Trainer for Appeals and Grievances
Greg Coren	Senior Manager, Provider Networks
James Hart	Senior Compliance Analyst, UHC Audit Management
Jeremiah Fluke	Director, Contract Administration., Prime Contract Manager
Jesse Eller	Vice President, Individual Markets and Network Operations
Kendra Peters	CHP+ Contract Manager and RAE Program Operation Support
Kim Herek	Director of Quality Improvement
Kim Nordstrom	Chief Medical Officer
Marci Wright O'Gara	Senior Director of Business Operations
Maura Cameron	Director of Clinical Quality and Accreditation
Meg Taylor	Vice President, Behavioral Health
Melissa Keele	Director of Compliance, Quality Assurance and Medicare Programs
Monika Tuell	Chief Operations Officer
Patrick Gordon	Chief Executive Officer

RMHP Participants	Title
Rhonda Michaelson	Supervisor, Appeals and Grievances
Sarah Vaine	Vice President, Community Integration, RAE Program Officer
Shanna Hauser	Associate Regulatory Adherence Analyst
Shawna Sayers	Appeals and Grievances Coordinator
Tiffany Kikta	Manager, Utilization Management of Physical Health
Todd Lessley	Vice President, Clinical Services
Violet Willett	Director, Care Management
Zach Kareus	Director of Pharmacy
Department Observers	**Title**
Tyller Kerrigan-Nichols	Managed Care Contract Specialist
Lindsey Folkerth	Managed Care Contract Specialist
Helen Desta	Quality Section Manager
Jeff Helm	CHP+ Section, Benefits and Services Division
Russ Kennedy	Quality and Compliance Specialist
Amy Ryan	CHP+ Contracts and Program Administrator

Appendix D. Corrective Action Plan Template for FY 2022–2023

If applicable, the MCE 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 MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to 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 MCE must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
If applicable, the MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) 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 and HSAG will: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and also to proceed with resubmission.	
Step 4	**Documentation substantiating implementation**
Once the MCE has received Department approval of the CAP, the MCE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The MCE will submit documents as evidence of completion one time only on or before the 90-day deadline for all required actions in the CAP. If any revisions to the planned interventions are deemed necessary by the MCE during the 90 days, the MCE should notify the Department and HSAG. If the MCE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in advance from the Department to extend the deadline.	

Step	Action
Step 5	**Technical assistance**
At the MCE's request or at the recommendation of the Department and HSAG, technical assistance (TA) calls/webinars are available. The session may be scheduled at the MCE's discretion at any time the MCE determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.	
Step 6	**Review and completion**
Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the MCE as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the three-month deadline will result in a continued corrective action with a new date for resubmission established by the Department. HSAG will continue to work with the MCE until all required actions are satisfactorily completed.	

The CAP template follows on the next page.

Table D-2—FY 2022–2023 Corrective Action Plan for RMHP RAE 1 and Prime

Standard I—Coverage and Authorization of Services (RAE 1 and Prime)
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
11. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* RAE Contract: Exhibit B-8—8.6.1 Prime Contract: Exhibit M-10—8.7.13.5 10 CCR 2505-10 8.209.4.A.1
Findings
RMHP identified a large-scale issue where member letters related to retrospective claims denials were not mailed. RAE 1: This impacted three out of the 10 denial samples. Prime: This impacted four out of the 10 denial samples.
Required Actions
RMHP must show evidence of this long-term update and ongoing monitoring as part of the CAP process.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard I—Coverage and Authorization of Services (RAE 1 and Prime)
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services (Prime)
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
12. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* *Memo: HCPF FFS UM Policy Requirements for SUD Benefit—August 4, 2020* RAE Contract: Exhibit B-8—8.6.6, 8.6.8 Prime Contract: Exhibit M-10—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)
Findings
Denial sample #7 was received in March, logged in September, and a decision was documented on October 1, 2022. This decision time frame exceeded the 30-day processing policy for RMHP Prime retroactive claims.
Required Actions
RMHP Prime must enhance its procedures for monitoring decision-making time frames.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard I—Coverage and Authorization of Services (Prime)
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services (RAE 1)
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
16. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* RAE Contract: Exhibit B-8—8.6.3.1, 8.6.5–8.6.8 Prime Contract: Exhibit M-10—8.6.3.1, 8.6.5-8.6.8 10 CCR 2505-10 8.209.4.A.3
Findings
Three out of the 10 denial samples were not sent within timeliness standards, and the *UM Program Description* included incorrect authorization timelines on page 14 that miscommunicated the timeline from the time of the decision or after the time of verbal notification.
Required Actions
RMHP must show evidence of its long-term update to ensure member letters are mailed and ongoing monitoring of denial notification timeliness as part of the CAP process. Additionally, RMHP must update its language related to authorization timelines in the *UM Program Description* to clarify that the time frame starts at the time of the request.

Standard I—Coverage and Authorization of Services (RAE 1)
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard I—Coverage and Authorization of Services (Prime)
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
17. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* RAE Contract: Exhibit B-8—8.6.3.1, 8.6.5–8.6.8 Prime Contract: Exhibit M-10—8.6.3.1, 8.6.5-8.6.8 10 CCR 2505-10 8.209.4.A.3
Findings
Four out of the 10 denial samples were not sent within timeliness standards, and the *UM Program Description* included incorrect authorization timelines on page 14 that miscommunicated the timeline from the time of the decision or after the time of verbal notification.
Required Actions
RMHP Prime must show evidence of its long-term update to ensure member letters are mailed and ongoing monitoring of denial notification timeliness as part of the CAP process. Additionally, RMHP Prime must update its language related to authorization timelines in the *UM Program Description* to clarify that the time frame starts at the time of the request.

Standard I—Coverage and Authorization of Services (Prime)
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard II—Adequate Capacity and Availability of Services (RAE 1 and Prime)
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
7. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care *(RAE only):* – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *(RAE only)* *42 CFR 438.206(c)(1)(i)* RAE Contract: Exhibit B-8—9.4.13, 9.4.13.1-4, 9.4.13.5.1-2 Prime Contract: Exhibit M-10—9.3.9.1
Findings
While the standards for timely access to care and services were accurately detailed in the *Network Plan*, the *Standards for Practitioner Office Sites* policy incorrectly stated that RMHP evaluates the availability of scheduling for urgent services between 24 and 48 hours and non-urgent care visits at 14 days and did not include any exceptions for the American Academy of Pediatrics Bright Futures Periodicity Schedule related to well-care visits.
Required Actions
RMHP must update the *Standards for Practitioner Office Sites* policy to include the correct standards for timely access to care related to urgent services and non-urgent care visit and should include the exceptions related to when well-care visits should be scheduled prior to one month.

Standard II—Adequate Capacity and Availability of Services (RAE 1 and Prime)
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems (RAE 1 and Prime)
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* RAE Contract: Exhibit B-8—8.7.6 Prime Contract: Exhibit M-10—8.7.6, 8.7.7 10 CCR 2505-10 8.209.4.F
Findings
RMHP's *Appeals Policy and Procedure* accurately stated that a member can request an appeal verbally or in writing and a verbal request will be treated the same as a written request. However, its *UM Program Description,* page 17, stated that telephone notifications to initiate the standard appeals process must be followed up by a written confirmation from the member or provider.
Required Actions
RMHP must remove from the *UM Program Description* any references that require a member to submit appeal information in writing.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:

Standard VI—Grievance and Appeal Systems (RAE 1 and Prime)
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems (RAE 1 and Prime)
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
26. 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 that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* RAE Contract: Exhibit B-8—8.7.14.3, 8.7.14.4 Prime Contract: Exhibit M-10—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M
Findings
RAE 1: RMHP had four sample appeal resolution letters that required the member to request continuation of benefits in writing. Prime: RMHP Prime had six sample appeal resolution letters that required the member to request continuation of benefits in writing.
Required Actions
RMHP must remove language that continuation of benefits must be submitted "in writing" as it is not a requirement by the federal regulations or State contract.

Standard VI—Grievance and Appeal Systems (RAE 1 and Prime)
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Standard VI—Grievance and Appeal Systems (Prime)
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • 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 an appeal in accordance with required time frames. * *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. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* RAE Contract: Exhibit B-8—8.7.13.1 Prime Contract: Exhibit M-10—8.7.13.1 10 CCR 2505-10 8.209.4.T
Findings
RMHP Prime accurately stated in the *Prime Member Handbook* that a member can request continued benefits within 10 days of the appeal decision. However, RMHP Prime did not include a bullet point that states a member can request continuation of benefits within 10 days of the NABD.
Required Actions
RMHP Prime must update its *Prime Member Handbook* to include a bullet point under the section "Continuing Your Benefits" on page 44 with the following language:

Standard VI—Grievance and Appeal Systems (Prime)
• You must tell RMHP if you want to keep getting your services through the appeal process. You must do it within 10 days of the notice of adverse determination letter.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:
Monitoring and Follow-Up Activities Planned:
Documents to Be Submitted as Evidence of Completion:
HSAG Initial Review:
Documents Included in Final Submission:
Date of Final Evidence:

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the MCE provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The MCEs also submitted lists denials, grievances, and appeals that occurred between January 1, 2022, and December 31, 2022 (to the extent available at the time of the review). MCEs submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for the review. HSAG notified the MCE five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2022–2023 Department-approved Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.

COLORADO

Department of Health Care Policy & Financing

Appendix F:

Fiscal Year 2022–2023 Compliance Review Report

for

Rocky Mountain Health Plans Medicaid Prime

May 2023

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

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix F: Table of Contents

1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposal 2017000265, the Department of Healthcare Policy & Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service primary care providers and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). In addition, the **Rocky Mountain Health Plans** (**RMHP**) Region 1 RAE contract incorporates into the RAE a limited managed care initiative for capitated physical health (PH) services (managed care organization [MCO]), applicable to a designated service area within the region. 42 CFR requires PCCM entities, PIHPs, and MCOs to comply with specified provisions of 42 CFR 438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PCCM entities, PIHPs, and MCOs, to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. The Department has elected to complete this requirement by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2022–2023 compliance review activities for the Region 1 limited managed care initiative—**Rocky Mountain Health Plans Medicaid Prime** (**RMHP Prime**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2022–2023 compliance monitoring review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2021–2022 compliance review activities. Appendix F1 contains the compliance monitoring tool for the review of the standards. Appendix F2 contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record review tools.

Summary of Compliance Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

Table 1-1 presents the scores for **RMHP Prime** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix F1—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	33	31	28	3	0	2	90%
II. Adequate Capacity and Availability of Services	13	13	12	1	0	0	92%
VI. Grievance and Appeal Systems	35	35	32	3	0	0	91%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**87**	**85**	**78**	**7**	**0**	**2**	**92%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

Table 1-2 presents the scores for **RMHP Prime** for the denials, grievances, and appeals record reviews. Details of the findings for the record reviews are in Appendix F2—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	100	70	65	5	30	93%
Grievances	60	50	50	0	10	100%
Appeals	60	60	54	6	0	90%
Totals	**220**	**180**	**169**	**11**	**40**	**94%**

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

Standard I—Coverage and Authorization of Services

Evidence of Compliance and Strengths

The **RMHP Prime** utilization management (UM) department ensured services were sufficient in amount, duration, and scope through the use of standardized review tools and clear policies and procedures. Oversight of denial decisions was evident in **RMHP Prime** reports, committee meeting minutes, and delegate monitoring of eviCore as well as Advanced Medical Reviews (AMR), which is contracted for specialty cases. Inter-rater reliability testing for **RMHP Prime** and eviCore was well above the goal of 80 percent, at 97 percent reliability or higher overall. In terms of technology updates, eviCore uses intelliPath, which is a technology-based UM system that was implemented two years ago, and scans documentation and approves authorizations that align when it detects sufficient documentation (a medical director is still involved for denials). While many UM requests are submitted through the provider portal, American Society of Addiction Medicine (ASAM) requests were not fully integrated at the time of the review and required faxes or secure email; however, the UM department reported an overall 98 to 99 percent timeliness of processing authorization requests, and the ASAM procedures that occurred outside the portal do not appear to be a barrier. **RMHP Prime**'s turnaround time reference document demonstrated that **RMHP Prime** responded to requests for covered outpatient drugs within 24 hours of the request.

A portion of the sample notice of adverse benefit determination (NABD) letters included retrospective claims denials which required member notification. While the NABD letter was not based on the Department's template, for retrospective claims denials, the letters contained the minimum required information. Other NABDs related to medical necessity, administrative denials, and out-of-network requests followed the Department's NABD template.

Documentation within the denial samples demonstrated extensive outreach to the provider when additional information or clarification is needed. Most files included at least two outreaches and some files included 10 or more documented efforts. Some NABDs included clear recommendations for the member to obtain the recommended alternative level of care and listed available providers in the area, including contact information. HSAG recognizes this as a best practice.

Lastly, **RMHP Prime** accurately defined emergency services and poststablilization in accordance with State and federal requirements. The claims production manager described how these service codes are set up in the claims system to pass through or be immediately approved upon the manual review process. Monitoring included annual review of trends with pended claims and internal audits. No major findings were noted during the review period and staff members confirmed that the service codes and locations are fairly easy to spot as the combinations are common and can be easily manually adjudicated.

Opportunities for Improvement and Recommendations

Many of the NABDs reviewed included acronyms or clinical terminology that could be explained in a more member friendly manner. HSAG recommends additional internal review and plain language explanations whenever possible.

Committee minutes noted high denial and overturn rates from eviCore. In some instances within the denial samples, the denial was issued prior to the end of the authorization review period. **RMHP Prime** has the opportunity to consider using the full allotted timeline for making authorization decisions and to use extensions if it is in the best interest of the member.

Required Actions

While preparing the denial samples, **RMHP Prime** identified an issue related to member claims denial notices. Staff members described that a glitch in the member letter file did not trigger the next step to notify the support services team, which processes and mails the member letters. As a result of the corrupt file, **RMHP Prime** estimates that roughly 2,000 member letters were not mailed. Upon discovery of the issue, these member letters were processed in early February 2023, and the letters included a timeline to file an appeal 60 days from the date of the delayed written notice. Staff members reported that roughly 20 to 30 members have contacted **RMHP Prime** with questions. Staff members described actions taken to prevent this from occurring again, such as additional information technology, UM, and support services communication and monitoring. However, due to the large-scale issue, **RMHP Prime** must show evidence of this long-term update and ongoing monitoring as part of the CAP process.

Additionally, **RMHP Prime** must update its language related to authorization timelines in the *UM Program Description* to clarify that the time frame starts at the time of the request.

Standard II—Adequate Capacity and Availability of Services

Evidence of Compliance and Strengths

During the interview, staff members described ongoing efforts to continue expanding the **RMHP Prime** network, which includes seeking Behavioral Health Administration funding whenever possible. Leadership noted a significant network gain with the provider, Integrated Insights Therapy, that serves the Delta, Gunnison, and Montrose regions. **RMHP Prime** provided support to this provider in order to scale and grow into new offices in western Montrose.

Regarding women's specialist services, staff members described how members are documented in the system, and customer service representatives have a robust reference guide to help answer member's benefits questions, even referencing the claims adjudication system, if needed. Staff members also reported that provider advocates have a geographic focus and can help members find specialists.

Regarding second opinions, staff members again confirmed that all inquiries are tracked, and care management is assigned for additional support if follow-up is needed.

UM representatives described how out-of-network requests, when approved, are processed promptly between UM and the provider networking team. The director of care management also discussed how care management staff members stay involved, as needed, to inform members about any updates to the out-of-network request.

Appointment timeliness standards were accurately captured in the provider manual, most relevant policies, and the Prime member handbook. Monitoring efforts included provider self-monitoring and member surveys. However, member survey responses were notably low. The director of care management described additional monitoring through emergency department data. Other staff members from network operations added that a new format of member surveying is currently being considered. **RMHP Prime** submitted thorough documentation of the leadership team reviewing appointment timeliness reports and trends at the committee level, raising any access complaints from the grievance department, and the executive leadership team described making personal efforts to follow up with providers and initiating CAPs.

RMHP Prime's cultural competency trainings, outreach, and initiatives submitted in documentation and described by staff members were extensive and specifically targeted to its membership. Staff members discussed a focus on social determinants of health and increasing assessments. Data analysis has pointed specifically to the importance of member needs surrounding housing and transportation as a key focus for its members.

Submitted documentation described Latinx community outreach and support for the deaf and hard of hearing population, including grants. Trainings developed and facilitated by **RMHP Prime**'s practice transformation team included the following: implicit bias; health equity; connecting across cultures; cultural humility; the basics of lesbian, gay, bisexual, transgender, and queer (LGBTQ) affirming care; caring for patients with brain injury; and cultural competency related to Americans with Disabilities Act, among others. **RMHP Prime** described the ABIDE (Ambassadors for Belonging, Inclusion, Diversity, and Equity) employee advisory council which was formed with the goal of connecting **RMHP Prime** staff members to the community and encouraging diverse representation of members in **RMHP Prime** initiatives. To encourage participation in its extensive cultural competency initiatives and ensuring that members feel comfortable accessing care, **RMHP Prime** demonstrated a tiered value-based payment (VBP) initiative that has been expanded to encourage psychosocial screeners, representation of diverse membership on patient and family advisory councils, and providers' enhanced ability to report on member satisfaction measures.

Opportunities for Improvement and Recommendations

All opportunities for improvement HSAG identified resulted in a required action.

Required Actions

While the standards for timely access to care and services were accurately detailed in the *Network Plan*, the *Standards for Practitioner Office Sites* policy incorrectly stated that **RMHP Prime** evaluates the availability of scheduling for urgent services between 24 and 48 hours and non-urgent care visits at 14 days, and did not include any exceptions for the American Academy of Pediatrics Bright Futures Periodicity Schedule related to well-care visits. **RMHP Prime** must update *the Standards for Practitioner Office Sites* policy to include the correct standards for timely access to care related to urgent services and non-urgent care visits, and should include the exceptions related to when well-care visits should be scheduled prior to one month.

Standard VI—Grievance and Appeal Systems

Evidence of Compliance and Strengths

RMHP Prime has a thorough process in place to receive and accept grievances and appeals through its standard system, Macess. Documentation and evidence submitted included the *Prime Member Handbook, Provider Manual*, *Appeals Policy and Procedures*, *Non-discrimination Policy and Procedures*, *Grievance Policy and Procedures*, and multiple other documents that outline how staff members process grievances and appeals. Staff members reported the grievances and appeals department's organizational structure included a supervisor, managers, and five care coordinators that assisted members when filing a grievance or appeal. **RMHP Prime** offered many opportunities for training internally to its staff members upon hire through SupportPoint. Training is conducted ongoing and biweekly so that new staff members understand the benefits.

Submitted documentation described how members received reasonable assistance such as staff member help in completing forms, offering auxiliary aids and other services upon request, and the opportunity to present evidence, testimony, and make legal factual arguments in person. Staff members described how they would assist the member by collecting information from the member and submitting it on behalf of the member for State fair hearing reviews, when the member had difficulties completing the submission on their own.

RMHP Prime has a system in place to receive, log, and track grievances from members at any time. **RMHP Prime** submitted a full sample of 10 grievances that met 100 percent compliance for readability and timeliness of acknowledgment and resolution letters HSAG reviewed **RMHP Prime**'s documentation submission and noted that the term "grievance" was accurately defined within the policy and procedures, *Provider Manual,* and *Prime Member Handbook.*

Although the time frame for **RMHP Prime** to accept appeals from the member is 60 calendar days after the NABD, **RMHP Prime** reported accepting appeals beyond the 60 calendar day window, under certain circumstances. Staff members reported during the interview that if the member needed a service,

they would assist the member in filing an appeal or start a new request for the alternative level of care recommended in the NABD.

Clinical decision makers who review appeals to decide whether to uphold or overturn denials are not involved in the initial denial decision. Staff members described an internal process in which the grievance and appeal coordinator sends an email with the name of the medical director who made the initial denial in the subject line so that other medical directors or other teammates with clinical expertise who were not previously involved may work on the appeal case. **RMHP Prime** staff members reported that if clinical expertise for a specialty case was not available, **RMHP Prime** would outsource to AMR. Additionally, the timeliness of mailing member letters was described by staff members to be very important to **RMHP Prime** and associated metrics are tracked and trended.

Opportunities for Improvement and Recommendations

All opportunities for improvement HSAG identified resulted in a required action.

Required Actions

RMHP Prime's *Appeals Policy and Procedure* accurately stated that a member can request an appeal verbally or in writing and a verbal request will be treated the same as a written request. However, its *UM Program Description,* page 17, stated that telephone notifications to initiate the standard appeals process must be followed up by a written confirmation from the member or provider. **RMHP Prime** must remove from the *UM Program Description* any references that require a member to submit appeal information in writing.

RMHP Prime had six sample appeal resolution letters that required the member to request continuation of benefits in writing. **RMHP Prime** must remove language that continuation of benefits must be submitted "in writing," as it is not a requirement by the federal regulations or State contract.

RMHP Prime accurately stated in the *Prime Member Handbook* that a member can request continued benefits within 10 days of the appeal decision. However, **RMHP Prime** did not include a bullet point that states a member can request continuation of benefits within 10 days of the NABD. The *Prime Member Handbook* must be updated to include a bullet point under the section "Continuing Your Benefits" on page 44 with the following language:

- You must tell **RMHP Prime** if you want to keep getting your services through the appeal process. You must make the request within 10 days of the notice of adverse determination letter.

Standard XII—Enrollment and Disenrollment

Evidence of Compliance and Strengths

RMHP Prime submitted an *Enrollment and Disenrollment Policy and Procedure* that describes a process in which member enrollment is completed for all lines of business. Staff members described a thorough overview of how the enrollment process works beginning when the Electronic Data Interchange (EDI) 834 files are received from the Department daily, Monday through Friday, and are processed in the order of receipt, indicated by the timestamp displayed at the top of the file with no restriction. Staff members reported that although **RMHP Prime** has a cap on how many members are allowed to be enrolled under **RMHP Prime**, it has never exceeded the cap; and if it does, **RMHP Prime** would be in communication with the Department. Additionally, staff members reported that there is a monthly validation completed on 834 files received, using the process of exchanging the Health Care Eligibility Benefit Inquiry and Response (270/271) information with the Department for reconciliations purposes.

RMHP Prime does not discriminate according to staff members who described a process that the MCO begins working with the member and providing healthcare services promptly. If a member complained of an allegation of discrimination, **RMHP Prime** would process the complaint through the appropriate channels and investigate that accusation; however, staff members were not aware of any instances of a member reporting accusations of discrimination during this reporting period or prior.

Although in the past **RMHP Prime** has described one instance where **RMHP Prime** requested disenrollment of a member in another line of business, staff members reported that only in the most extreme cases would they request a disenrollment of the member, and staff members would do what they can and take all avenues necessary to meet the member's needs. In these types of situations, the Department and **RMHP Prime** would discuss the request. **RMHP Prime** and the Department discuss member topics during a biweekly meeting.

Opportunities for Improvement and Recommendations

HSAG recommends that **RMHP Prime** develop a mechanism to compare disenrollment files to member reported quality-of-care concerns for tracking and trending purposes.

Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2022–2023 Compliance Monitoring Activities

For the FY 2022–2023 compliance 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 performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the MCO's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in November 2020, with an effective date of December 2020. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was January 1, 2022, through December 31, 2022. HSAG conducted a desk review of materials submitted prior to the compliance review activities; a review of records, documents, and materials requested during the compliance review; and interviews of key MCO personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and compliance review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to denials of authorization, grievances, and appeals. While the RAE and MCO managed care requirements were reviewed simultaneously, HSAG delineated results for each product line into individual separate reports. However, required corrective actions for the MCO are the responsibility of the RAE and are incorporated into Appendix D of the RAE Region 1 report.

HSAG reviewed a sample of the MCO's administrative records related to denials, grievances, and appeals to evaluate implementation of federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of the denials, grievances, and appeals. Using a random sampling technique, HSAG selected the samples from all MCO denial, grievance, and appeal records that occurred between January 1, 2022, and December 31, 2022. For the record review, the MCO received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E of the RAE Region 1 report contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2022–2023 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontractual Relationships and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT).

Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the MCO regarding:

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

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

FY 2021–2022 Corrective Action Methodology

As a follow-up to the FY 2021–2022 compliance review, each MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the MCO 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 MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP Prime** until it completed each of the required actions from the FY 2021–2022 compliance monitoring review.

Summary of FY 2021–2022 Required Actions

For FY 2021–2022, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard V—Member Information Requirements, and Standard XI—EPSDT.

Related to Standard V—Member Information Requirements, **RMHP Prime** was required to complete two corrective actions as follows:

- Revise critical informational materials such as the *Getting Started Guide*, *Prime Member Handbook*, *Directory of Participating Providers*, formulary list, and member letter templates to include all required components of a tagline.
- Update its policy to include the language, "or 30 days prior to the effective date of the termination."

Summary of Corrective Action/Document Review

RMHP Prime submitted a proposed CAP in June 2022. HSAG and the Department reviewed and approved the proposed plan and responded to **RMHP Prime**. **RMHP Prime** submitted final documents that included but were not limited to the following:

- *Combined_1557Notice_0MLIS_09302022 (Medicaid CHP+)*
- *Combined_1557Notice_0MLIS_09302022 (Medicaid CHP+) (Spanish)*
- *PRIME Member Handbook_updatedJuly2022_V2*
- *PRIME Member Handbook_updatedJuly2022_SPA_V2*
- *RMHP PRIME-CHP Formulary_8.1.22_V2*

- *PRIME Provider Directory_Sept 2022_ENG_V2*
- *PRIME Provider Directory_Sept 2022_SPA_V2*
- *RAE-PRIME Getting Started Guide_MD11-GSG_V2*
- *Overturn Denial No Medical Review Template*
- *RAE Prime Denial Letter Adult Template*
- *RAE Prime Denial Letter Child Template*

In addition, the updated *Notification of Provider Terminations* policy was submitted in September 2022, and the CAP was completed in October 2022.

Summary of Continued Required Actions

RMHP Prime successfully completed the FY 2021–2022 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* RAE Contract: Exhibit B-8—14.6.2 Prime Contract: Exhibit M-10—14.1.1.1, 14.4.2	Note: Federal requirements only apply to MCOs and PIHPs (behavioral health services of RAEs) unless otherwise noted. **Both RAE and Prime:** *I_UM_UM Program Description_2022* Page 4, Section II, Paragraph 2: This describes that RMHP's UM Program is designed to ensure that medical services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the Plan. *I_UM_Preauthorization Policy & Procedure* Page 6, Section 6, Paragraph 6.18: This describes that as part of its procedure RMHP ensures that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *I_PNM_2021 RMHP Provider Manual* Page 97, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the Member. Further, RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan. **RAE-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: N/A	
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* RAE Contract: Exhibit B-8—14.6.4 Prime Contract: Exhibit M-10—14.1.1.3, 14.4.4	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 7, Section 6, Paragraph 6.23.1: This states that RMHP does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the Member. *I_PNM_2021 RMHP Provider Manual* Page 97, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the Member. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose. – For Utilization Management, provided family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.	**Both RAE and Prime:** *I_UM_Clinical Criteria for UM Decisions* Page 1, Paragraph 1.1 This describes that RMHP applies objective and evidence-based criteria when determining medical appropriateness (necessity) of health care services. *I_UM_Preauthorization Policy & Procedure* Page 8, Section 6.23.6 - 6.23.6.2 This describes that RMHP may place appropriate limits on services on the basis of criteria applied under the State (medical necessity) and for the	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: The Contractor shall not deny or reduce the amount, duration, and scope of services provided under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) as long as the service is supporting a member to maintain stability or level of functioning or making treatment progress. *42 CFR 438.210(a)(4)* RAE Contract: Exhibit B-8—14.6.2.1; 14.6.5; 14.6.5.2; 14.6.5.2.3 Prime Contract: Exhibit M-10—14.4.5	purpose of utilization control, provided that the services furnished can reasonably be expected to achieve their purpose. Page 8, Paragraph 6.23.6.4 Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. *I_UM_Preauthorization Policy & Procedure* Page 8, Paragraph 6.23.6.6 RMHP will not deny or reduce the amount, duration, and scope of services provided under EPSDT for RAE or RAE Prime Members as long as the service is supporting a member to maintain stability or level of functioning or making treatment progress. *I_PNM_2021 RMHP Provider Manual* Page 97, Paragraph 3: This states that RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan. Family Planning services are included in this in accordance with the State plan. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). • The Contractor shall only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or substance use disorder benefits, in any classification, in a manner comparable to and no more stringently than, the processes, strategies, evidentiary standards, or other factors applied to the same NQTL in the same benefit classification of the members' medical/surgical benefits. *42 CFR 438.905* *HB19-1269: Section 3–10-16-104(3)(B)* RAE Contract: Exhibit B-8—14.6.5.2.1, 14.6.5.2.2 Prime MCO Contract: Exhibit M-10—Not Applicable	**RAE-specific:** *I_UM_Preauthorization Policy & Procedure* Page 8, Section 6, Paragraph 6.23.6.3: This states that for the purpose of utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive that the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Members (whether or not the benefits are furnished by the same Contractor). *I_UM_Clinical Criteria for UM Decisions* Paragraph 3.2.4.2.1 - 3.2.4.2.2. This states that clinical criteria is clinically sound and based upon analysis of clear, professionally recognized, current clinical and medical/surgical and/or behavioral evidence of effectiveness, where available. Criteria used is compliant with all Federal and State regulations, including those relating to Mental Health Parity. Where regulations overlap, the stricter guidance shall apply.	**Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet 1: *I_PNM_2021 RMHP BH Provider Manual* Page 9 "Mental Health Parity Reports (HCPF Website)," this section states that: The MHPAEA is designed to ensure that Medicaid managed care organizations and Medicaid alternative benefit plans providing mental health or substance use disorder (MH/SUD) benefits apply limitations on those benefits that are comparable to and no more stringent than those limitations imposed upon medical and surgical (M/S) benefits in the same classifications.	
5. The Contractor covers all medically necessary covered treatments for covered behavioral health (BH diagnoses), regardless of any co-occurring conditions. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered BH service. *HB19-1269: Section 12—25.5-5-402(3)(h-i)*	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 6, Section 6, Paragraph 6.19: This states that RMHP ensures that a diagnosis of an intellectual disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health service. *I_PNM_2021 RMHP BH Provider Manual* Page 35, bullets in the "Utilization Management Procedures" section: This describes Medical Necessity as defined by the Department, which includes intellectual or developmental disability, neurological or neurocognitive disorder, or a traumatic brain injury diagnosis is not precluded from receiving a covered BH service.	**Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** *PRIME Member Handbook_July 2022* Page 12, "What does 'medically necessary' mean?; This describes that, as a HFC or RMHP PRIME member, medically necessary services are covered. Page 41, "Member Rights and Responsibilities"; "It is your right" describes that it is the Member's right to medically necessary services and the discussion to be presented in a manner appropriate to the condition and Member's ability to understand. Page 66, "Glossary - Covered Services"; This describes that Medically Necessary services are covered services. Page 70; "Glossary - Medically Necessary"; definition of Medically Necessary.	
6. The Contractor definition of "medically necessary": • Is no more restrictive than that used in Colorado's Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Colorado statutes and regulations, the Health First Colorado plan, and other Colorado policies and procedures; and • Addresses the extent to which the MCO is responsible for covering services that address: – The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.	**Both RAE and Prime:** *I_UM_UM Program Description_2022* Page 4, Section I: This describes that RMHP's UM Program is designed to ensure quality medically necessary care is provided to Members with optimal outcomes and cost efficiency across the continuum of healthcare services and in accordance with regulatory and accreditation requirements. Page 14-15, Section X: This describes RMHP's use of nationally accepted	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. *Note: For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth at Section 8.076.1.8.b–g.* *The Contractor shall determine medical necessity under EPSDT for members ages 20 and under based on an individualized clinical review of a member's medical status and in consideration that the requested treatment can correct or ameliorate a diagnosed health condition.* *Note: The Contractor shall utilize the American Society of Addiction Medicine (ASAM) criteria to determine medical necessity for residential and inpatient substance use disorder treatment services. (RAE Only)* *42 CFR 438.210(a)(5)* RAE Contract: Exhibit B-8—14.6.5.1.1 Prime Contract: Exhibit M-10—7.7.5.3.6, 7.7.5.5.7 10 CCR 2505-10 8.280.4.E.2 10 CCR 2505-10 8.205.10.B.4.a	evidence-based guidelines that span the continuum of care, such as MCG Care Guidelines®, ASAM Criteria®, and other nationally recognized criteria established by organizations such as the American Academy of Obstetrics, Gynecology or Pediatrics. Use of these criteria ensures that RMHP provides services in accordance with professionally recognized standards for healthcare in the United States. *I_UM_Clinical Criteria for UM Decisions* Page 1, Section 3: This describes that RMHP applies written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services. Further this states that RMHP clinical policies are sound and based upon analysis of clear, professionally recognized evidence of effectiveness, and are financially responsible. *I_UM_Preauthorization Policy & Procedure* Page 1-2, Section 4, Paragraph 4.1: This provides the definition of "Medical Necessity" that complies with 42 CFR 438.210(a)(5). *I_PNM_2021 RMHP Provider Manual* Page 70, Paragraph 2, under "RMHP Prime, Rae and CHP+" section: This describes the full definition of medical necessity. *I_PNM_2021 RMHP Provider Manual* *Page 74, 2nd bullet:*	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Medically necessary treatments for conditions discovered by any screening or diagnostic procedure — even if they are not covered by Health First Colorado — may under certain circumstances be covered by RMHP as EPSDT exceptions. A provider can request an EPSDT exception by submitting a prior authorization request in accordance with the instructions in this manual. The request will be reviewed based on EPSDT and approved or denied. I_PNM_2022 Professional Services Contract Page 5, BB.- "Medically Necessary:" This describes the full definition of medical necessity. **RAE-specific: N/A** **Prime-specific: N/A**	
7. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* RAE Contract: Exhibit B-8—14.8.2 Prime Contract: Exhibit M-10—14.6.2	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 1, Section 1, Paragraph 1.1 Purpose: This policy addresses the processing of requests for initial and continuing authorization of services. *I_UM_UM Program Description_2022* Page 11, Section IX This describes that RMHP has a well-structured UM program with a continuum of processes to address requests for initial and continuing authorization of services. **RAE-specific: N/A** **Prime-specific:**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_eviCore_Delegation_Oversight_Summary_2022 Page 1, UM 1- Utilization Management Structure: This describes that eviCore has a well-structured UM program with policies that promote utilization decisions affecting the health care of Members in a fair, impartial and consistent manner.	
8. The Contractor and its subcontractors have mechanisms in place to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* RAE Contract: Exhibit B-8—14.8.2.6 Prime Contract: Exhibit M-10—14.6.2.6	**Both RAE and Prime:** *I_UM_Clinical Criteria for UM Decisions* Page 3, Section 3.3 This describes that RMHP applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Page 6, Section 3.7: This describes how RMHP annually assesses the consistency with which reviewers apply UM criteria in decision making and acts upon opportunities to improve consistency, if applicable. *I_UM_Preauthorization Policy & Procedure* Page 7, Section 6, Paragraph 6.23: This provides that the criteria for authorization decisions are applied consistently. **RAE-specific: N/A** **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2022*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2, UM 2: Clinical Criteria for Utilization Management Decisions: This demonstrates that eviCore uses evidence-based, objective criteria that are reviewed at least annually.	
9. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* RAE Contract: Exhibit B-8—14.8.2.5 Prime Contract: Exhibit M-10—14.6.2.5	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 13, Section 6, Paragraph 6.31.5: This describes that RMHP allows discussion with the attending physician, PCP or requesting physician to collect necessary information to make a preauthorization decision. Page 16, Section 6, Paragraph 6.33: This describes that RMHP allows a rendering provider to request a peer-to-peer review to discuss an adverse determination. **RAE-specific: N/A** **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2022* Page 2, UM 2: Clinical Criteria for Utilization Management Decisions: This demonstrates that the eviCore policies include assessment of the individual needs of the Member and consideration of the local delivery system. Input from outside physicians/practitioners with specific expertise is considered.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical or BH needs. The Contractor's utilization management program includes identification of the type of personnel responsible for each level of utilization management decision-making. *42 CFR 438.210(b)(3)* RAE Contract: Exhibit B-8—14.6.6, 14.8.2.4 Prime Contract: Exhibit M-10—14.4.6, 14.6.2.4	**Both RAE and Prime:** *I_UM_Appropriate Professionals for UM and Pharmacy* Page 3, Section 3.2: This describes the expertise required for the Chief Medical Officer (CMO), Medical and Behavioral Health Associate Medical Directors, and the Clinical Pharmacist. Pages 3-4, Section 3.3: This describes the process for practitioner review for medical, behavioral health, and pharmacy denials. Page 4, Section 3.4: This describes the process for use of board-certified consultants in instances where RMHP Clinical Pharmacists and Associate Medical Directors do not have clinical expertise in the areas for which services or pharmaceuticals are being requested. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 6.22: This describes that UM decisions are made by individuals with the knowledge and skills to evaluate working diagnoses and proposed treatment plans for the Member's medical or behavioral health needs. *I_UM_UM Program Description 2022* Page 6-10, Section V:	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This describes all roles in the UM Department and level of decision-making responsibility. **RAE-specific: N/A** **Prime-specific: N/A**	
11. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* RAE Contract: Exhibit B-8—8.6.1 Prime Contract: Exhibit M-10—8.7.13.5 10 CCR 2505-10 8.209.4.A.1	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 13-16, Section 6.32: This describes the procedures that RMHP has in place to notify Members and requesting providers of decisions to deny or modify service authorization requests, which may be completed orally or in writing. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: RMHP Prime identified a large-scale issue where member letters related to retrospective claims denials were not mailed. This impacted four out of the 10 denial samples.		
Required Actions: RMHP Prime must show evidence of this long-term update and ongoing monitoring as part of the CAP process.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* *Memo: HCPF FFS UM Policy Requirements for SUD Benefit—August 4, 2020* RAE Contract: Exhibit B-8—8.6.6, 8.6.8 Prime Contract: Exhibit M-10—8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	**Both RAE and Prime:** **Bullet #1:** *I_UM_Timeliness of UM Decisions Policy and Procedure* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Turn Around Times, Notification, and Extension Requirements* This document is a grid of regulatory timeframes that RMHP follows for notification of authorization decisions. The grid indicates that RMHP provides notice of standard authorization decisions within 10 calendar days. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 6.31.1: This describes that RMHP follows regulatory timelines for UM decisions as outlined in the UM Turn Around Times, Notification, and Extension Requirements document. **Bullet #2:** *I_UM_Timeliness of UM Decisions Policy and Procedure* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions.	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_Turn Around Times, Notification, and Extension Requirements This document is a grid of regulatory time frames that RMHP follows for notification of expedited authorization decisions. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 6.31.3 This sets forth the process for issuing a notice for an authorization decision no later than 72 hours after receipt of the request for those instances when the Member's condition requires an expedited decision. **RAE-specific: N/A** **Prime-specific: N/A**	
Findings: Denial sample #7 was received in March, logged in September, and a decision was documented on October 1, 2022. This decision time frame exceeded the 30-day processing policy for RMHP Prime retroactive claims.		
Required Actions: RMHP Prime must enhance its procedures for monitoring decision-making time frames.		
13. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)*	**Both RAE and Prime:** *I_UM_Timeliness of UM Decisions* Page 4, Section 6.11 RMHP may extend the time frame for making a standard or expedited authorization decision by up to 14 additional calendar days if: The member or the provider requests an extension, or RMHP justifies a need for the additional information and how the extension is in the member's interest.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—8.6.6.1, 8.6.8.1 Prime Contract: Exhibit M-10—8.6.6.1, 8.6.8.1	*I_UM_Preauthorization Policy & Procedure* Page 13, Paragraph 6.31.9 Refers employees to the Timeliness of UM Decisions Policy and Procedure and the UM Turn-around-Time and Notification Requirements Grid for information on extensions. *I_UM_UM_Turn Around Times, Notification, and Extension Requirements* Page 3 Outlines extension timeframes and requirements for RAE and RAE Prime. **RAE-specific: N/A** **Prime-specific: N/A**	
14. The Contractor provides telephonic or telecommunications response within 24 hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(d)(3)* *42 US Code 1396r-8(d)(5)(a)* Prime Contract: Exhibit M-10—14.2.1.6.3.2.1	**Prime-specific:** I_UM_Pharmacy Preauth TATs and Notification Requirements This document shows the regulatory TATs RMHP follows for notification of pharmacy decisions.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. The notice of adverse benefit determination must be written in language easy to understand, available in State-established prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* RAE Contract: Exhibit B-8—8.6.1–8.6.1.4 Prime Contract: Exhibit M-10—8.6.1-8.6.1.4	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 14, Paragraph 6.32.4.1 This describes that notification will be provided to a Member in writing in a manner calculated to be understood by the Member. Paragraph 6.32.4.2.2 Describes that the notice will be available in English	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10 CCR 2505-10 8.209.4.A.1	and prevalent non-English languages spoken by Members throughout the State and available in alternative formats for persons with special needs. *I_UM_Medicaid Denial Letter BH_PH 5.2.22* *I_UM_Medicaid Denial Letter SUD 5.2.22* *I_UM_Redacted Sample CHP+ Denial Letter* These letter templates demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) **RAE-specific: N/A** **Prime-specific:** *I_RX_Member denial letter_MD_PA_template* *I_RX_Member denial letter_MD_QL_template* This pharmacy letter sample demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. Note: the 1557/MLIS notice is attached to these letters at mailing.	
16. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor or its subcontractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits).	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 14-15, Section 6.32.4.2.3 This describes the content of notices of action or adverse benefit determination and includes the entire list of regulatory requirements. *I_UM_Medicaid Denial Letter BH_PH 5.2.22* *I_UM_Medicaid Denial Letter SUD 5.2.22* These letter templates demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b)	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's right (or member's designated representative) to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due. • The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. • How each dimension of the most recent edition of ASAM criteria was considered when determining medical necessity for any adverse determination concerning residential or inpatient substance use disorder services *(RAE only)*. *42 CFR 438.404(b)* *SB21-137: Section 10-25.5-5-424(3)* RAE Contract: Exhibit B-8—8.6.1.5–8.6.1.13 Prime Contract: Exhibit M-10—8.6.1.5-8.6.1.12 10 CCR 2505-10 8.209.4.A.2	**RAE-specific: N/A** **Prime-specific:** *I_RX_Member denial letter_MD_PA_template* *I_RX_Member denial letter_MD_QL_template* This pharmacy letter sample demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. Note: the 1557/MLIS notice is attached to these letters at mailing.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* *42 CFR 438.210(d)* RAE Contract: Exhibit B-8—8.6.3.1, 8.6.5–8.6.8 Prime Contract: Exhibit M-10—8.6.3.1, 8.6.5-8.6.8 10 CCR 2505-10 8.209.4.A.3	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 14, Section 6.32 This incorporates the circumstances in which notices of adverse benefit decisions are sent. *I_UM_UM Turn Around Times, Notification, and Extension Requirements* This document explains decision notification timeframes and extension timeframes. **Bullet #1:** *I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 6.4.1: This indicates RMHP must notify the Member at least 10 days before the date of action for termination, suspension, or reduction of previously authorized Medicaid/CHP+-covered services. **Bullet #2:** *I_UM_Preauthorization Policy & Procedure* Page 14, Paragraph 6.32.1: This indicates that RMHP provides notices of determination in compliance with regulatory timelines.	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_UM Turn Around Times, Notification, and Extension Requirements Page 2: This shows the notification requirement for retrospective determinations (denial of payment). **Bullet #3:** *I_UM_Preauthorization Policy & Procedure* Page 13, Paragraph 6.32.1: This indicates that RMHP provides notices of determination in compliance with regulatory timelines. *I_UM_Turn Around Times, Notification, and Extension Requirements* Page 2: This shows notification for standard determinations is made within 10 calendar days. **Bullet #4:** *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 6.31.3: This indicates that RMHP will response to expedited service authorization requests within 72 hours of receipt.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_Turn Around Times, Notification, and Extension Requirements Page 2: This shows notification for urgent preservice determinations is made within 72 hours. **Bullet #5:** *I_UM_Turn Around Times, Notification, and Extension Requirements* Page 3: This shows notification is sent once decision is made or no later than the expiration date of the extension. **Bullet #6:** *I_UM_Turn Around Times, Notification, and Extension Requirements* Page 1 This indicates that if no decision has been made within the allotted turnaround time, notification of appeal rights must be sent on the date the turnaround time expires." **RAE-specific: N/A** **Prime-specific: N/A**	
Findings: Four out of the 10 denial samples were not sent within timeliness standards, and the *UM Program Description* included incorrect authorization timelines on page 14 that miscommunicated the timeline from the time of the decision or after the time of verbal notification.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: RMHP Prime must show evidence of its long-term update to ensure member letters are mailed and ongoing monitoring of denial notification timeliness as part of the CAP process. Additionally, RMHP Prime must update its language related to authorization timelines in the *UM Program Description* to clarify that the time frame starts at the time of the request.		
18. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least 10 days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Contractor has factual information confirming the death of a member. – The Contractor receives a clear written statement signed by the member that the member no longer wishes services or gives information that requires termination or reduction of services and indicates that the member understands that this must be the result of supplying that information. – The member has been admitted to an institution where the member is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Contractor mail directed to the member indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician.	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 6.4.1: This describes that for reduction, suspension, or termination of previously authorized Health First Colorado RAE/Prime covered services, RMHP notifies the Member at least ten (10) days before the intended effective date of the proposed adverse benefit determination (action). **Bullet #1:** *I_UM_Preauthorization Policy & Procedure* Pages 3 Paragraphs 6.4.1.1 - 6.4.1.7: This describes the scenarios in which RMHP provides notice for reduction, suspension, or termination of a previously authorized Medicaid covered service on or before the intended effective date of the proposed adverse benefit determination. **Bullet #2:** *I_UM_Preauthorization Policy & Procedure* Page 4 Paragraph 6.4.2: This describes that if probable Member fraud has been verified, RMHP gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* RAE Contract: Exhibit B-8—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.8 Prime Contract: Exhibit M-10—8.6.3.1-8.6.3.2, 8.6.4.1-8.6.4.8 10 CCR 2505-10 8.209.4.A.3(a)	**RAE-specific: N/A** **Prime-specific: N/A**	
19. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.404(c)(4)* RAE Contract: Exhibit B-8—8.6.6.2 Prime Contract: Exhibit M-10—8.6.6.2 10 CCR 2505-10 8.209.4.A.3 (c)(1*)*	**Both RAE and Prime:** *I_UM_Extension Letter Template* This is the template loaded into RMHP's authorization system to create extension letters. The template includes a notice of why the extension is needed and that a Member can file a grievance if they disagree with the extension. *I_UM_Timeliness of UM Decisions Policy and Procedure* Page 4, Paragraph 6.11.3.1.2: This states that if RMHP requires an extension, RMHP sends a written notice of the reason for the extension that includes the specific information required to complete the request as well as a notice	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	that the member has the right to file a grievance if the Member disagrees with the need for the extension. **RAE-specific: N/A** **Prime-specific: N/A**	
20. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* RAE Contract: Exhibit B-8—14.8.7 Prime Contract: Exhibit M-10—14.6.6	**Both RAE and Prime:** *I_UM_Appropriate Professionals for UM and Pharmacy* Page 4, Section 3.5: This describes RMHP's Affirmative Statement about incentives. *I_UM_Program Description 2022* Page 4, Section II: This states that RMHP does not reward practitioners or other individuals for issuing denials of coverage or care and offers no incentives for pharmacy or UM decision makers to encourage decisions that result in underutilization. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;	**Both RAE and Prime:** *I_UM_UM Emergency Department Claim Review Policy* This policy describes that RMHP makes payment for all emergency department services without medical necessity review. *I_UM_Preauthorization Policy & Procedure* Page 2, Paragraph 4.6: This defines "emergency medical condition" as a	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* RAE Contract: Exhibit B-8—2.1.36; 7.3.8.1.6.1 Prime Contract: Exhibit M-10—2.1.39, 7.3.8.1.6.1	condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 6.6.1: This describes that RMHP will not deny treatment to a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *I_PNM_2021 RMHP Provider Manual* Page 88, "Definition of Emergent Care:" Includes the regulatory definition of “emergency medical condition.” **RAE-specific: N/A** **Prime-specific:**	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	PRIME Member Handbook July 2022 Page 16-17, "When to use the Emergency Room" This informs Members about when to use the emergency room, describing the circumstances contained in the regulatory definition of "emergency medical condition" (definition on page 66) – in plain language.	
22. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to deliver these services and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* RAE Contract: Exhibit B-8—2.1.37 Prime Contract: Exhibit M-10—2.1.40	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 2, Paragraph 4.5: This defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *I_PNM_2021 RMHP Provider Manual* Page 88, "Definition of Emergent Care:" Includes the regulatory definition of "emergency medical condition." This illustrates that emergency services means covered inpatient and outpatient services furnished by a provider qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Pages 20, Emergency Services:	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This defines emergency services for Members and informs that services for evaluation and stabilization are covered.	
23. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* RAE Contract: Exhibit B-8—2.1.82 Prime Contract: Exhibit M-10—2.1.85	**Both RAE and Prime:** *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* Page 2, Section 4 This contains the regulatory definition of post-stabilization care. *I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 4.7: This defines "post-stabilization care services" as defined as covered services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the Member's condition. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 20, Section – Emergency Services This explains that post-stabilization care to Members, including that these are covered services.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
24. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* RAE Contract: Exhibit B -8—14.5.6.2.2	**Both RAE and Prime:** *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (full manual available electronically onsite upon request) Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care,	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Prime Contract: Exhibit M-10—14.2.1.2.1	Professional Services, paragraph: "Emergent/Urgent Services" The claims manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph 3.2: This describes that RMHP covers emergency department services by participating and non-participating practitioners and providers. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 6.6: This describe that preauthorization is not required in medically urgent/emergent situations. *I_UM_Program Description 2022* Page 13, 4th bullet from the top: This states that urgent and emergent services do not require prospective review and all emergency room claims are paid without review through the normal claims payment processes. *I_PNM_2021 RMHP Provider Manual* Page 28, "Access to Care" section, paragraph 2: This describes that RMHP will not deny payment for emergency services if the services were provided by	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	an out-of-network provider or when instructed by a representative of RMHP to seek emergency services. **RAE-specific: N/A** **Prime-specific: N/A**	
25. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* RAE Contract: Exhibit B-8—14.5.6.2.6 Prime Contract: Exhibit M-10—14.2.1.2.1.2	**Both RAE and Prime:** *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph 3.1: This describes that appropriateness of services is assumed based on Prudent Layperson definition. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 6.6.1 - 6.6.1.3 This describes that RMHP will not deny treatment to a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. RMHP will not deny treatment if a representative of RMHP instructed the Member to seek emergency services. *I_PNM_2021 RMHP Provider Manual* Page 88, "Definition of Emergent Care:" This defines emergent care and describes that RMHP	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	will not deny payment for treatment obtained under the circumstances described in the regulation and contract. Page 28, "Access to Care" section, paragraph 2: RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider or when instructed by a representative of RMHP to seek emergency services. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Pages 16-17, Section – When to use the emergency room: This informs Members about when to use the emergency room, explains the prudent layperson standard, and provides examples of when a person should go to the emergency room.	
26. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)*	**Both RAE and Prime:** *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph 3.1: This states that RMHP makes payment for all emergency department services at a claim processer level without medical necessity review. Appropriateness of services is assumed based on Prudent Layperson definition. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraphs 6.6.3 - 6.6.4	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—14.5.6.2.8 Prime Contract: Exhibit M-10—14.2.1.4.1, 14.2.1.2.1.3	This describes that RMHP will not limit what constitutes an emergency based on a list of diagnoses or symptoms. RMHP will not refuse to cover emergency services based upon failure of the emergency room provider, hospital, or fiscal agent to notify the Member's primary care provider or RMHP of the Member's screening and treatment within 10 calendar days of presentation for emergency services. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (full manual available electronically onsite upon request) Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services, paragraph: "Emergent/Urgent Services" The claims manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* RAE Contract: Exhibit B-8—14.5.6.2.9 Prime Contract: Exhibit M-10—14.2.1.2.1.4	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 6.6.5: This describes that RMHP will not hold a Member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (full manual available electronically onsite upon request) Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services, paragraph: "Emergent/Urgent Services" The claims manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* RAE Contract: Exhibit B-8—14.5.6.2.10 Prime Contract: Exhibit M-10—14.2.1.2.1.5	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 4-5, Paragraph 6.6.6: This describes that RMHP allows the attending emergency physician, or the provider actually treating the Member, to be responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on RMHP who is responsible for coverage and payment. *I_PNM_2021 RMHP Provider Manual* Page 28, "Access to Care" section, paragraph 2: This describes that the attending emergency physician or provider actually treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 20, Section – Emergency Services: This informs Members that the Member's doctor will decide when the Member receiving emergency services is ready for transfer or discharge.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor is financially responsible for poststabilization care services that are prior authorized by an in-network provider or Contractor's representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(i)* RAE Contract: Exhibit B-8—14.5.6.2.11 Prime Contract: Exhibit M-10—14.2.1.2.1.6	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 6.7: This describes that RMHP is financially responsible for post-stabilization services that are prior authorized by an in-network provider or RMHP representative, regardless of whether they are provided within or outside of RMHP's network of providers. *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 1: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have been pre-approved (prior authorized) by RMHP or its representative. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(ii)* RAE Contract: Exhibit B-8—14.5.6.2.12 Prime Contract: Exhibit M-10—14.2.1.2.1.7	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 6.9: This describes that RMHP is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if: RMHP does not respond to a request for pre-approval within 1 hour. *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 2: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have not been pre-approved (prior authorized) by RMHP or its representative. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within one hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(2)(iii) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iii)* RAE Contract: Exhibit B-8—14.5.6.2.12 Prime Contract: Exhibit M-10—14.2.1.2.1.7.1-3	**Both RAE and Prime:** *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1-2, Section 3.0, Paragraph 3: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have not been pre-approved by RMHP or its representative under all of the circumstances set forth in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraphs 6.10 - 6.10.3 This describes that RMHP is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if: RMHP does not respond to a request for pre-approval within 1 hour, RMHP cannot be contacted, or RMHP's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, RMHP gives the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the Member until a plan provider is reached.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific: N/A**	
32. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* RAE Contract: Exhibit B-8—14.5.6.2.14 Prime Contract: Exhibit M-10—14.2.1.2.1.8	**Both RAE and Prime:** *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 3(c): This describes that RMHP's financial responsibility for post-stabilization services it has not pre-approved ends when any of the four situations occur as stated in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraphs 6.10.4 - 6.10.4.4: This describes that RMHP's financial responsibility for post-stabilization care services it has not pre-approved ends when: a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care, or the Member is discharged. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. If the member receives poststabilization care services from a provider outside the Contractor's network, the Contractor does not charge the member more than they would be charged if they had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* RAE Contract: Exhibit B-8—14.5.6.2.13 Prime Contract: Exhibit M-10—14.2.1.2.1.7.4	**Both RAE and Prime:** *I_CS_Post-stabilizationSrvs_MCaid_CHP+ Responsibility* Page 2, Section 6.0, Paragraph D: This describes that Member liability is limited to an amount no greater than what RMHP would charge the Member if he or she had obtained the services through RMHP. *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 6.8: This describes that if a Member receives post-stabilization services from a provider outside RMHP's network, RMHP does not charge the Member more than he or she would be charged if he or she had obtained services through an in-network provider. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 20, Section - Emergency Services: This describes that Member costs for post-stabilization care rendered by a non-RMHP provider will be no more than what the Member would have paid if treated by a RMHP provider.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard I—Coverage and Authorization of Services—Prime							
Total	Met	=	28	X	1.00	=	28
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	28
				Total Score ÷ Total Applicable		=	90%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO maintains and monitors a network of providers that are supported by written agreements and is sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Family planning providers • Gerontologists • Internal medicine providers • Physician specialists *RAE Only* • Adult mental health providers • Pediatric mental health providers • Substance use disorder providers • Psychiatrists • Child psychiatrists • Psychiatric prescribers *42 CFR 438.206(b)(1)* RAE Contract: Exhibit B-8—9.3.1, 9.5.1.1, 9.5.1.3 Prime Contract: Exhibit M-10—9.1.1, 9.4.1.1, 9.4.3.2.1	**Both RAE and Prime:** *II_PNM_2022 Professional Services Agreement:* Written agreements for RAE Behavioral Health and PRIME Specialty providers. *II_PNM_2022 Physician Medical Services Agreement* Written agreements for RAE Behavioral Health and PRIME Specialty providers who are also MD and DO's. *PNM_2021 RMHP Provider Manual* Page 102, Provider Rights and Responsibilities- "Accommodations for People with Disabilities" section, paragraph 3: This describes that RMHP recommends that providers have a policy and/or procedure that documents how they ensure effective communication with Members with limited English proficiency. It also urges provider's offices and/or facilities to accommodate people with disabilities and/or special health care needs. *II_CI_R1_RM_NetworkMangPln_FY 22-23* Pages 36-38, Provider Type Counts: The Annual Network Management Strategic Plan is an annual contract deliverable to the Department that describes how the provider network is maintained,	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	monitored, and incentivized to provide adequate access to quality services for RAE and PRIME Members. Provider counts are shown on in the appendix on the pages noted. **RAE-specific:** *II_PNM_2022 RAE Provider Directory:* This illustrates providers who are able to serve Members with limited English proficiency as well as if they are handicap accessible with a H for handicap accessibility and abbreviations for the languages spoken. *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_R1* The Network Report is a quarterly contract deliverable to the Department for network adequacy reporting. This is the spreadsheet component of the report. See BH Summary tab. This includes the identified providers for this element. **Prime-specific:** *II_PNM_2022 PRIME Provider Directory:* This illustrates providers who are able to serve Members with limited English proficiency as well as if they are handicap accessible with a H for handicap accessibility and abbreviations for the languages spoken.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_MRM We report on PRIME specialists on the PH Summary tab. This includes the identified providers for this element.	
2. The Contractor ensures that its provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Specialists—adult and pediatric: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 24 and 25, "Prime/RAE Network Geographic and Time Standards": Informs providers of the RAE & Prime network time and distance standards. Page 23, "Prime, RAE, and CHP+ Network Availability Standards:" This informs providers of the RAE and Prime Member/Provider ratios. *II_PNM_Practioner Availability and Accessibility P&P*: This P&P describes how RMHP maintains an effective organizational process for monitoring network adequacy, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues. *II_PNM_Availability of Practitioners Analysis* Pages 10, 16-17, 22-23 This report shows the distance/drive time analysis per requirements regarding Primary Care Practitioners, Pediatric Primary Practitioners, OB/GYN, and Specialists for CHP+, RAE, and	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes *RAE Only* • Psychiatrists and psychiatric prescribers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • Mental health providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B2—9.4.10.1)*	PRIME. Pages 24-26 This shows the distance/drive time analysis per requirements for BH Practitioners, Marriage and Family Therapy, Psychology, and Psychiatry. **RAE-specific:** *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_R1* The physical health tab on the Geo Access report evaluates the availability of physical health providers in the network by examining time and distance standards. Includes: Adult Primary Care Providers, Pediatric Primary Care Providers, Acute Care Hospitals, and OBGYN Providers. The behavioral health tab on the Geo Access report evaluates the availability of behavioral health providers in the network by examining time and distance standards. Includes: Adult Mental Health Providers, Pediatric Mental Health Providers, Adult Psych Prescriber Providers, Pediatric Psych Prescriber Providers, and Substance Use Disorder Providers **Prime-specific:** *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_MRM* The physical health tab on the Geo Access report evaluates the availability of physical health providers in the network by examining time and	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.206(a) RAE Contract: Exhibit B-8—9.4.7; 9.4.9 Prime Contract: Exhibit M-10—9.3.8	distance standards. Includes: Adult Primary Care Providers, Pediatric Primary Care Providers, OB/GYN Providers, Adult and Pediatric Specialists, and Pharmacies.	
3. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* RAE Contract: Exhibit B-8—9.2.7 Prime Contract: Exhibit M-10—9.2.8.3.2	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 71, first paragraph: This describes how RMHP provides female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services and is in addition to the Member's designated source of primary care if that source is not a women's health care specialist. *II_CM_Direct Access for OB GYN Care* Page 1, Policy, first bullet: Rocky Mountain provides for a covered woman to have "direct access" to a contracting obstetrician or gynecologist (OB/GYN) for her reproductive and gynecological care. This applies to reproductive health care and gynecological care for both the normal and abnormal processes of the female reproductive system, including medical and surgical management of disorders, pregnancy, childbirth, related preventive care and family planning services. *II_CI_R1_RM_NetworkMangPln_FY 22-23* Page 13, Women's Health: This describes direct access for women's health within the network. **RAE-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: *PRIME Member Handbook July 2022* Page 12, Care for pregnancy and other health care for women: This describes direct access within the network for women's health care.	
4. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* RAE Contract: Exhibit B-8—9.4.17 Prime Contract: Exhibit M-10—9.3.13	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 118, RMHP Prime, RAE, and CHP+ Members, "It is your right:" Bullet 12: This informs providers that Members can get a second opinion with no referral and at no cost to the Member. AND This shows that RMHP covers one second opinion per medical condition without a referral. *II_CM_Second Opinions_Out of Network Services* Page 1, 1.0 Purpose: RMHP provides for a second opinion from an in-network provider or arranges for the Member to obtain a second opinion outside the network. If RMHP is unable to provide a necessary and covered service to a Member in-network, RMHP must adequately and timely cover those services out-of-network for as long as RMHP is unable to provide the service **RAE-specific: N/A** **Prime-specific:**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	PRIME Member Handbook July 2022 Page 26 Second Opinion: This informs Members that second opinions are covered without copayment and explains how to obtain one. Page 39-40 Copayment Table: This informs Members that second opinions are covered without copayment.	
5. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* RAE Contract: Exhibit B-8—14.6.1 Prime Contract: Exhibit M-10—9.3.10.1	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 71, Out-of-Network/ Out -of-Plan Services: This informs providers of out-of-network/out-of-plan services available to Members in a timely manner at the in-network benefit level. *II_CM_Second Opinions_Out of Network Services* Page 2-3, Section 6.2: If the RMHP network is unable to provide necessary services covered under the Member's Evidence of Coverage (EOC), RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. RMHP will coordinate payment with the out of network practitioner to ensure that the cost to the Member is no greater than it would be if the services were furnished in-network. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 11, Section "Doctors that do not work with	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP": This describes that a Member may receive care, with permission from RMHP, with doctors who do not work with RMHP and that the Member will not have to pay extra for the care received.	
6. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* RAE Contract: Exhibit B-8—14.6.11.1 Prime Contract: Exhibit M-10—None	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 71, Out-of-Network/ Out -of-Plan Services: This informs providers that out-of-network/out-of-plan services are available to members at the in-network benefit level. *II_CM_Second Opinions_Out of Network Services* Page 2, section 6.2 "Services not available in network": RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. RMHP will coordinate payment with the out of network practitioner to ensure that the cost to the Member is no greater than it would be if the services were furnished in-network. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook July 2022* Page 11, Section "Doctors that do not work with RMHP": This describes that a Member may receive care, with permission from RMHP, with doctors who do not	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	work with RMHP and that the Member will not have to pay extra for the care received.	
7. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care *(RAE only):* – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *(RAE only)* *42 CFR 438.206(c)(1)(i)* RAE Contract: Exhibit B-8—9.4.13, 9.4.13.1-4, 9.4.13.5.1-2 Prime Contract: Exhibit M-10—9.3.9.1	**Both RAE and Prime:** *PNM_2021 RMHP Provider Manual* Page 26-27: This lists the RAE and Prime Appointment Wait Time Standards that demonstrate RMHP's guidelines and standards around emergency behavioral care, urgent care, non-urgent symptomatic care, well care visits within 30 days after the request, outpatient follow up appointments, and explains that Members will not be placed on waiting lists for initial routine services. AND This lists the RAE and PRIME appointment wait time requirements that include specifics for behavioral health services and explains that Members may not be placed on waiting lists for initial routine behavioral health Services. *II_PNM_Appointment Availability Analysis* This report describes RMHP access to service and wait time standards. It reviews how Member surveys are sent annually to ensure that appointment availability is sufficient. Page 15-16: This describes the results from the Member survey relating to the standards for timely access to care and services.	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_R1_RM_NetworkMangPln_FY 22-23 Pages 8-10 This describes Emergency BH care, urgent care and non-urgent care standards information. Page 10, BH Appointment Availability Grid: This describes that Members may not be placed on waiting lists for initial routine services. **RAE-specific: N/A** **Prime-specific: N/A**	
Findings: While the standards for timely access to care and services were accurately detailed in the *Network Plan*, the *Standards for Practitioner Office Sites* policy incorrectly stated that RMHP Prime evaluates the availability of scheduling for urgent services between 24 and 48 hours and non-urgent care visits at 14 days, and did not include any exceptions for the American Academy of Pediatrics Bright Futures Periodicity Schedule related to well-care visits.		
Required Actions: RMHP Prime must update the *Standards for Practitioner Office Sites* policy to include the correct standards for timely access to care related to urgent services and non-urgent care visits, and should include the exceptions related to when well-care visits should be scheduled prior to one month.		
8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8:00 a.m. to 5:00 p.m. Mountain Time, Monday through Friday. • Extended hours on evenings and weekends, including access to clinical staff, not just an answering service or referral service. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)*	**Both RAE and Prime:** **Bullet 1:** *PNM_2021 RMHP Provider Manual* Page 70, "RMHP Prime, RAE, and CHP+": This informs providers that they may not limit their hours of operation in a manner which is less than is offered to Members of non-publicly-financed programs. Page 20, "Service Coverage" This section describes that RMHP highly recommends providers to have minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday, and for extended hour on evening	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—9.4.3–9.4.4 Prime Contract: Exhibit M-10—9.3.3-4	and weekends. *II_PNM_2022 Physician Medical Services Agreement* Page 6, Section A, Medical Services to Covered Persons: This states that providers arrange for the provision of medical services required by any Health Care Plan which is offered by RME to covered persons in the service area. (Due to the numerous lines of business we offer we must write the agreements in general terms to meet all contractual obligations.) Page 16, Section EE, Non-Discrimination- Publicly Financed Programs: This provider contract template describes that providers may not discriminate against any covered person enrolled in a publicly financed program, including limiting the hours of operation. **Bullet 2:** *II_PNM_RMHP Behavioral Health Provider Demographic Tool;* *II_PNM_RMHP PRIME_CHP Specialist Demographic Tool;* *II_PNM_RMHP PCMP_Demographic Tool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	directories and provide relevant information to Members. The questions asked on the tools include Appointment Availability questions for extended hours on evenings and weekends. Note: There are 3 versions of this tool: PCMP, BH Provider, and Specialist. *II_PNM_Provider Insider Plus NL_June 2022* Page 7, "Giving Eligible Members Instant Access to Care via CirrusMD": This includes news about CirrusMD, a tool that can be used by RAE, PRIME and CHP+ Members as an alternative to emergency department visits for after-hours urgent care. *II_CI_CirrusMD Webpage Screenshot* This document contains a link and screenshot of the CirrusMD for RMHP webpage on RMHP.org. CirrusMD can be used by Members as an alternative to emergency department visits for after-hours urgent care. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* RAE Contract: Exhibit B-8—9.4.6 Prime Contract: Exhibit M-10—9.3.7	**Both RAE and Prime:** *II_PNM_2022 Physician Medical Services Agreement* Page 16, Section BB- "24-Hour Coverage": This describes the requirement for providers to provide or arrange for 24-hour coverage for emergency medical services. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* RAE Contract: Exhibit B-8—9.4.14 Prime Contract: Exhibit M-10—9.1.14	**Both RAE and Prime:** *II_PNM_Appointment Availability Surveys P&P:* This P&P describes how RMHP maintains an effective organizational process for monitoring appointment scheduling and wait times, through the use of member surveys, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues if applicable. *II_PNM_Appointment Availability Analysis* Page 17-20, Appendix/Appendices: The Appointment Wait Time Surveys are sent annually to Members as a mechanism to ensure compliance with access by network providers, which includes behavioral health providers (prescribing and non-prescribing); primary care providers; and specialists (high-volume & high-impact).	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	PNM_2021 RMHP Provider Manual Page 20, Access to Care: This describes how RMHP maintains quality standards to identify, evaluate, and remedy problems relating to access of care. It also identifies RMHPs targets (goals) for Member/provider ratios, time and distance drive time standards as well as appointment wait time standards. *II_CQI_Annual Tier Assessment Process* *II_CQI_Tier Attestation Process; Page/Slide 11* *II_CQI_Tier Attestation Tree* These documents detail expectations of practices by Tier as it relates to Medicaid access within the PCMP offices. Higher Tier practices must be open to Medicaid. *II_CQI_2023 Project Charter* Page 1: The Value Based Contracting Review Committee (VBCRC) Charter details the aim, scope and general structure of the committee that evaluates practices in value-based contracts with RMHP for compliance with contractual expectations and requirements. This committee evaluates practices in Tiers 1, 2, & 3. *II_CQI_2022 VBCRC PROCESS* Page 2 – 4: This explains how the Value Based Contracting Review Committee (VBCRC) evaluates practices in	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	value based contracts with RMHP as it relates to contractual expectations and requirements. Specifically, this document details the frequency of review as well as how practices are notified if there is failure to comply with any requirements and a corrective action plan is implemented. *II_CQI_RAE PCMP Tiering & Attribution Analysis (not an evidence document)* This analysis demonstrates that 128/201 (63.68%) of RAE PCMPs and 51/64 (79.69%) of Prime PCMPs are evaluated within the VBCRC process for the Value Based Payment Tiering Program. This accounts for 81.01% of the attributed RAE Member population and 89.72% of the attributed Prime Member population. These Tier 1 & 2 practices must meet all the criteria required, which includes access standards, in order to participate in value-based payment programming. RAE Practices: · Tier 1 – 3: 128 (63.68%) · Total: 201 · RAE Tier 1 – 3 Attribution:153,985 (81.01%) · RAE Total Attribution: 190,077 PRIME Practices: · RAE Tier 1 – 3: 51 (79.69%) · Total: 64 · PRIME Attribution within a RAE Tier 1 –	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	3 practice: 17,040 (89.72%) · PRIME Total Population: 18,992 **RAE-specific: N/A** **Prime-specific: N/A**	
11. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. and sex. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* RAE Contract: Exhibit B-8—7.2.1–7.2.6 Prime Contract: Exhibit M-10—7.2.1-5	**Both RAE and Prime:** **Bullet #1:** *II_PNM_RMHP Behavioral Health Provider Demographic Tool;* *II_PNM_RMHP Prime_CHP+ Specialist Demographic Tool;* *II_PNM_RMHP PCMP_Demographic Too*l: The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. The questions asked on the tools include Staff Training elements. Note: There are 3 versions of this tool: PCMP, BH Provider, and Specialist. **Bullet #2:** *PNM_2021 RMHP Provider Manual* Page 115-116: This describes cultural competency and provides direction to providers about where and how to complete cultural competency training. **Bullet #4:** *II_PNM_Provider Insider Plus NL_June 2022*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 7, "Health Equity Education Highlights" The newsletter provides information about the Culturally and linguistically appropriate services (CLAS), a free resource for providers who may need language assistance services for deaf, hard of hearing or deafblind patients. *II_CQI_HE Report Exec Summary* Pages 4-5, This is an overview of the health equity report with identified opportunities for interventions on specific populations and pertains to all lines of business. This is for internal staff and provider training to promote the delivery of culturally competent services. The following documents illustrate that RMHP delivers services to Members in a culturally competent manner to all Members. *COMBINED_1557Notice_MLIS_2022 Mcaid_CHP+* RMHP's notice of nondiscrimination provides for meaningful access and effective communication and includes protections for those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. *II_CI_Cultural-DisabilityCompTrn_Screenshots_2023-2022* This screenshot lists the links to Cultural and	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Disability competency resources on the UHCPRovider.com and RMHP.org websites that providers can access for further training. *II_CM_UM_Communication Policy and Procedure* Page 1, section 3.1: This describes RMHP's commitment to meaningful and effective communication. *II_CM_Culturally Sensitive Services* Page 3, Section 5.0, Paragraph 1: This explains how RMHP facilitates culturally and linguistically appropriate care and outreach to members with diverse cultural and ethnic backgrounds for prevention, health education and treatment for diseases prevalent to those groups. *II_CM_UM_Communication Policy and Procedure* Page 1, Section 3.1 This describes RMHP's commitment to meaningful and effective communication. Page 2, Paragraph 3.1.3: This describes that RMHP ensures written materials that are critical to obtaining services are available in prevalent non-English languages. Pages 6-9, Section 6.7 through 6.12: This describes translation, interpreter, and auxiliary services that RMHP has available to communicate with members. *II_QI_RMHP 2021 Annual Culture and Linguistic Needs Report*	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of Members and the actions RMHP takes to meet those needs. **Bullet #1** Page 5: Describes that written Member materials can be translated into any language requested and that RMHP keeps many materials such as the Getting Started Guide and Provider Directory on hand in Spanish. **Bullet #2** Page 10: Describes that Care Management staff participated in Bridges out of Poverty Bridges to Health and Healthcare training. Page 11: Describes disability competent care trainings for our provider network facilitated by the Colorado Commission for the Deaf, Hard of hearing and DeafBlind and the Mental Health Center of Denver. Page 11: Describes that RMHP offers provider resources for culturally responsive care through a variety of virtual learnings and on our website. **Bullet #3** Page 10: Describes work to improve access to healthcare and other important services for the deaf and hard of hearing. **Bullet #4** Page 5: Describes that RMHP contracts with a language services vendor, LanguageLine Solutions (LLS) that is available for all employees and	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providers (when needed) to use in assisting Members. *II_QI_RMHP P&P Collection of REL & SOGI Data_draft* **Bullet #3-5** This draft P&P describes the process for the collection of race, ethnicity, language, sexual orientation and gender identity data from Members in order to provide equitable access to health care. **RAE-specific: N/A** **Prime-specific: N/A**	
12. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* RAE Contract: Exhibit B-8—9.1.4.5, 9.1.7.1, 9.5.1.2 Prime Contract: Exhibit M-10—9.4.1.2	**Both RAE and Prime:** *II_PNM_RMHP Behavioral Health Provider Demographic Tool;* *II_PNM_RMHP PRIME_CHP+ Specialist Demographic Tool;* *II_PNM_RMHP PCMP_Demographic Tool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tools include a provider's ability to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical disabilities.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Specialist.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_PNM_Standards for Practitioner Office Sites: This P&P describes how RMHP maintains an effective organizational process for monitoring the quality and safety of clinical care and services provided to Members. **RAE-specific: N/A** **Prime-specific: N/A**	
13. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Adequacy Report is submitted to the State quarterly. *42 CFR 438.207(b)* RAE Contract: Exhibit B-8—9.5.1–9.5.4 Prime Contract: Exhibit M-10—9.4.2-3	**Both RAE and Prime:** *II_CI_R1_RM_NetworkMangPln_FY 22-23* This annual report provides an overview of RMHP's RAE and PRIME Provider Network Management Strategic Plan. It is submitted annually to the Department. **RAE-specific:** *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_R1 (MS Excel)* *II_CI_R1_NetworkRpt_Q1FY22-23 (MS Word)* This quarterly report contains 2 parts: a quantitative report in an Excel spreadsheet and a narrative report in a Word document. This comprehensive report provides Member/Provider ratios and time and distance reporting according to contract standards and is submitted to the Department quarterly. **Prime-specific:** *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_MRM (MS Excel)*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_RM_NetworkRpt_Q1FY22-23 (MS Word) This quarterly report contains 2 parts: a quantitative report in an Excel spreadsheet and a narrative report in a Word document. This comprehensive report provides Member/Provider ratios and time and distance reporting according to contract standards and is submitted to the Department quarterly.	

Results for Standard II—Adequate Capacity and Availability of Services—Prime							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	13	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	92%

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an established internal grievance and appeal system in place for members, providers acting on their behalf, or designated member representatives. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* RAE Contract: Exhibit B-8—8.1 Prime Contract: Exhibit M-10—8.1 10 CCR 2505-10 8.209.1	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *VI_CS_MD - Uphold Denial Med Review* *VI_CS_MD - Uphold Denial No Med Review* *VI_CS_MD.CHP - Overturn Denial Med Review* *VI_CS_MD.CHP - Overturn Denial No Med Review* *VI_CS_Process for Accepting Appeal or Grievance* *VI_CS_MD.CHP - Designated Representative Request - Appeal* *VI_CS_MD.CHP - Designated Representative Request - Grievance* *COMBINED_1557Notice_MLIS_2022 Mcaid_CHP+ I_CS_Multilanguage and Notice of Nondiscrimination P&P* The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 14, Subsection 2.7, Paragraph 2.7.1-2.7.7: This defines "Adverse Benefit Determination."	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities). *42 CFR 438.400(b)* RAE Contract: Exhibit B-8—2.1.3 Prime Contract: Exhibit M-10—2.1.3 10 CCR 2505-10 8.209.2.A	Page 14 Section 2.7.6 addresses the circumstances of a resident of a rural area to exercise their right to obtain services outside the network due to various reasons. *VI_CL_Pend Codes* Page 2, "Steps to follow when information is not received" and Page 14 "Review" grid - New Code: RV60 item: "Unclean Claims" requiring additional information for adjudication are not denied to the member as an adverse benefit determination. The information needed is requested from the provider before a determination is made. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook_July 2022* Page 43, Section A. Appeal an Adverse Decision; This describes the example of the kinds of decisions a Member may appeal which includes when RMHP denies certain services.	
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* RAE Contract: Exhibit B-8—2.1.6 Prime Contract: Exhibit M-10—2.1.5 10 CCR 2505-10 8.209.2.B	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 14, Section 2.6 This defines "appeal" as a review by RMHP of an adverse benefit determination. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* RAE Contract: Exhibit B-8—2.1.46, 8.6.6.2 Prime Contract: Exhibit M-10—2.1.49, 8.6.6.2 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.(i)	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 13, Section 2.5: Definition of a Grievance *VI_CS_Grievance Policy and Procedure* Page 6, Section 4.1-4.1.1 - Definitions: In both documents, grievance is defined as a verbal or written expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to quality of care or services provided, aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by RMHP to make an authorization decision. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives acting on behalf of the member (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).*	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 2.2: This indicates that a Member or their designated representative may file grievances. Page 2, Section 2.2.4: This states that RMHP must obtain authorization in writing from the Member or his/her designated client representative, including a treating health care professional, to represent his or her interests related to grievances.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.402(c) RAE Contract: Exhibit B-8.5.1, 8.7.1, 8.7.15.1, 8.7.5 Prime Contract: Exhibit M-10—8.5.1, 8.5.3, 8.7.1, 8.7.15.1, 8.7.5	*VI_CS_Appeals Policy and Procedure* Page 2, Section1.1, Subsection 1.1.3: This indicates that procedures for authorized representatives to appeal on a Member's behalf are outlined in the "Designation of Representatives" Process. Page 10, Section 1.7: Subsection 1.7.1- 1.7.4: This states that the Member or their DCR may request a State Fair Hearing. *VI_CS_Process Designation of Representatives* Page 1, "Process" Section 3.0, Paragraph 2: This states that a Member, or a designated client representative acting on behalf of a Member with the Member's written consent, or the legal representative of a deceased Member's estate, may file a grievance, a health plan-level appeal, and may request a State Fair Hearing. **RAE-specific: N/A** **Prime-specific: N/A**	
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities.	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 2, Section 1.1, Subsection 1.1.2: This explains how RMHP assists Members in completing any forms required, putting verbal requests, including requests for a State fair hearing, into writing and taking other procedural steps.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.406(a) RAE Contract: Exhibit B-8—8.3 Prime Contract: Exhibit M-10—8.3 10 CCR 2505-10 8.209.4.C	*VI_CS_Grievance Policy and Procedure* Page 2, Section 2 - General Information, Subsection 2.2: This explains how RMHP assists Members with completing any forms or completing other procedural steps. *COMBINED_1557Notice_MLIS_2022 Mcaid_CHP+* Tagline and Notice of Nondiscrimination This document is sent with all significant Member communications, including with all appeals and grievances Member mailings. Page 1: The Notice of Nondiscrimination states that RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge, including auxiliary aids and services. **RAE-specific: N/A** **Prime-specific: N/A**	
7. 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 nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, 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.	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 5, Section 1.4, Subsections 1.4.3 and paragraph 1.4.3.1 - 1.4.3.2: This describes the requirements for the grievances and appeals reviewers/decision-makers. The Medical Director and the clinical consultant must not have been involved in the initial decision or be the subordinate of the medical director involved in the initial review. The reviewer or consultant must have the appropriate clinical expertise in treating the	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* RAE Contract: Exhibit B-8—8.5.4, 8.7.4 Prime Contract: Exhibit M-10—8.5.3, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	Member's condition or disease. *VI_CS_Grievance Policy and Procedure* Page 5, Section 3 - Process, Subsection 3.1 - Standard Grievance/Compliant Process, 3.1. - 3.1.3.2.2: This indicates that RMHP ensures that individuals who make decisions on grievances are individuals who were not involved in any aspect of the circumstances or decision-making that led to the grievance nor a subordinate of any individual who was involved and have the appropriate clinical expertise in treating the Member's condition or disease. **RAE-specific: N/A** **Prime-specific: N/A**	
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* RAE Contract: Exhibit B-8—8.6.2 Prime Contract: Exhibit M-10—8.6.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Both RAE and Prime:** VI_CS_Appeals Policy and Procedure Page 5, Section 1.4, Subsections 1.4.3.4: This states that the individuals who make decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* RAE Contract: Exhibit B-8—8.5.3 Prime Contract: Exhibit M-10—8.5.3 10 CCR 2505-10 8.209.5.D	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 2., Subsection 2.1.: This lists the ways that RMHP accepts grievances, both orally and in writing. *VI_CS_Process for Accepting Appeal or Grievance* Pages 1 - 5: This describes the process that Customer Service Representatives follow to accept Member grievances orally by phone. *VI_CS_Complaints and Appeals Routing* Page 2, Section 6.0: This explains how Customer Service Representatives receive grievances by phone or email. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* RAE Contract: Exhibit B-8—8.5.3 Prime Contract: Exhibit M-10—8.5.3 10 CCR 2505-10 8.209.5.A	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 2., Subsection 2.2.: States that Members or their designated representative can file grievances at any time. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor sends the member written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* RAE Contract: Exhibit B-8—8.1 Prime Contract: Exhibit M-10—8.1 10 CCR 2505-10 8.209.5.B	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 2., Subsection 2.2., Subsubsection 2.2.6.: General Information Paragraph V: This states that acknowledgment letters are sent to Members within two working days of receipt. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a);(b)(1); and (d)(1)* RAE Contract: Exhibit B-8—8.5.5, 7.2.7.3, 7.2.7.5 Prime Contract: Exhibit M-10—8.5.4, 7.2.7.3, 7.2.7.4, 7.2.7.5. 10 CCR 2505-10 8.209.5.D	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 5, Section 3 Subsection 3.1, Subsubsection 3.1.2.: This states that RMHP must respond to a grievance within 15 working days from the date of receipt, or as expeditiously as the Member's health condition requires. **Bullet #1** Page 3 Section 2., Subsubsection 2.2.7.1.: This describes that the reviewer's resolution must be in language that is easily understandable. It must provide a rationale in sufficient detail that may be easily understood by the Member. *VI_CS_MD - Grievance and Explanation Resolution* This template is used to provide notice to the Member of the disposition/resolution of their grievance. It is in	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	a format and include standard language that can be easily understood by Members. **RAE-specific: N/A** **Prime-specific: N/A**	
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. *42 CFR 438.408(a)* RAE Contract: Exhibit B-8—8.5.8 Prime Contract: Exhibit M-10—8.1 10 CCR 2505-10 8.209.5.G	**Both RAE and Prime:** *VI_CS_MD - Grievance and Explanation Resolution* This template includes the disposition /resolution process and the date it was completed. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* RAE Contract: Exhibit B-8—8.1.1 Prime Contract: Exhibit M-10—8.1	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *VI_CS_MD - Uphold Denial Med Review* *VI_CS_MD - Uphold Denial No Med Review* *VI_CS_CHP - Uphold Denial Med Review* *VI_CS_CHP - Uphold Denial No Med Review* *VI_CS_Process for Accepting Appeal or Grievance* The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. The documents indicate that there is only one level of	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	appeal with the health plan for RAE and PRIME Members. Members are provided clear instructions about how to request a State Fair Hearing (or State Review) after exhausting RMHP's appeal process, or if RMHP fails to adhere to the required timeframes for processing appeals. **RAE-specific: N/A** **Prime-specific: N/A**	
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* RAE Contract: Exhibit B-8—8.7.5.1 Prime Contract: Exhibit M-10—8.7.5.1 10 CCR 2505 10 8.209.4.B	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* Page 1, Member Appeal Submission: This indicates the 60 calendar day time frame Members have to submit an appeal *VI_CS_Appeals Policy and Procedure* Page 2, Section 1.1, Subsection 1.1.4 This indicates that time frames for submitting appeals is in the "MD.CHP Timelines" grid **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and the Contractor must treat oral appeals in the same manner as appeals received in writing. The Contractor may not require that oral requests for an appeal be followed with a written request. *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* RAE Contract: Exhibit B-8—8.7.6 Prime Contract: Exhibit M-10—8.7.6, 8.7.7 10 CCR 2505-10 8.209.4.F	Inform health plan on-site that proposed federal rule changes include: Eliminate the requirement that an oral appeal must be followed by a written, signed appeal (must continue to treat oral appeals the same as written appeals). **Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 2, Section 1.1., Subsection 1.1.1: This indicates that appeals will be accepted by fax, e-mail, standard mail or verbally. Page 3-4, Section 1.2.: This explains how verbal appeals are acknowledged *VI_CS_Verbal Appeal Acknowledgment Template* This template explains to the Members what RMHP believes to be the reason for the appeal. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: RMHP Prime's *Appeals Policy and Procedure* accurately stated that a member can request an appeal verbally or in writing and a verbal request will be treated the same as a written request. However, its *UM Program Description,* page 17, stated that telephone notifications to initiate the standard appeals process must be followed up by a written confirmation from the member or provider.		
Required Actions: RMHP Prime must remove from the *UM Program Description* any references that require a member to submit appeal information in writing.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* RAE Contract: Exhibit B-8—8.1, 8.7.2 Prime Contract: Exhibit M-10—8.1, 8.7.3 10 CCR 2505-10 8.209. 4.D	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* This document indicates the two working day time frame to acknowledge receipt of a standard appeal. *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* These letter templates are used to provide written acknowledgement of verbal and written appeals and are sent within two working days of receipt of standard appeals. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The Contractor's appeal process must provide that included, as parties to the appeal, are: • The member and the member's representative, or • The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* RAE Contract: Exhibit B-8—8.7.6, 8.7.7, 8.7.11 Prime Contract: Exhibit M-10—8.7.11 10 CCR 2505-10 8.209.4.I	**Both RAE and Prime:** *VI_CS_Process Designation of Representatives* Page 1, Section 3.0 Paragraph 2: This explains that the Member, the Member's designated representative or the legal representative of a deceased Member's estate are the parties to the appeal. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The case file to the member and their representative, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* RAE Contract: Exhibit B-8—8.7.8–8.7.10 Prime Contract: Exhibit M-10—8.7.8–8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 3, Section 1.2, Subsection 1.2.1.1.: This explains how RMHP gives Members an opportunity to submit further evidence, including in cases of expedited resolution where time is limited. Page 4, Section 1.2, Subsection 1.2.1.1.3.: This explains how RMHP gives Members an opportunity to receive a copy of the Member's case file free of charge and in advance of the appeal resolution time **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook_July 2022* Page 43-44, "Standard Review," describes that Members will receive information in their acknowledgement letter about how to access their appeal file and that they may provide more information about their appeal to RMHP either in person, or in writing.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
20. 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; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that:	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 7-8, Section 1.5: This describes the expedited review process. **Bullet #1** Page 8, Section 1.5, Subsection 1.5.2, Subsubsection 1.5.2.3:	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* RAE Contract: Exhibit B-8—8.7.14.2.1, 8.7.12 Prime Contract: Exhibit M-10—8.7.12, 8.7.14.2.1 10 CCR 2505-10 8.209.4.Q-R	This states that punitive action will not be taken against a provider for requesting an expedited appeal or supporting a Member's appeal. *II_PNM_2022 Physician Medical Services Agreement* Page 23, Section G, "Limitations on Adverse Actions": This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. *II_PNM_2022 Professional Services Agreement* Page 25, Section G, "Limitations on Adverse Actions": This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. *VI_PNM_2022 Hospital Services Agreement* Page 26, Section G, "Limitations on Adverse Actions": This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if the member disagrees with that decision. *42 CFR 438.410(c)* RAE Contract: Exhibit B-8—8.7.14.2.2 Prime Contract: Exhibit M-10—8.7.14.2.2 10 CCR 2505-10 8.209.4.S	**Both RAE and Prime:** **Bullet 1:** *VI_CS_Appeals Policy and Procedure* Page 7-8, Section 1.5, Subsection 1.5.2, Subsubsection 1.5.2.1: This describes that if RMHP denies a request for expedited resolution, it will transfer the appeal decision to the standard time frame and will make reasonable efforts to give the Member verbal notice followed by written notice of the denial within two calendar days. **Bullet 2:** *VI_CS_Appeals Policy and Procedure* Page 8, Section 1.5, Subsection 1.5.2, Subsubsection 1.5.2.4: This describes that the Member has the right to file a grievance if he or she disagrees with the decision not to expedite the appeal. *VI_CS_MD.CHP - No Expedited Appeal* This template provides the standard text contained in a notice that an appeal will not be expedited and demonstrates that the content is in a format and language that may be easily understood by the Member. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. 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. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)(i)* *42 CFR 438.10* RAE Contract: Exhibit B-8—8.7.14.1. 7.2.7.3, 7.2.7.5 Prime Contract: Exhibit M-10—8.7.14.1.1, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	**Both RAE and Prime:** **Bullet 1:** *VI_CS_MD.CHP Timelines* This document provides timeframes for appeals process and decisions. **Bullet 2:** *VI_CS_Appeals Policy and Procedure* Page 7, Section 1.4, Subsection 1.4.4.3: This describes the content of appeal resolution letters, including that they must be in a format and language that is easily understood by the Member. *VI_CS_MD - Uphold Denial Med Review* *VI_CS_MD - Uphold Denial No Med Review* *VI_CS_MD.CHP - Overturn Denial Med Review* *VI_CS_MD.CHP - Overturn Denial No Med Review* These templates provides the standard text contained in a notice of appeal resolution and demonstrates that the content is in a format and language that may be easily understood by the Member. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours 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. *42 CFR 438.408(b)(3) and (d)(2)(ii)*	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* This document describes that the timeframe for resolving an expedited appeal is within 72 hours of receipt. *VI_CS_Appeals Policy and Procedure*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—8.7.14.2.3, 8.7.14.2.6 Prime Contract: Exhibit M-10—8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	Page 7, Section 1.5, Subsection 1.5.2: This describes that RMHP will make reasonable efforts to provide oral notice to the Member of the expedited resolution. **RAE-specific: N/A** **Prime-specific: N/A**	
24. 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 (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* RAE Contract: Exhibit B-8—8.7.14.2, 8.7.14.2.4, 8.5.6 Prime Contract: Exhibit M-10—8.5.5, 8.7.14.2.2, 8.7.14.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 10, Section 1.6, Subsection 1.6.8: This explains the circumstances under which RMHP will extend the time frames for resolution of both expedited and standard appeals. *VI_CS_Grievance Policy and Procedure* Page 5, Subsection 3.1.3.5 This explains the circumstances under which RMHP will extend the time frame for resolution of a grievance. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. If the Contractor extends the time frames for a grievance or appeal, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if the member disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires (14 days following the expiration of the original grievance or appeal resolution time frame). *42 CFR 438.408(c)(2)* RAE Contract: Exhibit B-8—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 Prime Contract: Exhibit M-10—8.5.6, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 10, Section 1.6, Subsection 1.6.8: This explains that if RMHP extends the time frame, reasonable efforts will be made to give the Member prompt oral notice of the delay and the Member will be given written notice of the reason for the delay within two calendar days, informing the Member that they may file a grievance if they disagree with the decision. Further, this P&P explains that the appeal will be resolved as expeditiously as the Member's health condition requires and no later than the date the extension expires. *VI_CS_Grievance Policy and Procedure* *Page 5, Subsection 3.1.3.5* This explains the circumstances under which RMHP will extend the time frame for resolution of a grievance. *VI_CS_MD.CHP - Plan Needs Additional Time* This template illustrates the notices that the plan needs additional time to complete appeal and the Member's rights. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. 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 that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* RAE Contract: Exhibit B-8—8.7.14.3, 8.7.14.4 Prime Contract: Exhibit M-10—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 6, Section 1.4.4 - 1.4.13.3 This describes the information that must be included in the notice of appeal resolution. *VI_CS_MD - Uphold Denial Med Review* *VI_CS_MD - Uphold Denial No Med Review* This template illustrates that the notices of appeal resolution contain the required language **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: RMHP Prime had six sample appeal resolution letters that required the member to request continuation of benefits in writing.		
Required Actions: RMHP Prime must remove language that continuation of benefits must be submitted "in writing" as it is not a requirement by the federal regulations or State contract.		

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of appeal resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* RAE Contract: Exhibit B-8—8.7.15.1–8.7.15.2 Prime Contract: Exhibit M-10—8.7.15.1-2 10 CCR 2505-10 8.209.4.N and O	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 10, Section 1.7, Subsection 1.7.1.: This explains that the Member or their DCR may request a State fair hearing within 120 days from the date of the notice of resolution. The P&P also explains that a Member is deemed to have exhausted the appeal process and may request a State fair hearing/State Review if RMHP does not adhere to the notice and timing requirements. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook_July 2022* Page 44, paragraph 3: This informs Members they may request a State Fair Hearing within 120 calendar days from the date of the notice of resolution and that if RMHP does not adhere to the notice and timing requirements, the Member may request a State Review.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The parties to the State fair hearing include the Contractor as well as the member and their representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* RAE Contract: Exhibit B-8—8.7.15.3 Prime Contract: Exhibit M-10—8.7.15.3	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 10, Section 1.7, Subsection 1.7.4: This explains that RMHP, as well as the Member and his or her representative, participate in the State Fair Hearing/State Review. *VI_CS_Process Designation of Representatives* Page 1, Section 3, Paragraph 2: This explains that a representative of a deceased	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member's estate is considered a party to a State Fair Hearing/State Review. **RAE-specific: N/A** **Prime-specific: N/A**	
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • 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 an appeal in accordance with required time frames. ** 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. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)*	**Both RAE and Prime:** **Both RAE and PRIME:** *VI_CS_Appeals Policy and Procedure* Page 10, Section 1.8.3.: This describes the policy for continuation of benefits during the appeal process. *VI_CS_MD – Uphold Denial Med Review* *VI_CS_MD – Uphold Denial No Med Review* Page 3, How to Ask for your Services to Continue During a State Fair Hearing: This Member notice describes the continuation of benefits policy while RMHP appeal and State Fair Hearing are pending. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—8.7.13.1 Prime Contract: Exhibit M-10—8.7.13.1 10 CCR 2505-10 8.209.4.T		
Findings: RMHP Prime accurately stated in the *Prime Member Handbook* that a member can request continued benefits within 10 days of the appeal decision. However, RMHP Prime did not include a bullet point that states a member can request continuation of benefits within 10 days of the NABD.		
Required Actions: RMHP Prime must update its *Prime Member Handbook* to include a bullet point under the section "Continuing Your Benefits" on page 44 with the following language: • You must tell RMHP if you want to keep getting your services through the appeal process. You must do it within 10 days of the notice of adverse determination letter.		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* RAE Contract: Exhibit B-8—8.7.13.2 Prime Contract: Exhibit M-10—8.7.13.1.6 10 CCR 2505-10 8.209.4.U	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 11-12, Section 1.8, Subsection 1.8.6: This describes how long benefits are continued while an appeal or State Fair Hearing is pending and the events that must occur before benefits can be discontinued. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, 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. *42 CFR 438.420(d)* RAE Contract: Exhibit B-8—8.7.13.3 Prime Contract: Exhibit M-10—8.7.13.2 10 CCR 2505-10 8.209.4.V	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section 1.8, Subsection 1.8.7, Subsubsection 1.8.7.1.: This describes the Member's responsibility for the cost of continued services if the appeal decision is adverse to the Member. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
32. 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 as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* RAE Contract: Exhibit B-8—8.7.13.4 Prime Contract: Exhibit M-10—8.7.13.3 10 CCR 2505-10 8.209.4.W	**Both RAE and Prime:** **Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section 1.8, Subsection 1.8.7, Subsubsection 1.8.7.3.: This describes RMHP's responsibility for effectuating the State Fair Hearing decision if it reverses RMHP's decision to deny, limit or delay services that were not furnished while the appeal was pending. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. 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. *42 CFR 438.424(b)* RAE Contract: Exhibit B-8—8.7.13.5 Prime Contract: Exhibit M-10—8.7.13.4 10 CCR 2505-10 8.209.4.X	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section 1.8, Subsection 1.8.7, Subsubsection 1.8.7.2.: This describes that RMHP must pay for services when 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. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a *Grievance and Appeals* report including this information. *42 CFR 438.416*	**Both RAE and Prime:** **Both RAE and Prime:** **Bullet 1:** *VI_CS_Appeals Policy and Procedure* Page 2-3, Section 1.1, Subsection 1.1.7: This describes the records of appeals that RMHP maintains. *VI_CS_Grievance Policy and Procedure* Page 4-5, Section 2.2, subsection 2.2.13.: This describes the records of grievances that RMHP maintains. **Bullet 2:** *VI_CS_Appeals Policy and Procedure* Page 11, Section 1.9, Subsection 1.9.1 This describes the process for quarterly reporting that is completed and submitted to HCPF.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—8.9.1–8.9.1.6 Prime Contract: Exhibit M-10—8.9.1-8.9.1.6 10 CCR 2505-10 8.209.3.C	**Bullet 2:** *VI_CI_R1_RM_GrieveAppealRpt_Q1-FY 2022-2023* This report, provides identified trends regarding timely response and completion of grievances and appeals, and any actions taken. Note: Grievance and Appeal approved template with Q1-FY22-23 data will be available via screenshare during interview. **RAE-specific: N/A** **Prime-specific: N/A**	
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system 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 after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – 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.	**Both RAE and Prime:** *VI_PNM_2022 Physicians Medical Services Agreement* Page 13, Section U. "Expressing Disagreement": Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or requested in written form. *VI_PNM_2022 Physicians Medical Services Agreement* Page13, Section T. "Compliance, Cooperation and Participation in RME's Policies and Procedures": Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *VI_PNM_2022 Professional Services Agreement* Page 13, Section Q. "Expressing Disagreement":	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.414 RAE Contract: Exhibit B-8—8.4 Prime Contract: Exhibit M-10—8.4 10 CCR 2505-10 8.209.3.B	Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 13, Section P. "Compliance, Cooperation and Participation in RME's Policies and Procedures": Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *VI_PNM_2022 Hospital Services Agreement* Page 15, Section W. "Expressing Disagreement": Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 15, Section V. "Compliance, Cooperation, and Participation in RME's Policies and Procedures": Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *PNM_2021 RMHP Provider Manual* Page 57, "Appeal and Grievance Processes- Prime, RAE, CHP+" : This describes the Appeals and Grievances process for RAE & PRIME. **RAE-specific: N/A**	

Standard VI—Grievances and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: N/A	

Results for Standard VI—Grievance and Appeal Systems—Prime							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	3	X	.00	=	3
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	91%

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor agrees to accept individuals eligible for enrollment into its MCO in the order in which they are assigned without restriction and according to the enrollment policies and procedures. Members will be enrolled with the appropriate aid eligibility category and in the service area until the enrollment cap has been met. *42 CFR 438.3(d)(1)* RAE Contract: Exhibit B-8—6.6 Prime Contract: Exhibit M-10—6.6, 6.6.1	**Both RAE and Prime:** *XII_ProRec_Medicaid 834 Processing* RMHP processes the 834 EDI files in the order in which they are generated. RMHP does not have any rules setup in the 834 intake process that would restrict members from being loaded into the system of record. *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* This P&P describes the RMHP Enrollment and Disenrollment process. Page 2, 6.0 Procedure, RMHP Enrollment for Medicaid and CHP+ Members, paragraph 2: This describes that RMHP reports irregularities exceeding enrollment limits to the State. *XII_ProRec_Medicaid and CHP Enrollment Reporting* This P&P describes the analysis that RMHP performs monthly to identify any enrollment trends. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, national origin, ancestry, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability. *42 CFR 438.3(d)(3-4)*	**Both RAE and Prime:** *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* Page 2, 6.0 Procedure, bottom of page: This describes that RMHP does not discriminate against any members that are eligible for enrollment or enrolled in our programs for any reason.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—6.5 Prime Contract: Exhibit M-10—6.5	*PNM_2021 RMHP Provider Manual* Page 116, "Equal Opportunity Policy Statement": This describes that it is the policy of RMHP to provide equal opportunity and to prevent discrimination based on race, color, sex, national origin, age, or disability in admission or access to, or treatment or employment in, RMHP programs, health care plans, and activities to the extent required by applicable law. *XII_CM_Culturally Sensitive Services* Page 1, Policy & Procedure Section 3.0, Equal Opportunity Policy Statement: It is the policy of Rocky Mountain Health Plans (RMHP) to provide equal opportunity and to prevent discrimination based on race, color, national origin, sex, sexual orientation, gender identity, age, or disability in admission or access to, or treatment or employment in, RMHP programs, health care plans, and activities to the extent required by applicable law. **RAE-specific: N/A** **Prime-specific:** *PRIME Member Handbook_July 2022* -Member Rights & Responsibilities, pg. 41 -1557 Notice (CRN), PDF pg. 3 RMHP does not discriminate against individuals eligible to enroll or use any policy or practice that has the effect of discriminating against individuals, based upon health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability. Members are notified of this policy through the Member Handbook.	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor may not request disenrollment of a member because of an adverse change in the member's health status or because the member's: • Utilization of medical services. • Diminished mental capacity. • Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the member or to other members). *42 CFR 438.56(b)(2)* RAE Contract: Exhibit B-8—None Prime Contract: Exhibit M-10—6.13.2	**Both RAE and Prime:** *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* Page 4, 1st paragraph: This describes that RMHP will request disenrollment for a Member because of an adverse change in the Member's health status, utilization of services, diminished mental capacity, or behavior. *XII_CS_Disenrollment from RAE PRIME or CHP+* Section 4.0, Paragraph 1: This describes the process of review for potential disenrollment, due to when a Member is not allowing CS to assist, which may cause an interference with the Member's health and well-being. *XII_CM_CM 10 People with SHCN Policy* Page 2, Section 3 Bullet 7: Rocky Mountain care coordinators cannot request disenrollment of a Member due to an adverse change in the Member's health status or because of the Member's utilization of medical services, diminished mental capacity or due to uncooperative or disruptive behavior resulting from the Member's special needs (except when Member's continued enrollment seriously impairs the Contractor's ability to furnish services to the Member or to other Members). **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor may initiate disenrollment of any member's participation in the MCO upon one or more of the following grounds: • Uncooperative or disruptive behavior such that continued enrollment would seriously impair the Contractor's ability to furnish services to the member or poses physical threat to the provider, to other providers, contractor staff, or other members. • For cause, at any time under the following circumstances: – Admission of the member to any federal, state, or county governmental institution for treatment of mental illness, narcoticism or alcoholism, or a correctional institute. – Receipt of comprehensive health cover, other than Medicaid. – Enrollment in a Medicare MCO or capitated health plan other than such plan offered by the Contractor. – Ongoing pattern of failure on the part the member to keep scheduled appointments or meet any other member responsibilities. – The member has moved out of the Contractor's service area.	**Both RAE and Prime:** *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* Page 3, section "RMHP Disenrollment for Medicaid and CHP+ Members": This describes that RMHP may initiate disenrollment for the identified reasons. *XII_CS_Disenrollment from RAE PRIME or CHP+* Section 4.0, Paragraph 1: This describes the process of review for potential disenrollment, due to when a Member is not allowing CS to assist, which may cause an interference with the Member's health and well-being. *XII_CM_Disenrollment from RAE PRIME or CHP+* Page 1-2, Section 3.0 Policy: This describes that RMHP may initiate disenrollment of a Member's participation in the MCO upon one or more of the identified reasons. *PNM_2021 RMHP Provider Manual* Page 104, section "Circumstances that May Result in Member Dismissal" This describes that RMHP may initiate disenrollment of a Member due to Provider reported issues regarding Member behavior and/or responsibilities.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The Contractor does not (due to moral or religious objections) cover the service the member needs. – The member needs related services to be performed at the same time, not all related services are available from the Contractor's network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk. – Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error. – Poor quality of care. – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs. – The member commits fraud or furnishes incorrect or incomplete information on applications, questionnaires, forms, or statements submitted as part of the member's enrollment. – Any other reason determined by the Department. *42 CFR 438.56(b)(1)* *42 CFR 436.56(d)(2)(i)-(v)*	*XII_CL_CoordofBenefitsProcessing_Medicaid Secondary P&P* Page 1, Section 6.0 The State of Colorado requires that a "third party" be responsible for the payment of claims before RMHP Medicaid. Benefits are to be exhausted by such third party before the claims are sent to RMHP for secondary consideration. Sometimes the "third party" is another commercial insurance through which the member has obtained coverage either as a dependent or as a subscriber. "Third Party" health benefits that are obtained through an employer group (active or as a retiree), individual plans or Tricare/Champus (Military Benefits) are considered primary to Medicaid. Medicaid is the payor of last resort. **RAE-specific: N/A** **Prime-specific: N/A**	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-8—None Prime Contract: Exhibit M-10—6.13.1.1-7		
5. To initiate disenrollment of a member's participation with the MCO, the Contractor must provide the Department with documentation justifying the proposed disenrollment. *42 CFR 438.56(b)(3)* RAE Contract: Exhibit B-8—None Prime Contract: Exhibit M-10—6.13.1.7.4	**Both RAE and Prime:** *XII_ProRec_Member Change of Circumstance* This P&P describes the process to provide notification to the Department for the identified changes of circumstances for Members. *XII_CI_R1_RM_MmbrChange_MM_YY* This HCPF template is used to provide monthly reporting of a Member's change in circumstance. *XII_CS_Disenrollment from RAE PRIME or CHP+* Section 4.0, Paragraph 1: This describes the process of review for potential disenrollment (RAE/MCO reassignment) request by RMHP with HCPF. **RAE-specific: N/A** **Prime-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The member may request disenrollment as follows: • For cause at any time, including: – The member has moved out of the Contractor's service area. – The Contractor does not (due to moral or religious objections) cover the service the member needs. – The member needs related services to be performed at the same time, not all related services are available from the Contractor's	**Both RAE and Prime:** *XII_ProRec_Medicaid and CHP Enrollment and Disenrollment P&P* Page 4, 2nd paragraph: This describes that RMHP acknowledges that as Member may request disenrollment for cause or without cause at any time for the reasons identified. *XII_CS_Disenrollment from RAE PRIME or CHP+* Section 4.0 Paragraph 2 This describes how Customer Service assists members wanting to disenroll. **RAE-specific: N/A**	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
network, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk. – Administrative error on the part of the Department or its designee or the Contractor including, but not limited to, system error. – Poor quality of care. – Lack of access to covered services, or lack of access to providers experienced with dealing with the member's specific needs. – The member enrolled with their provider and the provider leaves the Contractor. – The member is a resident of a long-term institutional care facility. – The member is enrolled into a Medicare managed care plan or Medicare capitated health plan other than the limited managed care capitation imitative offered by the Contractor and the Contractor cannot provide the member with reasonable access to a Medicare-approved provider or, if the member is enrolled in a Medicare managed care plan, and the Contractor cannot provide the member with providers participating in both plans.	**Prime-specific:** *PRIME Member Handbook_July 2022* Page 13-14, Section "*If you must leave Rocky Mountain Health Plans"* This describes that a Member may initiate disenrollment from RMHP for cause or without cause any time for the identified reasons.	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The member is in long-term community-based care. – The member is an Indian member and there is not timely access to an Indian Health Care Provider. • Without cause at the following times: – During the 90 days following the date of the member's initial passive enrollment. – At least once every 12 months thereafter. – Upon automatic re-enrollment if temporary loss of eligibility has caused the member to miss the annual disenrollment opportunity. – When the Department has imposed sanctions on the MCO (consistent with 42 CFR 438.702(a)(4). *42 CFR 438.56(2)(i)-(v)* RAE Contract: Exhibit B-8—6.10 Prime Contract: Exhibit M-10—6.13.4.1.1-12, 6.13.4.2.1-4		

Results for Standard XII—Enrollment and Disenrollment—Prime							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
			Total Score ÷ Total Applicable			=	100%

Appendix F2. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Denials Record Review
for
Rocky Mountain Health Plans Prime

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	March 7–8, 2023
Reviewer:	Crystal Brown
Participating MCE Staff Member(s):	Billie Bemis

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****		****				
Date of Initial Request [XX/XX/XXXX]	3/31/2022	3/18/2022	6/28/2022	8/9/2022	8/24/2022	9/19/2022	3/1/2022	9/26/2022	9/23/2022		8/18/2022				
Type of Denial: Termination (T), New Request (NR), Claim (CL)	NR	CL	CL	NR	CL	NR	CL	CL	CL		NR				
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	S	R	R	S	R	S	R	R	R		E				
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	4/1/2022	4/9/2022	7/23/2022	8/18/2022	9/17/2022	9/28/2022	10/1/2022	10/1/2022	10/15/2022		8/19/2022				
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	4/1/2022	4/13/2022	7/26/2022	8/18/2022	2/6/2023	9/28/2022	2/7/2023	2/7/2023	2/7/2023		8/19/2022				
Notice Sent to Provider and Member? [I.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met		Met				
Number of Hours or Days for Decision (H/D)	1 D	22 D	25 D	9 D	24 D	9 D	214 D	5 D	22 D		1 D				
Number of Hours or Days for Notice (H/D)	1 D	26 D	28 D	9 D	166 D	9 D	343 D	134 D	137 D		1 D				
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.12] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections	Met	Met	Met	Met	Met	Met	Not Met	Met	Met		Met				
Notice Sent Within Required Time Frame? [I.17] Standard: 10 calendar days Expedited: 72 hours SUD: 72 hours (calendar) or 24 hours (calendar) for special connections Termination: 10 calendar days before the date of action	Met	Met	Met	Met	Not Met	Met	Not Met	Not Met	Not Met		Met				
Was Authorization Decision Timeline Extended? Yes or No	No	No	No	No	No	No	No	No	No		No				
If Extended, Extension Notification Sent to Member? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA				
If Extended, Extension Notification Includes Required Content? [I.19]	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA				
NABD Includes Required Content [I.15-16]	Met	Met	Met	Met	Met	Met	Met	Met	Met		Met				
Authorization Decision Made by Qualified Clinician? [I.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met		Met				
If Denied for Lack of Information, Was the Requesting Provider Contacted for Additional Information or Consulted (if applicable)? [I.9]	NA	NA	NA	NA	NA	NA	NA	NA	NA		NA				
Was the Decision Based on Established Authorization Criteria (i.e., not arbitrary)? [I.2]	Met	Met	Met	Met	Met	Met	Met	Met	Met		Met				
Was Correspondence With the Member Easy to Understand? [I.14]	Met	Met	Met	Met	Met	Met	Met	Met	Met		Met				
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	7	7	7	7	7	7	7	7	7		7				
Compliant (Met) Elements	7	7	7	7	6	7	5	6	6		7				
Percent Compliant	100%	100%	100%	100%	86%	100%	71%	86%	86%		100%				
Overall Total Applicable Elements	**70**														
Overall Total Compliant Elements	**65**														
Overall Total Percent Compliant	**93%**														

Comments:
File 5: NABD was not generated until 2/6/2023.
File 7: Received 3/1/2022, input 9/28/2022, paid 10/1/2022. NABD was not generated until 2/7/2023.
File 8: NABD was not generated until 2/7/2023.
File 9: NABD was not generated until 2/7/2023.
File 10: This request was closed, and later the same day, provider submitted documentation. Service was approved under a different authorization number. An oversample was pulled.

Yes and No = not scored—for informational purposes only
**** = Redacted Member ID

Appendix F2. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Grievances Record Review
for
Rocky Mountain Health Plans Prime

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	March 7–8, 2023
Reviewer:	Crystal Brown
Participating MCE Staff Member(s):	Rhonda Michaelson and Marci Wright O'Gara

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date Grievance Received [XX/XX/XXXX]	2/23/2022	5/9/2022	7/7/2022	8/2/2022	8/17/2022	9/12/2022	9/26/2022	10/7/2022	10/21/2022	12/5/2022					
Date of Acknowledgement Letter [XX/XX/XXXX]	2/24/2022	5/11/2022	7/11/2022	8/4/2022	8/18/2022	9/13/2022	9/27/2022	10/11/2022	10/24/2022	12/6/2022					
Days From Grievance Received to Acknowledgement	1	2	2	2	1	1	1	2	1	1					
Acknowledgement Letter Sent in 2 Working Days [VI.11]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Date of Written Notice [XX/XX/XXXX]	3/15/2022	5/11/2022	7/11/2022	8/23/2022	8/18/2022	9/30/2022	9/27/2022	10/11/2022	10/24/2022	12/27/2022					
# of Days to Notice	14	2	2	15	1	14	1	2	1	15					
Resolved and Notice Sent in Time Frame* [VI.12,24] Standard: 15 working days Extension: 15 working days + 14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker Not Involved in Grievance [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Appropriate Level of Expertise (If Clinical) [VI.7]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA					
Resolution Letter Includes Required Content [VI.13]**	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Easy to Understand [VI.12]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Scoring	**File 1**	**File 2**	**File 3**	**File 4**	**File 5**	**File 6**	**File 7**	**File 8**	**File 9**	**File 10**	**File OS1**	**File OS2**	**File OS3**	**File OS4**	**File OS5**
Applicable Elements	5	5	5	5	5	5	5	5	5	5					
Compliant (Met) Elements	5	5	5	5	5	5	5	5	5	5					
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
Overall Total Applicable Elements	**50**														
Overall Total Compliant Elements	**50**														
Overall Total Percent Compliant	**100%**														

Comments:

* Grievance timeline for resolution and notice sent is 15 working days (unless extended, then up to 14 calendar days).

**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.

**** = Redacted Member ID

Appendix F2. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Appeals Record Review
for
Rocky Mountain Health Plans Prime

Review Period:	January 1, 2022–December 31, 2022
Date of Review:	March 7–8, 2023
Reviewer:	Crystal Brown
Participating MCE Staff Member(s):	Rhonda Michaelson and Marci Wright O'Gara

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Member ID #	****	****	****	****	****	****	****	****	****	****					
Date Appeal Received [XX/XX/XXXX]	2/16/2022	5/5/2022	6/6/2022	7/5/2022	8/26/2022	9/27/2022	10/24/2022	11/22/2022	12/8/2022	12/28/2022					
Date of Acknowledgement [XX/XX/XXXX]	2/8/2022	4/27/2022	6/8/2022	7/6/2022	8/24/2022	9/21/2022	10/25/2022	11/23/2022	12/9/2022	12/29/2022					
Days From Appeal Received to Acknowledgement	-8	-8	2	1	-4	-6	1	1	1	1					
Acknowledgement Sent Within 2 Working Days? [VI.17]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker Not Previous Level [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Decision-Maker—Clinical Expertise [VI.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Expedited Appeal: Yes or No	No	No	No	No	No	No	No	Yes	No	No					
Time Frame Extended: Yes or No	No	No	No	No	No	No	No	No	No	No					
Date Resolution Notice Sent [XX/XX/XXXX]	3/2/2022	5/16/2022	6/15/2022	7/12/2022	9/12/2022	10/5/2022	11/4/2022	11/23/2022	12/19/2022	1/6/2023					
Hours or Days From Appeal Filed to Resolution Notice Sent	9 D	7 D	7 D	5 D	10 D	5 D	9 D	1 D	7 D	7 D					
Notice Sent Within Time Frame*? [VI.22-25] Standard Resolution: 10 working days Expedited Resolution: 72 hours Time Frame Extended: +14 calendar days	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Resolution Letter Includes Required Content [VI.26]**	Not Met	Not Met	Met	Not Met	Not Met	Met	Not Met	Met	Met	Not Met					
Resolution Letter Easy to Understand [VI.22]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1	File OS2	File OS3	File OS4	File OS5
Applicable Elements	6	6	6	6	6	6	6	6	6	6					
Compliant (Met) Elements	5	5	6	5	5	6	5	6	6	5					
Percent Compliant	83%	83%	100%	83%	83%	100%	83%	100%	100%	83%					
Overall Total Applicable Elements	**60**														
Overall Total Compliant Elements	**54**														
Overall Total Percent Compliant	**90%**														

Comments:
Files 1, 2, 4, 5, 7, and 10 included language in the appeal resolution letters that said continuation of benefits request must be in writing. Continuation of benefits requests are not required in writing.

*__Appeal resolution letter time frame__ does not exceed 10 working days from the day the MCE receives the appeal (unless expedited—72 hours; or unless extended—+14 calendar days).

**__Appeal resolution letter required content__ includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request (does not apply to CHP+).

**** = Redacted Member ID