CHP+

Child Health Plan *Plus*

Fiscal Year 2022–2023 Compliance Review Report

for

Rocky Mountain Health Plans

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

Table of Contents

1. Executive Summary

Introduction

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) to comply with provisions of the Code of Federal Regulations, Title 42 (42 CFR)—Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP MCOs effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. The Department administers and oversees the Child Health Plan *Plus* (CHP+) program (Colorado's implementation of CHIP).

The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs (collectively referred to as managed care entities [MCEs]) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's CHP+ MCOs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2022–2023 was January 1, 2022, through December 31, 2022. This report documents results of the FY 2022–2023 compliance review activities for **Rocky Mountain Health Plans** (**RMHP**). For each of the 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 reviews. Appendix C lists HSAG, CHP + MCO, and Department personnel who participated in some way in the compliance review process. Appendix D describes the corrective action plan (CAP) process the CHP+ MCO 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]

[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 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** 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 the Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	34	34	33	1	0	0	97%
II. Adequate Capacity and Availability of Services	14	14	13	1	0	0	93%
VI. Grievance and Appeal Systems	31	31	29	2	0	0	94%
XII. Enrollment and Disenrollment	6	6	6	0	0	0	100%
Totals	**85**	**85**	**81**	**4**	**0**	**0**	**95%**

*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** 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	68	61	7	32	90%
Grievances	60	50	50	0	10	100%
Appeals	60	55	54	1	5	98%
Totals	**220**	**173**	**165**	**8**	**47**	**95%**

*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 eviCore as well as Advanced Medical Reviews (AMR), which is contracted for specialty cases. Inter-rater reliability testing for **RMHP** 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**'s turnaround time reference document demonstrated that **RMHP** 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** 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.

Information regarding the Children and Youth Mental Health Treatment Act (CYMHTA) was not included in templates at the time of the audit. However, the information was not applicable to the cases reviewed in the denial samples. HSAG recommends occasional quality assurance verification procedures to ensure that templates are aligned with the correct line of business.

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** 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.

Lastly, although all CHP+ denials were mailed in a timely manner, **RMHP** has the opportunity to update the UM Program Description to clarify that the time frame starts at the time of the request.

Required Actions

Denial sample files four through 10 included references to paying for benefits continued during an appeal or State fair hearing under the section "Understanding The Results Of Your Appeal, Quick Appeal, Or State Review." Continuation of benefits no longer applies to the CHP+ line of business. **RMHP** must update its NABD template for the CHP+ line of business to remove all references to continuation of benefits.

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**. Documentation included a policy that demonstrates **RMHP**'s responsibility to submit a report to the State regarding any unexpected or anticipated material changes to the network within five days after identifying the deficiency.

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 CHP+ 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** 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.

Related to accessibility for members with physical and mental health issues, provider demographic collection tools helped **RMHP** gather data for special accommodations or specialty training, although not all components appeared in the online provider directory at the time of the review.

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** 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 *CHP+ 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** 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 grievances from members 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, *Provider Manual,* and *CHP+ Member Handbook*.

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, in the *CHP+ Member Handbook*, on page 90 under the Standard Review section, it stated that if the member calls with an appeal request, **RMHP** will send a letter that must be signed by the member and returned in order to confirm that **RMHP** understands the verbal request. Additionally, **RMHP**'s *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 update the *CHP+ Member Handbook* and *UM Program Description* to remove any references that require a member to submit appeal information in writing.

Although the *Appeals Policy and Procedure* accurately mentioned the written notice of appeal resolution and what the appeal resolution letter includes (i.e., the results, date of completion, rights of the member to request a State fair hearing, and how to do so), the policy did not specify that the right to request benefits/services continue while the State fair hearing is pending and how to make the request does not apply to CHP+ members. **RMHP** must update its *Appeals Policy and Procedure* on pages 7, 10, and 11 to specify that continuation of benefits is not applicable to CHP+ members. In addition, **RMHP** had one sample appeal resolution letter that contained information regarding how a member could request continuation of benefits. The remainder of sample appeal resolution letters for the review period did not include continuation of benefits; therefore, **RMHP** has rectified this issue internally and no required action is needed regarding NABD updates.

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 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 and no limits to CHP+ newborn members. 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 reconciliation purposes.

RMHP 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 was to complain 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 described one instance where **RMHP** 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** would discuss the 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 CHP+ MCO's contract requirements and regulations specified by the federal Medicaid and CHIP 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 CHP+ MCO personnel to determine compliance with 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 CHP+ 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 CHP+ MCO denial, grievance, and appeal records that occurred between January 1, 2022, and December 31, 2022. For the record review, the CHP+ 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 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, and Standard X—Quality Assessment and Performance Improvement (QAPI).

Objective of the Compliance Review

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

- The CHP + 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 CHP + 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 CHP + MCO, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the CHP + 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 CHP+ 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 CHP+ 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 CHP+ MCO 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 VIII—Credentialing and Recredentialing, and Standard X—QAPI.

Summary of Corrective Action/Document Review

HSAG identified no required actions; therefore, **RMHP** was not required to complete a CAP.

Summary of Continued Required Actions

HSAG identified no required actions; therefore, **RMHP** was not required to complete a CAP.

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)* Contract: Exhibit B—11.11.1	*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.	☒ 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)* Contract: Exhibit B—11.11.3	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. – 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. *42 CFR 438.210(a)(4)* Contract: Exhibit B—11.11.2, 11.11.4.1, 11.11.4.2, and 11.11.4.2.2	*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. *I_UM_Preauthorization Policy & Procedure* Page 8, Paragraph 6.23.6.4 Family planning services are provided in a manner	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	that enables the member to be free from coercion and choose the method of family planning to be used. *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.	
4. 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)* Contract: Exhibit B—11.9.1.3	*I_UM_Preauthorization Policy & Procedure* Page 6, Section 6, Paragraph 6.20: RMHP covers all medically necessary covered treatments for covered behavioral health (BH) diagnoses, regardless of any co-occurring condition 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- "Utilization Management Procedures": 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. 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 CHP+ 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. – The ability for a member to achieve age-appropriate growth and development. – The ability for a member to attain, maintain, or regain function capacity. *42 CFR 438.210(a)(5)* Contract: Exhibit B—2.1.71 and 11.1.2 10 CCR 2505-10 8.076.1.8	*I_UM_Preauthorization Policy & Procedure* Page 2, Section 4.2, Paragraphs 4.2.1-4.2.10 This states that medical necessity is defined as consistent with the symptom, diagnosis and treatment of the Member's medical condition and widely accepted by the practitioner's peer group as effective and reasonably safe based on scientific evidence and not experimental, investigational, unproven, unusual, or not customary. Not solely for cosmetic purposes. Not solely for the convenience of the Member, subscriber, physician, or other provider. The most appropriate level of care that is medically necessary is care that can be safely provided to the Member, and failure to provide the service would adversely affect the Member's health. When applied to inpatient care, medically necessary services cannot be safely provided in an ambulatory setting and are no more costly than other equally effective treatment options. *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_2022 Professional Services Agreement Page 5, BB.- "Medically Necessary": This describes the full definition of medical necessity. *CHP+Member-Handbook_July2022* Page 78, Glossary: definition of Medical Necessity.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. 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)* Contract: Exhibit B—11.12.2	*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. *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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. 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)* Contract: Exhibit B—11.12.2	*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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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. I_UM_eviCore_Delegation_Oversight_Summary_2022 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.	
8. 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)* Contract: Exhibit B—11.12.2.4	*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. *I_UM_eviCore_Delegation_Oversight_Summary_2022* Page 2, UM 2: Clinical Criteria for Utilization Management Decisions:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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.	
9. 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 treating the member's medical or BH needs. *42 CFR 438.210(b)(3)* Contract: Exhibit B—11.11.5	*I_UM_Appropriate Professionals for UM and Pharmacy* Page 3, Section 3.3: This describes the process for practitioner review of non-behavioral and behavioral healthcare 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, Section 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.	☒ 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 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)* Contract: Exhibit B—8.5.1	*I_UM_Preauthorization Policy & Procedure* Pages 14-16, 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. 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)* Contract: Exhibit B—8.5.3.5; 8.5.3.7	**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_UM Turn Around Times, Notification, and Extension Requirements* This document is a grid of regulatory timeframes that RMHP follows for notification of preauthorization decisions. The grid indicates that RMHP provides notice of standard authorization decisions within 10 calendar days. *I_UM_Preauthorization Policy & Procedure* Page 12, Section 6.31: This policy sets for the requirement that staff follows the Timeliness of UM Decisions Policy and Procedure	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and the UM Turn Around Times, Notification, and Extension Requirements protocols when making UM decisions. **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. *I_UM_Preauthorization Policy & Procedure* Page 13, Section 6.31, 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. *I_UM_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.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. 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)* Contract: Exhibit B—8.5.3.5.1-2; 8.5.3.7.1	*I_UM_Timeliness of UM Decisions Policy and Procedure* Page 4, Section 6.11, Paragraph 6.11.3.1.1: This describes that 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. 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)* Contract: Exhibit B—11.9.2.2.1	*I_UM_Pharmacy Preauth TATs and Notification Requirements* This document shows the regulatory TATs RMHP follows for notification of pharmacy decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)* Contract: Exhibit B—8.5.1.1-4	*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) *I_RX_Member denial letter_CHP_PA_template* *I_RX_Member denial letter_CHP_QL_template* *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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor 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 (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review 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 review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's right to appeal under the Child and Youth Mental Health Treatment Act (CYMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B—8.5.1.5-12	Inform CHP+ MCOs that federal rule changes in May 2016 for CHIP excluded the requirement that member information include "benefits will continue when the member files an appeal." The Department CHP+ MCO contract removed the requirement in July 2021. *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_Redacted Sample CHP+ Denial Letter* This letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) i *I_RX_Member denial letter_CHP_PA_template* *I_RX_Member denial letter_CHP_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.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

Denial sample files four through 10 included references to paying for benefits continued during an appeal or State fair hearing under the section "Understanding The Results Of Your Appeal, Quick Appeal, Or State Review." Continuation of benefits no longer applies to the CHP+ line of business.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: RMHP must update its NABD template for the CHP+ line of business to remove all references to continuation of benefits.		
16. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes their rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), and (II), and (III)* Contract: Exhibit B—8.5.1.13.1-3	*I_UM_Preauthorization Policy & Procedure* Page 16, Paragraph 6.32.4.2.3.7.1: This describes that the notice of adverse benefit determination includes a statement explaining that Members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits, may be no greater than any limitations placed on access to medical and surgical benefits. Page 16, Paragraph 6.32.4.2.3.7.2: This describes that the notice of adverse benefit determination includes a statement providing information about contacting the office of the ombudsman for BH care if the Member believes his/her rights under the MHPAEA have been violated. Page 15-16, Paragraph 6.32.4.2.3.8. This describes that the notice of adverse benefit determination includes a statement specifying that Members be entitled to a copy of the medical necessity criteria for any BH, mental health and SUD benefit (free of charge upon request to RMHP). *I_UM_Medicaid Appeal Rights* This is an example of the appeal rights attached to adverse benefit decisions.	☒ 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_CHP Appeal Rights This is an example of the appeal rights attached to adverse benefit decisions.	
17. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized CHP+-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, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of 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)* Contract: Exhibit B—8.5.3.5-7	*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. *I_UM_UM Turn Around Times, Notification, and Extension Requirements*	☒ 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: 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. *I_UM_Turn Around Times, Notification, and Extension Requirements* Page 2: This shows notification for urgent preservice determinations is made within 72 hours.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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.	
18. For reduction, suspension, or termination of a previously authorized CHP+-covered service, the Contractor gives notice at least ten (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.	*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 (Medicaid)/CHP+-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	☒ 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 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 Contractor establishes that the member has been accepted for CHP+ 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* Contract: Exhibit B—8.5.3.1-2 and 8.5.3.3.1-8	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.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)* Contract: Exhibit B—8.5.3.5.2	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* Contract: Exhibit B—11.12.6	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B—2.1.37.1-3	*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 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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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." *CHP+Member-Handbook_July 2022* Page 36, "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" 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)* Contract: Exhibit B—2.1.38	*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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	needed to evaluate or stabilize an emergency medical condition. *CHP+Member-Handbook_July2022* Page 37, "What Emergency Care Service are Covered": This defines emergency services for Members and informs Members 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)* Contract: Exhibit B—2.1.87	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. CHP+Member-Handbook_July2022 Page 37, "What Emergency Care Services are Covered": This explains poststabilization care to Members, including that these are covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor does not require prior authorization for emergency services or urgently needed services. *42 CFR 438.10(g)(2)(v)(B)* Contract: Exhibit B—11.9.4.8	*I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 6.6: This describes that preauthorization is not required in medically urgent/emergent situations. *I_UM_Program Description 2022* Page13, Bullet 4 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-HMO Group and Individual Plans, Medicare, RMHP Prime, CHP+" section, paragraph 2: This describes that Urgent and Emergent, life and limb-threatening care is available, without prior authorization, for all Members 24 hours a day, 7 days a week. *CHP+Member-Handbook_July2022* Page 35, "Emergency Care": This informs Members that they do not need an "OK" (prior authorization) from RMHP to go to the emergency room for a true emergency.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. 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)* Contract: Exhibit B—11.9.4.2	*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. *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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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. *CHP+Member-Handbook_July2022* Page 16, "Doctors that do not work with RMHP": This informs Members that the requirement for obtaining care from doctors that work with RMHP does not apply to emergency care.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. 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)* Contract: Exhibit B—11.9.4.4.1-2	*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 contains the definition of "Emergency/Life and Limb-Threatening Medical Care" including 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_PNM_2021 RMHP Provider Manual 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. *CHP+Member-Handbook_July 2022* Page 37, "What emergency care services are covered": This inform Members that emergency services are covered, explains when to use the emergency room, defines the prudent layperson standard, and provides examples of when a person should go to the emergency room.	
27. 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)* Contract: Exhibit B—11.9.4.5 and 11.9.4.15.3	*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 emergency room provider, hospital, or fiscal agent to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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.	
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B—11.9.4.6	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.	☒ 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. *CHP+Member-Handbook_July2022* Page 37, "What emergency care services are covered": This informs Members that emergency care necessary to screen and stabilize is covered.	
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B—11.9.4.9	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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. *CHP+Member-Handbook_July2022* Page 37, Paragraph 2, "What emergency care services are covered": This informs Members that post-stabilization services are covered and explains that these are services that the provider seeing the Member in the emergency room determines are needed before discharge or transfer.	
30. The Contractor is financially responsible for poststabilization care services that are prior authorized by an in-network provider or the 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)* Contract: Exhibit B—11.9.4.10	*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 poststabilization services obtained within or outside	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	of the network that have been pre-approved by RMHP or its representative.	
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 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)* Contract: Exhibit B—11.9.4.11	*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-Policy, Paragraph 2: This describes that RMHP is financially responsible for poststabilization services obtained within or outside of the network that have not been pre-approved by RMHP or its representative.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that 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)* Contract: Exhibit B—11.9.4.11.1-3	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 poststabilization 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • 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)* Contract: Exhibit B—11.9.4.13.1-4	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 poststabilization services it has not pre-approved ends when any one 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
34. 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 the member had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)(iv)* Contract: Exhibit B—11.9.4.12	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.	☒ 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_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.	
	CHP+Member-Handbook_July2022 Page 37, Paragraph 2, "What emergency care services are covered": This informs Members that their costs for poststabilization care provided by out-of-network providers will be no more than what the member would pay if services were received from in-network providers	

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	33	X	1.00	=	33
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	34	**Total Score**		=	33
				Total Score ÷ Total Applicable		=	97%

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers 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: primary care (adult and pediatric), OB/GYN providers, specialists, hospitals, pharmacies, and behavioral health (mental and substance use disorder, adult and pediatric). *42 CFR 438.206(b)(1)* Contract: Exhibit B—9.1.1; 9.3.1; 9.5.1.1	*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_PNM_2022 CHP+ Provider Directory*: Indicates 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_R1_RM_CHP+_NetworkPlan_SFY21-22* *II_CI_RMHP CHP+_NetworkPlan_SFY22-23* Page 2 on both documents: This describes that RMHP strives to contract with all available acute care hospitals, Primary Care Medical Providers (PCMPs), behavioral health providers, specialists and sub-specialists who meet RMHP's credentialing and quality standards. In addition, RMHP's philosophy is to contract with all available PCMPs, pharmacies, Essential Community Providers (ECPs), behavioral health	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	providers and hospitals that meet RMHP's credentialing and quality standards.	
2. The Contractor ensures that its primary care and specialty care provider network complies with time and distance standards as follows: • 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 • Pediatric specialty care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 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 • Physical therapy/occupational therapy/speech therapy: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—100 miles or 100 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes	*PNM_2021 RMHP Provider Manual* Page 25-26 "CHP+ Network Geographic and Time Standards:" This informs providers of the CHP+ time and distance standards for the network *II_PNM_Practitioner 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* Page 11 This shows the distance/drive time analysis per requirements for CHP+ regarding Primary Care (Family Practice) and Pediatrics. Page 16-17 This shows the distance/drive time analysis per requirements for CHP+ regarding OB/GYN and PT. Page 12-23 This shows the distance/drive time analysis per requirements for CHP+ regarding specialty care providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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 *42 CFR 438.206(a)* Contract: Exhibit B—9.3.10	*II_CI_RMHP CHP+_NetworkPlan_SFY22-23* Pages 12-28: This demonstrates RMHP meets the time/distance standards in regard to the identified providers in the CHP+ network. *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_CHP* 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, OB/GYN Providers, Adult and Pediatric Specialists, Pharmacies and Acute care hospitals. *II_CI_CHP_Access Report - Jan 2023* Page 5: This demonstrates RMHP meets the time/distance standards in regard to PT/OT/ST providers in the CHP+ network since these categories are not defined in the quarterly GeoAccess reports.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for 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 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 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 B—9.3.11.2)* *42 CFR 438.206(a)* Contract: Exhibit B-1—10.2.1.12, 10.2.1.13.1	*PNM_2021 RMHP Provider Manual* Page 25-26 "CHP+ Network Geographic and Time Standards:" This informs providers of the CHP+ Member/Provider ratios as well as time and distance standards. *II_PNM_Practitioner 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 25-26 This shows the distance/drive time analysis per requirements for CHP+ regarding BH Practitioners, Marriage and Family Therapy, Psychology, and Psychiatry. *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_CHP* 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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prescriber Providers, and Substance Use Disorder Providers, and hospitals.	
4. 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)* Contract: Exhibit B—9.3.13	*PNM_2021 RMHP Provider Manual* Page 78, second paragraph under "CHP+": 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. *CHP+Member-Handbook_July2022* Page 16, Paragraph 3: This informs Members that they may directly access women's healthcare specialists within the network. Page 19, "Member Rights", 10th bullet:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This informs Members that they have the right to receive family planning services from any provider without referral.	
5. 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)* Contract: Exhibit B—9.3.22	*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. *II_CM_Second Opinions_Out of Network Services* Page 2, section 6.1 "Second Opinions", 2nd paragraph: This explains that RMHP provides for a second opinion from an in-network provider or arranges for the Member to obtain a second opinion outside the network at no cost to the Member. *CHP+Member-Handbook_July2022* Page 19, "Member Rights", Bullet 12: This informs Members that they have the right to get a second opinion with no referral.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must cover the services (timely and without compromising the member's quality of care or health) out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B—9.3.23.1	*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": This explains that if the RMHP network is unable to provide necessary covered services, RMHP will	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. *CHP+ Member Handbook July 2022* Page 27, Section "Services from out-of-network providers" Non-emergency services from out-of-network providers (one who is not contracted to provide services for RMHP CHP+ Members) are not covered unless they are authorized by RMHP. If services from an out-of-network provider are authorized, the copayments for these authorized services are the same as copayments for covered services received from an in-network provider.	
7. 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)* Contract: Exhibit B—9.3.23.2	*PNM_2021 RMHP Provider Manual* Page 78, Out-of-Network/ Out -of-Plan Services: This informs providers that Members may obtain covered services from out-of-network/out-of-plan providers at the in-network benefit level in certain circumstances such as for continuity of care. *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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CHP+ Member Handbook July 2022 Page 27, Section "Services from out-of-network providers" Non-emergency services from out-of-network providers (one who is not contracted to provide services for RMHP CHP+ Members) are not covered unless they are authorized by RMHP. If services from an out-of-network provider are authorized, the copayments for these authorized services are the same as copayments for covered services received from an in-network provider.	
8. 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: – 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 calendar days after member request. • Non-urgent medical or non-symptomatic well care within one month after member request (unless required sooner to ensure the American Academy of Pediatrics Bright Futures Schedule).	*PNM_2021 RMHP Provider Manual* Page 27-28: "CHP+ Network Appointment Availability Standards": The Contractor ensures that services are available as follows: • Emergency BH care: –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 calendar days after member request. • Non-urgent medical or non-symptomatic well care within one month after member request (unless required sooner to ensure the American Academy of Pediatrics Bright Futures Schedule).	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Outpatient follow-up appointments within seven days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B—9.3.17	• Outpatient follow-up appointments within seven days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *II_CI_RMHP CHP+_NetworkPlan_SFY22-23* Pages 5-6 This describes Emergency BH care, urgent care and non-urgent care standards information. Page 6, BH Appointment Availability Grid: This describes that Members may not be placed on waiting lists for initial routine services.	
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 visits, and should include the exceptions related to when well-care visits should be scheduled prior to one month.		
9. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or that are comparable to other CHP+ providers. 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 staff.	**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 21, "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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B—7.3.4.2; 9.3.5-9.3.6.1	through Friday, and for extended hour on evening and weekends. *II_PNM_2022 Physicians Medical Services Agreement* Page 6, Section A: Medical Services to Covered Persons: This states that providers must arrange for the provision of medical services to covered persons at such time and in such location as required by any health care plan which is offered by RMHP to covered persons in the service area. (Due to the numerous lines of business we offer, we write the agreements in general terms to meet all contractual obligations.) Page 16, Section, EE: Non- Discrimination - Publicly Financed Programs: This 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	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 tools ask providers to report whether they offer extended hours on evenings and/or weekends. Note: There are 3 versions of this tool: PCMP, BH Provider, and Specialist. These providers are also in the CHP+ Network. *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.	
10. 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)* Contract: Exhibit B—9.3.8; 9.3.9; 9.3.17.1; 11.9.4.7	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. 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, including research to determine solutions for any causal systemic issues. • Taking corrective action and notifying the Department if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B—9.3.17-9.3.19	*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* Pages 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 and high-impact). *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 RMHP's targets (goals), for Member/provider ratios, time and distance drive time standards as well as appointment wait time standards.	☒ 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_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. Document is general to PCMP's which includes CHP+, PRIME and RAE Providers. *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 details how the Value Based Contracting Review Committee (VBCRC) evaluates practices in 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.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CQI_CHP+ PCMP Tiering Analysis (not an evidence document): This analysis demonstrates that 34/48 (70.8%) of CHP+ (Tier 1 & Tier 2) PCMPs are evaluated within the VBCRC process for the Value Based Payment Tiering Program. These Tier 1 & 2 practices must meet all the criteria required, which includes access standards, in order to participate in value-based payment programming.	
12. 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. This includes: • Developing and/or providing cultural 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 during orientation or while being served by providers. *42 CFR 438.206(c)(2)* Contract: Exhibit B—2.1.27; 7.2	**Bullet 1:** *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 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, "Cultural Competency Training" Section:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 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_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 6-8, Section 4.3.6: This describes translation, interpreter, and auxiliary services that RMHP has available to communicate with members. 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	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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_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. 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 Members and the actions RMHP takes to meet those needs. Bullet #1	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 10: Describes that Care Management staff participated in Bridges out of Poverty and 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 #2 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. Page 10: Describes work to improve access to healthcare and other important services for the deaf and hard of hearing. II_QI_RMHP P&P Collection of REL & SOGI Data_draft Bullet #3-5 This 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.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 providers can access for further training.	
13. The Contractor must ensure that network providers have the ability to provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B—9.1.6.7	*II_PNM_PNM.CR.10.21- 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. *II_PNM_RMHP Behavioral Health Provider Demographic Tool* *II_PNM_RMHP PRIME_CHP+ Specialist Demographic Tool*	☒ 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_RMHP PCMP_Demographic Tool The PCMP Demographic Tool is the form that RMHP sends on a quarterly basis to primary care 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 tool asks providers to report their ability to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical disabilities**. Note: There are 3 versions of this tool: PCMP, Specialist, and Behavioral Health Provider. Many of these providers are in the CHP+ network. *II_PNM_Provider Directory CHP+ Screenshot Examples* These screenshots from the RMHP online provider directory demonstrate that RMHP informs Members about accommodations for people with physical disabilities at provider offices.	

Standard II—Adequate Capacity and Availability of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. 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 adequate 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 Report* is submitted to the State quarterly. • A *Network Changes and Deficiencies Report* is submitted to the State within five days after the Contractor's knowledge of an unexpected or anticipated material change to the network or a network deficiency that could affect service delivery, availability, or capacity within the network. *42 CFR 438.207(b)* Contract: Exhibit B—9.4-9.5	*II_CI_RMHP CHP+_NetworkPlan_SFY22-23* This annual report provides an overview of RMHP's RAE and PRIME Provider Network Management Strategic Plan. It is submitted annually to the Department. *II_CI_FY 2023 Q1_QtrlyRpt_GeoaccessComp_RMHP_CHP(MS Excel)* *II-CI_RMHP_CHP_NetworkRpt_Q1FY22-23 (MS Word)* This quarterly report is 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard II—Adequate Capacity and Availability of Services							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	13
				Total Score ÷ Total Applicable		=	93%

Standard VI—Grievance 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, or providers acting on their behalf, or designated member representatives. A grievance and appeal 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)* CHP+ Contract: Exhibit B—8.1 10 CCR 2505-10 8.209.1	*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_CHP - Uphold Denial Med Review* *VI_CS_CHP - 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance 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). *Note: A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR §447.45(b) is not an adverse benefit determination.* *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.1 10 CCR 2505-10 8.209.2.A	*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. *CHP+Member-Handbook_July2022* Page 90, 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. *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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—2.1.3 10 CCR 2505-10 8.209.2.B	*VI_CS_Appeals Policy and Procedure* Page 14, Section 2.6 This defines "appeal" as a review by RMHP of an adverse benefit determination.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines "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)* CHP+ Contract: Exhibit B—2.1.50 10 CCR 2505-10 8.209.2.D, 8.209.4.A.3.c.i	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has provisions for who may file: • A member may file a grievance, 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, 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.* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B—8.5.1.7; 8.6.5	*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:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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.	
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, providing interpreter services and toll-free numbers that have adequate TeleTYpe/Telecommunications Device for the Deaf (TTY/TTD) and interpreter capability. *42 CFR 438.406(a)* CHP+ Contract: Exhibit B—8.2 10 CCR 2505-10 8.209.4.C	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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.	
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)* CHP+ Contract: Exhibit B—8.4.4; 8.6.3 10 CCR 2505-10 8.209.5.C, 8.209.4.E	*VI_CS_Appeals Policy and Procedure* Page 5, Section 1.4, Subsections 1.4.3 and paragragh 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:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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.	
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 their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B—8.5.2 10 CCR 2505-10 8.209.5.C, 8.209.4.E	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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B—8.4.3 10 CCR 2505-10 8.209.5.D	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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B—8.4.3 10 CCR 2505-10 8.209.5.A	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.4.5 10 CCR 2505-10 8.209.5.B	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the enrollee'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)* Contract: Exhibit B—8.4.6; 8.4.8 10 CCR 2505-10 8.209.5.D	*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 Point** 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VI_CS_CHP - 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. *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.	
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)* CHP+ Contract: Exhibit B1—8.4.6. 10 CCR 2505-10 8.209.5.G	*VI_CS_CHP - Grievance and Explanation Resolution* This template includes the disposition /resolution process and the date it was completed. *VI_CS_MD - Grievance and Explanation Resolution* This template includes the disposition /resolution process and the date it was completed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	*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_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 if RMHP fails to adhere to the required timeframes for processing appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* CHP+ Contract: Exhibit B—8.6.5.1 10 CCR 2505 10 8.209.4.B	*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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance 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)* CHP+ Contract: Exhibit B—8.6.5.2 10 CCR 2505 10 8.209.4.F	*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.	☐ 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, in the *CHP+ Member Handbook*, on page 90 under the Standard Review section, it stated that if the member calls with an appeal request, RMHP will send a letter that must be signed by the member and returned in order to confirm that RMHP understands the verbal request. Additionally, RMHP's *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 update the *CHP+ Member Handbook* and *UM Program Description* to remove any references that require a member to submit appeal information in writing.		
17. The Contractor sends written acknowledgement of each appeal within two working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—8.6.2.1 10 CCR 2505-10 8.209. 4.D	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)* CHP+ Contract: Exhibit B—8.6.11 10 CCR 2505-10 8.209.4.I	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* CHP+ Contract: Exhibit B—8.6.8-8.6.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	*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 *CHP+Member-Handbook_July2022* Page 90, "Standard Review," paragraph 2, 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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: • 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)* CHP+ Contract: Exhibit B—8.6.12; 8.6.13.2 10 CCR 2505-10 8.209.4.Q-R	*VI_CS_Appeals Policy and Procedure* Pages 7-8, Section 1.5: This describes the expedited review process. **Bullet** Page 8, Section 1.5, Subsection 1.5.2, Subsubsection 1.5.2.3: 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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	action against a provider for assisting a Member in seeking reconsideration of a coverage decision.	
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)* CHP+ Contract: Exhibit B—8.6.13.2.2 10 CCR 2505-10 8.209.4.S	**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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance 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* CHP+ Contract: Exhibit B—8.6.13.1 10 CCR 2505-10 8.209.4.J.1	**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.CHP - Overturn Denial Med Review* *VI_CS_MD.CHP - Overturn Denial No Med Review* *VI_CS_CHP - Uphold Denial Med Review* *VI_CS_CHP - Uphold 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.	☒ 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)*	*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* Page 7, Section 1.5, Subsection 1.5.2: This describes that RMHP will make reasonable	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—8.6.13.2.3; 8.6.13.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	efforts to provide oral notice to the Member of the expedited resolution.	
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)* CHP+ Contract: Exhibit B—8.4.7; 8.6.13.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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 (2) 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)* CHP+ Contract: Exhibit B—8.4.7.1; 8.6.13.2.5 10 CCR 2505-10 8.209.4.L, 8.209.4.K, 8.209.4.A. 3.C(ii), 8.209.5.E	*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*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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.	
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. *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—8.6.13.3 10 CCR 2505-10 8.209.4.M	In May 2016, the federal rule changes for CHIP excluded from the requirement that member information must include "benefits will continue when the member files an appeal." However, the Department removed the statement from the CHP+ MCO contract requirement in July 2021. *VI_CS_Appeals Policy and Procedure* Page 6, Section 1.4, Subsection 1.4.4 - 1.4.4.4 & 1.4.8.: This describes the information that must be included in the notice of appeal resolution. *VI_CS_CHP - Uphold Denial Med Review* *VI_CS_CHP - Uphold Denial No Med Review* These templates illustrates that the notices of appeal resolution contains the required language.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although the *Appeals Policy and Procedure* accurately mentioned the written notice of appeal resolution and what the appeal resolution letter includes (i.e., the results, date of completion, rights of the member to request a State fair hearing, and how to do so), the policy did not specify that the right to request benefits/services continue while the State fair hearing is pending and how to make the request does not apply to CHP+ members.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
In addition, RMHP had one sample appeal resolution letter that contained information regarding how a member could request continuation of benefits. The remainder of sample appeal resolution letters for the review period did not include continuation of benefits; therefore, RMHP has rectified this issue internally and no required action is needed regarding NABD updates.		
Required Actions: RMHP must update its *Appeals Policy and Procedure* on pages 7, 10, and 11 to specify that continuation of benefits is not applicable to CHP+ members.		
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)* CHP+ Contract: Exhibit B—8.6.14.1 10 CCR 2505-10 8.209.4.N and O	*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. *CHP+Member-Handbook_July2022* Page 91, paragraph 2: This informs Members they may request a State Review 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.	☒ 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)* CHP+ Contract: Exhibit B—8.6.14.3	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VI_CS_Process Designation of Representatives Page 1, Section 3, Paragraph 2: This explains that a representative of a deceased Member's estate is considered a party to a State Fair Hearing/State Review.	
29. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424* CHP+ Contract: Exhibit B—8.6.13.4 10 CCR 2505-10 8.209.4.W	*VI_CS_Appeals Policy and Procedure* Page 12, Subsection 1.8, Subsection 1.8.7, Subsubsection 1.8.7.3: This describes RMHP's responsibility for effectuating the State hearing decision if it reverses RMHP's decision to deny, limit or delay services that were not furnished while the appeal was pending.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
30. 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.		☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor must review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department's quality strategy. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* CHP+ Contract: Exhibit B—8.1; 8.7 10 CCR 2505-10 8.209.3.C	**Bullet #1:** *VI_CS_Appeals Policy and Procedure* Page 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. *VI_CI_RMHP_CHP+_GrieveAppealRpt_Q1-FY 22-23* 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.	
31. 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.	*VI_PNM_2022 Physicians Medical Services Base 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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• 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. *42 CFR 438.414* CHP+ Contract Exhibit B—8.3 10 CCR 2505-10 8.209.3.B	which can be accessed online or requested in written form. *VI_PNM_2022 Physicians Medical Services Base Agreement* Page 13, 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 Physicians Medical 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. *VI_PNM_2022 Professional Services Agreement* 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	

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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 CHP.	

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	29	X	1.00	=	29
	Partially Met	=	2	X	.00	=	2
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	29
				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 apply without restriction (unless authorized by CMS) up to the limits set under that contract. • The Contractor may not apply limits to newborns. • In the event that the Contractor reaches the enrollment limits, the Contractor shall notify the Department. *42 CFR 438.3(d)(1)* Contract: Exhibit B—6.3.3; 6.3.7	*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. This document is used for all 834 processing, to include CHP+. Note: RMHP monitors enrollment trends on a monthly basis and reports any irregularities to the HCPF systems team. *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 and that RMHP does not apply limits to newborns' enrollment. *XII_ProRec_Medicaid and CHP Enrollment Reporting* This P&P describes the analysis that RMHP performs monthly to identify any enrollment trends.	☒ 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, sex, sexual orientation, gender identity, or disability.	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.3(d)(3-4) Contract: Exhibit B—6.3.3.1	*CHP+Member-Handbook_July2022* -Member Rights & Responsibilities, pg. 19 -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. *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.	

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 of the member's: • Utilization of medical services • Diminished mental capacity or adverse changes in the member's health status. • Behavior (e.g., uncooperative or disruptive) resulting from the member's special needs (except when the member's continued enrollment seriously impairs the Contractor's ability to furnish services to the member or to other members). • Failure to pay a copayment if that member is a child. *42 CFR 438.56(b)(2)* Contract: Exhibit B—6.5.2.2	*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, behavior, or failure to pay copayment if Member is a child. *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_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).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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	*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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contractor's ability to furnish services to the member or to other members. • For cause, at any time under the following circumstances: – 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 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 *42 CFR 438.56(b)(1)* Contract: Exhibit B—6.5.5.1	*CHP+Member-Handbook_July2022* Page 30, Section "Termination Policy" This describes that a Member's CHP+ plan may terminate due to one of the identified reasons. *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. *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.	

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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)* Contract: Exhibit B—6.5.2.1.9.3.1	*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_CHP Member Change of Circumstance Reporting_MM-YY* *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.	☒ 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 network, and the member's primary care provider (or another provider) determines that	*CHP+Member-Handbook_July2022* Page 2, 1st paragraph: This describes that a Member may request disenrollment from the plan at any time for any reason, as well as how to request disenrollment. *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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XII—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 • 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(c)-(d)(2)* Contract: Exhibit B—6.5.5		

Results for Standard XII—Enrollment and Disenrollment							
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 CHP+

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]	1/21/2022	3/21/2022	7/18/2022	9/7/2022	10/18/2022	10/12/2022	10/24/2022	10/31/2022	12/13/2022	12/23/2022					
Type of Denial: Termination (T), New Request (NR), Claim (CL)	CL	CL	CL	NR	NR	NR	NR	NR	NR	NR					
Type of Request: Standard (S), Expedited (E), Retrospective (R), SUD Inpatient/Residential (SUD), or SUD Inpatient/Residential Special Connections (SUD SC)	R	R	R	E	E	S	E	S	S	S					
Date of Decision for Adverse Benefit Determination [XX/XX/XXXX]	1/29/2022	4/9/2022	7/23/2022	9/9/2022	10/18/2022	10/19/2022	10/25/2022	11/10/2022	12/16/2022	12/28/2022					
Date Notice of Adverse Benefit Determination (NABD) Sent [XX/XX/XXXX]	2/3/2022	4/13/2022	7/27/2022	9/9/2022	10/18/2022	10/19/2022	10/25/2022	11/10/2022	12/16/2022	12/28/2022					
Notice Sent to Provider and Member? [I.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met					
Number of Hours or Days for Decision (H/D)	8 D	19 D	5 D	2 D	0 D	7 D	1 D	10 D	3 D	5 D					
Number of Hours or Days for Notice (H/D)	13 D	23 D	9 D	2 D	0 D	7 D	1 D	10 D	3 D	5 D					
Adverse Benefit Determination Decision Made Within Required Time Frame? [I.11] 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	Met	Met	Met	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	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met					
Authorization Decision Made by Qualified Clinician? [I.9]	NA	NA	NA	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.8]	NA	NA	NA	Met	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	6	6	6	8	7	7	7	7	7	7					
Compliant (Met) Elements	6	6	6	7	6	6	6	6	6	6					
Percent Compliant	100%	100%	100%	88%	86%	86%	86%	86%	86%	86%					
Overall Total Applicable Elements	**68**														
Overall Total Compliant Elements	**61**														
Overall Total Percent Compliant	**90%**														

Comments:
Files 1–3 involved retrospective claims denials that were found to be met on a 30-day review timeline.
Files 4–10 included references to paying for benefits that were continued during an appeal or State fair hearing under the section "Understanding The Results Of Your Appeal, Quick Appeal, Or State Review." Continuation of benefits no longer applies to CHP+.

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 CHP+

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]	1/14/2022	3/25/2022	4/14/2022	5/9/2022	6/27/2022	6/29/2022	7/29/2022	8/31/2022	11/22/2022	12/8/2022					
Date of Acknowledgement Letter [XX/XX/XXXX]	1/18/2022	3/28/2022	4/15/2022	5/10/2022	6/28/2022	6/30/2022	8/1/2022	9/2/2022	11/23/2022	12/12/2022					
Days From Grievance Received to Acknowledgement	2	1	1	1	1	1	1	2	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]	2/2/2022	4/15/2022	4/15/2022	5/10/2022	7/18/2022	6/30/2022	8/1/2022	9/21/2022	11/23/2022	12/23/2022					
# of Days to Notice	12	14	1	1	14	1	1	14	1	11					
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 B. Colorado Department of Health Care Policy & Financing
FY 2022–2023 External Quality Review
Appeals Record Review
for Rocky Mountain Health Plans CHP+

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]	2/24/2022	3/8/2022	7/26/2022	8/30/2022	9/19/2022	10/24/2022	10/27/2022	11/1/2022	11/16/2022	12/16/2022					
Date of Acknowledgement [XX/XX/XXXX]	2/28/2022	3/9/2022	7/27/2022	9/1/2022	9/21/2022	10/26/2022	10/28/2022	11/2/2022	11/7/2022	12/20/2022					
Days From Appeal Received to Acknowledgement	2	1	1	2	2	2	1	1	-8	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	Met	NA	NA	Met	Met	Met	NA	Met	NA					
Expedited Appeal: Yes or No	No	No	No	No	No	No	No	No	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]	3/8/2022	3/9/2022	8/9/2022	9/14/2022	9/29/2022	11/3/2022	11/3/2022	11/3/2022	11/30/2022	12/20/2022					
Hours or Days From Appeal Filed to Resolution Notice Sent	8 D	1 D	10 D	10 D	8 D	8 D	5 D	2 D	9 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]**	Not Met	Met	Met	Met	Met	Met	Met	Met	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	6	5	5	6	6	6	5	6	5					
Compliant (Met) Elements	4	6	5	5	6	6	6	5	6	5					
Percent Compliant	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%					
Overall Total Applicable Elements	**55**														
Overall Total Compliant Elements	**54**														
Overall Total Percent Compliant	**98%**														

Comments:
File 1 included a reference to continuation of benefits in the resolution letter to the member. Continuation of benefits is no longer applicable for CHP+.

*__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 CHP+

Standard I—Coverage and Authorization of Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
15. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor 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 (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review 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 review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's right to appeal under the Child and Youth Mental Health Treatment Act (CYMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B—8.5.1.5-12
Findings
Denial sample files four through 10 included references to paying for benefits continued during an appeal or State fair hearing under the section "Understanding The Results Of Your Appeal, Quick Appeal, Or State Review." Continuation of benefits no longer applies to the CHP+ line of business.
Required Actions
RMHP must update its NABD template for the CHP+ line of business to remove all references to continuation of benefits.

Standard I—Coverage and Authorization of Services
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
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
8. 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: – 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 calendar days after member request. • Non-urgent medical or non-symptomatic well care within one month after member request (unless required sooner to ensure the American Academy of Pediatrics Bright Futures Schedule). • Outpatient follow-up appointments within seven days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B—9.3.17
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 visits, 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
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
☐ 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)* CHP+ Contract: Exhibit B—8.6.5.2 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, in the *CHP+ Member Handbook*, on page 90 under the Standard Review section, it stated that if the member calls with an appeal request, RMHP will send a letter that must be signed by the member and returned in order to confirm that RMHP understands the verbal request. Additionally, RMHP's *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 update the *CHP+ Member Handbook* and *UM Program Description* to remove any references that require a member to submit appeal information in writing.
Planned Interventions:
Person(s)/Committee(s) Responsible:
Training Required:

Standard VI—Grievance and Appeal Systems
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
☐ 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. *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—8.6.13.3 10 CCR 2505-10 8.209.4.M
Findings
Although the *Appeals Policy and Procedure* accurately mentioned the written notice of appeal resolution and what the appeal resolution letter includes (i.e., the results, date of completion, rights of the member to request a State fair hearing, and how to do so), the policy did not specify that the right to request benefits/services continue while the State fair hearing is pending and how to make the request does not apply to CHP+ members. In addition, RMHP had one sample appeal resolution letter that contained information regarding how a member could request continuation of benefits. The remainder of sample appeal resolution letters for the review period did not include continuation of benefits; therefore, RMHP has rectified this issue internally and no required action is needed regarding NABD updates.
Required Actions
RMHP must update its *Appeals Policy and Procedure* on pages 7, 10, and 11 to specify that continuation of benefits is not applicable to CHP+ members.
Planned Interventions:
Person(s)/Committee(s) Responsible:

Standard VI—Grievance and Appeal Systems
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.