COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2020–2021 Site Review Report

for

Rocky Mountain Health Plans

Region 1

June 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

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

This report documents results of the fiscal year (FY) 2020–2021 site review activities for **Rocky Mountain Health Plans** (**RMHP**) **RAE**. For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process that the health plan will be required to complete for FY 2020–2021 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix F includes the compliance monitoring report for **RMHP Prime**.

Summary of Compliance Results

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

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
VII. Provider Participation and Program Integrity	16	16	15	1	0	NA	94%
VIII. Credentialing and Recredentialing	32	32	32	0	0	NA	100%
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	NA	75%
IX. Quality Assessment and Performance Improvement	17	17	17	0	0	NA	100%
Totals	**69**	**69**	**67**	**2**	**0**	**NA**	**97%**

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

Table 1-2 presents the scores for **RMHP RAE** and **RMHP Prime** combined for the credentialing and recredentialing 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)
Credentialing	100	88	88	0	12	100%
Recredentialing	90	78	78	0	12	100%
Totals	**190**	**166**	**166**	**0**	**24**	**100%**

*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 VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

RMHP described a provider network that supported payment models across multiple lines of business. Staff members noted the approach was not "off the shelf" but instead identified service gaps and rewarded high performance providers through a variety of reimbursement strategies and ultimately responded to the unique needs of its members to create choices within **RMHP**'s Medicaid system. Staff members also cited an "any willing provider" and grassroots approach to outreach, which included attending a variety of local community meetings and events to spread the word about **RMHP** and reduce the stigma about Medicaid through "myth busting" informational sessions that outlined the contracting process. However, with a well-established network across a geographically diverse landscape, ongoing outreach needs were fairly minimal. In-person efforts were further reduced by the coronavirus disease 2019 (COVID-19) changes throughout calendar year (CY) 2020. Toward the end of CY 2020, substance use disorder (SUD) providers were the focus of provider contract efforts, specifically for residential, intensive outpatient, step-down, and telehealth services to support the SUD expansion benefit. Staff members also noted efforts to support Grand County, which was heavily impacted due to fires. Single case agreements were reportedly used when necessary.

RMHP reported notable attendance of roughly 30 to 40 participants in the Program Improvement Advisory Committee (PIAC), which had been virtual prior to COVID-19 restrictions in order to encourage attendance over such a geographically diverse area. The PIAC forum was noted as the single broadest source of communication. Key leadership also had multiple ways to connect and share information with independent providers, and non-provider county and local leadership (i.e., human services, public health, and crisis services) attending an Executive Partnership Board, which met quarterly. Internally, the Network Advisory Committee included participants from network management, quality improvement (QI), and other departments to review network adequacy and provider-related reports to monitor overall performance.

The software system Facets contained provider configuration information and the Maces software system managed workflow details and captured credentialing information. While credentialing, provider contracting, provider relations, and provider administration were all rolled up through the provider network management department, **RMHP** also operated an independent internal audit department for added oversight and monitoring.

RMHP did not have any moral or religious objections to covered services. Providers with any objections, or members experiencing a provider who would not provide specific services, were directed to contact **RMHP**.

The compliance policies, procedures, and supporting documents submitted demonstrated a robust program integrity system, which was aligned with federal and State regulations. The UnitedHealthcare (UHC) compliance committee included the chief financial officer, chief medical officer (CMO), chief operating officer, clinical services management, and other executives. Participants of this committee

reviewed risk assessments and assigned priorities based on compliance and/or business risks. Additionally, a compliance scorecard was generated by UHC. Staff members reported there were minor billing errors noted as trends in CY 2020. Other trends were identified through the utilization management (UM) department. Additionally, the *Member Verification of Services* procedure included claims reports, confidence interval methodology, and sampled both adults and children.

Summary of Findings Resulting in Opportunities for Improvement

The compliance program documents described a robust approach to the establishment of policies and procedures to comply with federal, State, and contract requirements, including the appointment of a compliance officer, compliance committee, and oversight by the chief executive officer and board of directors. Training and education were clearly detailed for staff members and additional specialized trainings were produced for management and supported by an online platform, LearnSource. However, **RMHP** did not supply additional evidence of training and education specific to the compliance officer or compliance leadership. HSAG recommends further detailing credentialing leadership expectations (i.e., credentials, continuing education, etc.) within compliance program documents.

Summary of Required Actions

The *Professional Services Agreement*, *Physicians Medical Services Agreement*, and *BH Provider Manual* all provided accurate information regarding member liability for covered services. However, in the provider manual, the information regarding member liability was included under a heading titled "Cost Sharing" with the subheading "RMHP Prime Members" that was not entirely accurate for RAE members. The paragraph included a citation (Colorado Revised Statutes [CRS] 25.5-4-301[1]), which was not entirely accurate in regard to all physical health (PH) services as there are some instances in which members are required to pay a copay and/or prescription costs. **RMHP** must update the member liability language in the provider manual to accurately address the various lines of business that may have variations in copay and liabilities. HSAG recommends using 42 CFR 438.106 language as a basis, with additional consideration to the individual contract language.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

RMHP compiled a thorough submission that included sample templates, reports, delegate agreements, and CAPs. The *Credentialing Criteria and Process* document and other credentialing documents followed National Committee for Quality Assurance (NCQA) criteria and included verification of license, certification, hospital clinical privileges, drug enforcement agency or controlled dangerous substance certifications (where applicable, training/board certification), professional liability insurance, malpractice, work history, sanction status, and ability to perform job functions. Procedures were clearly outlined in terms of file management, file review, and notification to the providers.

Staff members highlighted timely turnaround procedures to fast-track providers where gaps in the network may exist, specifically PCPs. Timeliness efforts were further improved through increased focus around communicating with providers throughout the application process, which ensured any small details a provider may have inaccurately entered were easily resolved. Provider rights were clearly stated on the application document as well as the **RMHP** website.

RMHP described a three-tiered category system for review, which included clean files in category one, files with minor issues in category two, and files with significant issues in category three. The CMO or associate CMOs would review the full file if any category two or three issues were identified. The Medical Practice Review Committee also participated in reviewing files and was attended by a variety of specialists. Staff members reported it was common for reviewers to seek additional information prior to making a final decision. Practitioners were notified in a reasonable time frame regarding approval or denial, including details regarding appeal rights if denied.

Based on a review of initial and recredentialing files for individual providers, **RMHP** met 100 percent compliance with all required elements. Additional record review for organizational providers showed that, while **RMHP** did not always adhere to the internal goal of reviewing every two years, files were reviewed within the NCQA three-year standard, with one exception due to a COVID-19 delay, which prevented a timely site visit.

Summary of Findings Resulting in Opportunities for Improvement

While NCQA does not state specific criteria regarding credentialing file management in terms of years, HSAG noted that **RMHP**'s files were kept for seven years. HSAG recommends that **RMHP** align file storage guidelines to be aligned with the 10-year standard (i.e., contract citations 17.10.8.2 and 17.10.9.2).

Summary of Required Actions

HSAG did not identify any opportunities for improvement that resulted in required actions.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

RMHP maintained a set of policies that described the mechanisms in place for delegation and oversight of delegated activities. **RMHP** completed predelegation assessments for potential delegate organizations and presented the results to the **RMHP** Medical Advisory Committee. **RMHP** provided a comprehensive set of documents that reflected ongoing reporting and oversight activities, which included annual credentialing delegation audit reports. Oversight was provided by the department associated with delegated function, and delegation activities were described in a delegation policy for

each functional area. Most delegated activities were related to credentialing and recredentialing; other delegated functions included pharmacy benefit management, behavioral health services, and UM.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

While many of the **RMHP** subcontracts included language to grant the United States Department of Health and Human Services Office of Inspector General (HHS-OIG), Comptroller General, or other designees the right to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years, some of the delegated credentialing agreements failed to include this information and the other specific language used in the federal rule. **RMHP** must update the delegated credentialing agreements that do not include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

RMHP's QI program included an in-depth work plan that contained a list of goals, specific objectives, and a comprehensive mechanism for assessment. The *CY 2019 Annual Evaluation/Quality Assessment* document was very thorough, with a summary of each topic with associated data analysis, and reflected successes, ongoing opportunities, and identified barriers. Information was presented in various formats that ranged from high-level summaries to tables, graphs, and detailed procedural steps. The *CY 2019 Annual Evaluation/Quality Assessment* contained a graphic of the QI program structure and operation activities that reflected the various councils and committees that functioned within the QI Committee framework. These included the Population Health Management Committee and member, network provider, medical, data, and operations councils.

RMHP also produced an *RMHP Annual Evaluation Quality* report, which contained an informative executive summary and overview of key topics. The QI work plan included barrier analysis and goal setting, which was followed by targeted intervention, and the QI work plan outlined the frequency of monitoring and review of data, performance, and successes.

One of **RMHP**'s priority initiatives over the past year was the meaningful engagement of RAE stakeholders for **RMHP**'s advisory councils. Dashboards summarizing performance on key metrics were well-received by stakeholders over the past year and have been a focal point in community and stakeholder meetings.

In CY 2020, **RMHP** reported 45 quality of care concerns (QOCs) were tracked. While the term "QOC Grievance" was mentioned in procedures, grievances and QOCs were in fact separated and QOCs were addressed through the quality team with a higher degree of clinical oversight, while grievances not involving possible clinical issues were pursued by the member services team.

Member perception of accessibility and adequacy of services were surveyed through traditional means, and **RMHP** implemented an additional randomized survey through which members were outreached telephonically and asked a net promoter score question.

RMHP adopted clinical practice guidelines (CPGs) based on nationally recognized standards that included the American Academy of Obstetrics, Gynecology or Pediatrics, and other guidelines as approved by the CMO, associate directors, and Medical Advisory Committee. The Member Experience Advisory Council (MEAC) also reviewed the CPGs. The CPGs informed UM practices, care management, and member education materials. Members were informed about CPGs through the member handbook, targeted member educational materials aligned with CPGs, and also through newsletters until discontinued due to COVID-19.

RMHP monitored both over- and underutilization, with a specific focus on care gaps to identify underutilization within the population. To address gaps in care, **RMHP** used the program ELIZA to text appointment and other reminders to members. Prompts and gift cards were used in some circumstances to encourage attendance at medical appointments. Additionally, members with special health care needs (SHCN) were monitored through regular reporting and the Complex Care Management Program, which provided comprehensive coordination for members across a continuum of settings, including referrals to specialists and community programs.

Two performance improvement projects (PIPs) were implemented during FY 2019–2020:

- *Increasing the Number of Depression Screenings Completed for Regional Accountable Entity Members Ages 11 and Older*
- *Improving Well Child Visit (WCV) Completion Rates*

While interventions were initiated, the PIPs were discontinued early due to COVID-19, and the full evaluation of the PIPs was incomplete. During the time the PIPs were in place, claims data indicated positive progress toward improving completion rates for well-child visits, and some improvement was also seen in completed depression screens.

Member disenrollment data for reasons other than loss of eligibility were monitored through monthly files and reviewed through the reconciliation process. **RMHP** proactively analyzed member satisfaction data to assess potential causes of voluntary enrollment terminations and engaged the MEAC to evaluate disenrollment findings and satisfaction trends.

RMHP submitted a visual map of the health information operating system architecture that displayed integrated Department data, primary care and behavioral health claims, health information exchange information, and the community center analytics system interface. All these data sources were imported

to **RMHP**'s systems (Facets, care coordination tools, and other portals and data hubs) and demonstrated the ability to maintain, analyze, and report on key data elements.

The *Medicaid CHP+ Claim Encounter Data Submission* policy detailed a Health Insurance Portability and Accountability Act (HIPAA)-compliant process to generate and submit 837 files using the Facets and NextGen platforms. **RMHP** described the Department acknowledgement report and how it is uploaded to NextGen to perform a variety of data analytic validation and summary functions. The *PCP Practice Monthly Report* demonstrated a usable summary, which informed **RMHP** of member details, including both attribution rates and "assigned but unattributed" details. The summary sheet included total patients, risk adjustment information, and total cost of care. While **RMHP** only recently updated the *Medicaid CHP+ Claim Encounter Data Submission* policy to include the timeline of submitting encounter data to the State within 120 days of the adjudicated claim, **RMHP** described adhering to this timeline in practice during CY 2020 through weekly and monthly procedures, which were in alignment with regulations.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard VII—Provider Participation and Performance Improvement; Standard VIII—Credentialing and Recredentialing; Standard IX—Subcontractual Relationships and Delegation; and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. 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, 2020, through December 31, 2020. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and site 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 credentialing and recredentialing.

HSAG reviewed a sample of the RAE and Prime administrative records related to both credentialing and recredentialing to evaluate implementation of applicable 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 six records (to the extent that a sufficient number existed) for each of credentialing and recredentialing. For health plans that were contracted by the Department for administration of both the RAE and the managed care organization (MCO) for the RAE region, HSAG included five records from each of the RAE and the MCO for a total of 10 records applicable to both the RAE and the MCO. Using a random sampling technique, HSAG selected the samples from all RAE BH and Prime PH credentialing records, and all RAE BH and Prime PH recredentialing records that occurred between January 1, 2020, and December 31, 2020. For the record review, the health plan received a score of M (*Met*), NM (*Not Met*), or NA (*Not Applicable*) for each required element. HSAG separately calculated a record review score for each record review requirement and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard VII—Credentialing and Recredentialing.

The site review processes were consistent with *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 site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

Objective of the Site Review

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

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

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

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP RAE** until it completed each of the required actions from the FY 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievances and Appeals. There were no required actions related to access and availability.

Related to coverage and authorization of services, **RMHP** was required to complete three corrective actions, including:

- Correct UM policies to address the 10-calendar-day time frame for standard authorization decisions.
- Correct UM policies to address 14-calendar-day extensions for both standard and expedited authorization decisions.
- Ensure notices of adverse benefit determination are written in a manner that is easy for a member to understand (i.e., at or below the sixth grade reading level).

Related to Standard VI—Grievances and Appeals, **RMHP** was required to complete five required actions:

- Develop a mechanism to ensure grievances regarding treatment are reviewed by someone with clinical expertise.
- Ensure each grievance is thoroughly addressed.
- Communicate the appeal resolution and reason for the decision in member-friendly language.
- Update policies to accurately reflect continuation of benefits information (two required actions).

Summary of Corrective Action/Document Review

RMHP submitted a proposed CAP in June 2020. HSAG and the Department reviewed and approved the proposed interventions. **RMHP** submitted initial documents as evidence of completion in September 2020 and all required interventions were approved as complete.

Summary of Continued Required Actions

RMHP successfully completed the FY 2019–2020 CAP, resulting in no continued corrective action.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* RAE Contract Amendment #4: Exhibit B-4—9.1.6 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.7	**RAE:** *VII_PNM_CR.01.20 Credentialing Criteria and Process* This P&P defines a consistent credentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for credentialing of its providers. *VII_PNM_RC.01.20 Recredentialing Process* This policy defines a consistent recredentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for recredentialing of its providers. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* RAE Contract Amendment #4: Exhibit B-4—9.3.4.2.1; 9.3.5 Prime MCO Contract Amendment #4: Exhibit M-4—9.2.4	For RAE—applies only to BH providers For Prime—applies only to PH providers **RAE:** *VII_PNM_CR.01.20 Credentialing Criteria and Process* The Contractor complies with NCQA standards and guidelines for credentialing and recredentialing its providers. *VII_PNM_HDO.01.20 Health Delivery Organizations* Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA)	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. **RAE-specific:** N/A **Prime-specific:** N/A	
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.1-2 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.7.1-2	**RAE:** *VII_PNM_CR.14.20 Non Discriminatory Credentialing* This policy describes the process used to monitor for and prevent against discriminatory credentialing practices. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members.	**RAE:** *VII_PNM_CR.01.20 Credentialing Criteria and Process* Pg. 11 Section D Final Decision and Notifications: This section explains the notification procedure for practitioners applying to the RMHP panel and being denied.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.4 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.7.3	*VII_PNM_RC.01.20 Recredentialing Process* Pg. 11, Section E. Final Decision and Notification: This section sets forth the notification procedure for practitioners applying to the RMHP panel. *VII_PNM_RC.04.20 MPRC - Reduction, Suspension or Termination* Pages 2-5, Section 1. This policy outlines the process for notifying a provider of the reduction, suspension or termination of a health care provider's contracting status. **RAE-specific:** N/A **Prime-specific:** N/A	
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* RAE Contract Amendment #4: Exhibit B-4—9.1.13 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.15	**RAE:** *VII_PNM_Professional Services Agreement* Page, 6 Paragraph HH, "Professional Health Care Services" provides the term "Health Care Professional" who is legally authorized to provide services under Colorado law and under their licensure and or certification. This agreement is used for all behavioral health providers. *VII_PNM._Physicians Medical Services Agreement* Page 4, Paragraph GG, "Participating Physician" Provides that the term "participating physician" means a person who holds a degree of Doctor of Medicine or Doctor of Osteopathy, is licensed by the State of Colorado to practice medicine, has a written agreement directly with RMHP.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** *VII_PNM_Hospital Services Agreement* Page 4, Paragraph V, "Hospital Services" defines those services which are provided at a Hospital Facility.	
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* RAE Contract Amendment #4: Exhibit B-4—9.1.15, 17.9.4.2.5, 17.10.5.1-2 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.17, 17.9.4.1	**RAE:** *VII_PNM_CR.01.20 Credentialing Criteria and Process* This policy defines the credentialing process for Practitioners applying to the RMHP panel. Pg. 7: If a provider is on the OIG's list of debarred providers, credentialing/contracting will not be initiated. Pg. 8: RMHP's credentialing verification sources include License Sanction Status (#8), and Medicare/Medicaid Sanction Status (#9). *VII_PNM_ PNM-016 Initial Credentialing and Provider Notification of Request Process* Pages 2-3, Section C, Provides that before credentialing can begin, SAM, OFAC and OIG websites must be checked to ensure provider is not excluded from participation in federal healthcare programs. *VII_PNM_CR.05.20 National Practitioner Databank* Page 1, under "Policy," Describes RMHP's process for accessing the NPDB for all new practitioners and all currently contracted practitioners. This serves as primary	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	source verification of sanctions against or limitations on licensure, sanction activity by Medicare and Medicaid, and malpractice history. *VII_Compliance_New Hire and Periodic Employee Sanction Review Policy* This policy describes the process for ensuring that RMHP does not hire, continue to employ or contract with ineligible persons. *VII_Compliance_Prohibition Against Contracting With Any Person Policy* This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons. **RAE-specific:** N/A **Prime-specific:** N/A	
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract Amendment #4: Exhibit B-4—17.9.4.2.1-4 Prime MCO Contract Amendment #4: Exhibit M-4—17.9.4.2.1-4	**RAE:** *VII_Compliance_New Hire and Periodic Employee Sanction Review Policy* This policy describes the process for ensuring that RMHP does not hire, continue to employ or contract with ineligible persons. *VII_ Compliance_Economic Sanctions and Sanctions Monitoring Policy* Page 2, Section "General," demonstrates that RMHP is	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	prohibited from engaging in activities with, provide goods, insurance or services or employ or contract with individuals or entities prohibited by law. *VII_Compliance_Prohibition Against Contracting With Any Person Policy* This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons. **RAE-specific:** N/A **Prime-specific:** N/A	
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)*	**RAE:** *VII_PNM._Physicians Medical Services Agreement* Page, 13, Paragraph U, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation, and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with Members and will not penalize providers for such discussions. Page, 13, Paragraph V, "Medicaid Recipients Right to Participation"	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract Amendment #4: Exhibit B-4—14.7.3 Prime MCO Contract Amendment #4: Exhibit M-4—14.5.2	RMHP recognizes the Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. Page 23, Paragraph G, " Limitations on Adverse Actions" RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with the Member whether covered by the health plan or not. *VII_PNM_Professional Services Agreement* Pages 12-13 Paragraph Q, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with Members and will not penalize providers for such discussions. *VII_PNM_Hospital Services Agreement* Page 16, Paragraph W, "Expressing Disagreement"	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with Members and will not penalize providers for such discussions. Page 16, Paragraph X, "Medicaid Recipients Right to Participation" RMHP recognizes the Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. Page, 26, Paragraph G, "Limitations on Adverse Actions" RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with Member whether covered by the health plan or not. *2020 Provider Manual* Pg. 13 Affirmative Statement	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP encourages open communication between providers and Members in discussing appropriate treatment alternatives for medically necessary health care services, including medication treatment options, regardless of benefit coverage limitations. Contracted providers are not prohibited or discouraged from protesting or expressing disagreement with a medical decision, medical policy, or medical practice, including, without limitation, medication treatment options, made by RMHP or an entity representing or working for RMHP (e.g., a utilization review company). **RAE-specific:** N/A **Prime-specific:** N/A	
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(b)* RAE Contract Amendment #4: Exhibit B-4—7.3.6.1.13-14, 14.4.7 Prime MCO Contract Amendment #4: Exhibit M-4—7.1.6.1.13-14	**RAE:** NOTE: RMHP does not have objections to providing services on moral or religious grounds; therefore this requirement is not applicable. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the	**RAE:** **Bullet 1 -** *VII_Compliance_Compliance Program Document* Page 1, Introduction: Explains that the UHG/RMHP Program Promotes compliance with applicable legal requirements, fosters ethical conduct with the company, and provides guidance to its employees and contractors. Page 1, Introduction: Articulates that as part of the UHG/RMHP Program, the company has adopted a Code of Conduct, which is a guide to acceptable and appropriate business conduct by the company's employees and contractors. Page 3: Key Elements of Compliance/Written Standards, Policies and Procedures: Explains that compliance policies and procedures are posted and accessible online to employees. **Bullet 2 –** *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 1: Compliance Plan and Program Integrity Infrastructure: Notes the designation of an RMHP compliance officer who reports directly to the CEO and Board of Directors; the compliance officer is responsible for developing and implementing policies and procedures designed to ensure compliance with RMHP's contractual obligations.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract Amendment #4: Exhibit B-4—17.1.3, 17.1.5.1-7 Prime MCO Contract Amendment #4: Exhibit M-4—17.1.3, 17.1.5.1-7	**Bullet 3 –** *VII_Compliance_Compliance Program Document* Page 4: Compliance Committee Structure Describes the Compliance Committee structure. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 1: Key Preventive Structures and Processes/bullet 1, Provides information regarding program governance, including a regulatory compliance oversight committee. **Bullet 4 –** *VII_Compliance_Compliance Program Document* Page 4: Effective Training and Education Describes the annual company training and education requirements for all employees, which includes the Compliance Officer, management, and staff as well as vendors. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 1: Key Prevention Structures and Processes/bullet 3, Discusses training and education topics, training processes and record retention. **Bullet 5 –** *VII_Compliance_Compliance Program Document* Pages 5-6: Effective Lines of Communication Explains the various reporting mechanisms and communication mechanisms utilized to achieve effective communication to implement a successful compliance program.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_Compliance_RMHP Compliance Plan Addendum September 2020 Page 1: Key Preventive Structures and Processes/bullet 4, Describes communication mechanisms available to employees, Members and others to report issues and concerns to the RMHP Compliance Officer. **Bullet 6 –** *VII_Compliance_Compliance Program Document* Page 7: Enforcement and Disciplinary Guidelines Provides company expectations regarding compliance with laws, regulations and policies; it also notes that the enforcement and disciplinary guides are publicized in the code of conduct (the "Code"). *VII_Compliance_UHC-Code-of-Conduct* Page 4: About the Code of Conduct/Violations of the Code of Conduct and Policies This section explains that violations may result in discipline, up to and including termination and possible legal action, including referral to law enforcement. **Bullet 7 -** *VII_Compliance_Compliance Program Document* Page 7, Auditing and Monitoring This section describes RMHP's procedures and system for routine internal monitoring and auditing of compliance risks.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_Compliance_RMHP Compliance Plan Addendum September 2020 Page 2: Key Detection Structures and Processes Describes elements of compliance auditing and monitoring. *VII_PM&A-211 FWA Policy and Procedure Hotline Monitoring* Describes the process for daily monitoring of internally and externally reported compliance issues. **Bullet 8 -** *VII_Compliance_Compliance Program Document* Page 8: Responding to Identified Issues Describes internal coordination to respond promptly to suspected misconduct and to ensure appropriate corrective action and reporting. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 2: Key Correction Structures and Processes Describes the program's commitment to prompt response to identified issues and credible allegations and effective corrective action plans. *VII PM&A-203_Medicaid FWA Deterrence & Reporting* Pages 3-4, Section 6, describes the procedure for prompt response to compliance issues as they are raised, including identification of referral, preliminary review,	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	conducting the review, reporting internally and reporting to Regulatory Agencies. **RAE-specific:** N/A **Prime-specific:** N/A	
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12). *42 CFR 438.608(a)(6-8)* RAE Contract Amendment 4: Exhibit B-4—17.1.6, 17.1.5.9, 17.7.1, 17.5.1 Prime MCO Contract Amendment #4: Exhibit M-4—17.1.5.9, 17.1.6, 17.7.1, 17.5.1	**RAE:** **Bullet 1 -** *VII_Compliance_Control FWA Policy* Provides high-level depiction of how RMHP/UHC follow identified guidelines. *VII_Compliance_False Claims Act Compliance Policy RMHP 2020* Provides information regarding fraud, waste and abuse as it relates to the False Claims Act. Page 3, Whistleblower and Whistleblower Protections, describes the prohibition of retaliation when an employee provides any truthful information to a law enforcement officer that is related to any possible federal offense. **Bullet 2 -** *VII_PM&A-210_ Process for Monitoring, Investigating and Reporting Fraud, Waste and Abuse* Page 2, Section 2 – Reporting, A. and B. describes the process for prompt referral of any potential fraud to State Regulatory Agencies.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet 3 - *VII PM&A-203_Medicaid FWA Deterrence & Reporting* Page 3, Section 6 Paragraph B, describes the process for suspension of payments for which the State determines any credible allegation of potential fraud. **RAE-specific:** N/A **Prime-specific:** N/A	
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.7.2-5, 17.1.5.7.1, 17.1.5.7.6, 17.3.1.3.2.1, 17.3.1.1.2.3-4, 17.3.1.3.1.1	**RAE:** **Bullet 1 -** *VII_PM&A-210_ Process for Monitoring, Investigating and Reporting Fraud, Waste and Abuse* Page 2, Section 2 – Reporting, A. and B. describes the process for prompt referral of any potential fraud to State Regulatory Agencies. **Bullet 2 -** *VII_MEB-PP Notice to State_Enrollee Circumstance Change* This policy and procedure outlines the steps RMHP takes to notify the State when there is a change in a Member's circumstance which may affect the Member's eligibility. **Bullet 3 -** *VII_CI_Monthly FWA_Provider Term Notification Template*	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Prime MCO Contract Amendment #4: Exhibit M-4—17.1.5.6, 17.1.5.8.1.2, 17.1.5.7.1, 17.1.5.7.5, 17.3.1.3.1.1, 17.3.1.3.2.1, 17.3.1.1.2.3-4	This document is produced monthly and sent to the Department to report FWA activity as well as overpayment recoveries and Provider Termination from the RMHP network. *(This is an example of the template used monthly)* *Note: Actual monthly report will be available on site as it contains PHI.* *VII_CI_Monthly FWA_Provider Term Notification Dec 2020* Email example of notification to the Department of FWA, overpayment recoveries, and provider term notification. **Bullet 4 -** *VII_PM&A-215_Member Verification of Services Process* This document describes the process of verifying services delivered by network providers were received by Members. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608(b)* RAE Contract Amendment #4: Exhibit B-4—9.2.1.1, 9.3.2, 17.9.2 Prime MCO Contract Amendment #4: Exhibit M-4—17.9.2, 9.2.8.1.1	**RAE:** *VII_PNM_LAW EXHIBIT-Provider* Page 11, Paragraph 8 states that Contractor shall be enrolled with the State of Colorado in accordance with the disclosure, screening, and enrollment requirements of the State of Colorado for Medicaid and CHP+ providers. *VII_PNM_PNM-016 Initial Credentialing and Provider Notification of Request Process* Page 3, Section D (last bullet): RMHP credentialing department validates the providers State Medicaid ID number. If the provider has a valid Medicaid number a CP (Common Practitioner) will be created. If not, the request is returned to the PR Rep who notifies the applicant that a valid Medicaid ID number is required prior to the initiation of credentialing. *VII_PNM_Physicians Medical Services Agreement* Page 8, Paragraph F, "Enrollment Requirements" If the contractor serves Health First Colorado (Colorado Medicaid) or CHP+ Members, then the provider must be enrolled with Health First Colorado consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR Part 455, Subparts B and E and requirements of the State of Colorado. The provider must include in its RMHP enrollment application its Medicaid Identification number and the date of Health First Colorado enrollment or most recent validation.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** *VII_PNM_RAE_Prime Addendum 2020* This is an addendum to the PCMP contract that is executed by all Prime PCPs. Page 3, Paragraph F Enrollment Requirements, states that provider will be enrolled with State of Colorado in accordance with the disclosure, screening, and enrollment requirements of 42 CFR Part 455, Subparts B and E and the requirements of the State of Colorado for Medicaid and CHP+ providers.	
14. The Contractor has procedures to provide to the State: • Written discosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* RAE Contract Amendment #4: Exhibit B-4—17.3.1.5.1.1, 17.9.4.3, 17.10.2.1 Prime MCO Contract Amendment #4: Exhibit M-4—17.3.1.5.1.1, 17.9.4.3, 17.10.2.1	**RAE:** *VII_Compliance_Prohibited Affiliations PP* This policy states that RMHP will disclose to Colorado's Department of Health Care Policy and Finance ("HCPF") any relationship RMHMO has with an individual who is debarred, suspended or otherwise excluded from participating in a federal or state health care program. *VII_Compliance_Prohibition Against Contracting With Any Person Policy* This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_Compliance_Ownership & Control PP This policy indicates that RMHP will disclose to HCPF information on ownership and control in a form acceptable to HCPF, and delineates what the disclosures will include. *VII_PRGREC_Reporting Overpayments to State* This describes the procedure to identify and report within 60 calendar days any capitation or other payments in excess of the amounts specified in the contract. **RAE-specific:** N/A **Prime-specific:** N/A	
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.8, 17.3.1.2.4.4 Prime MCO Contract Amendment #4: Exhibit M-4—17.1.5.8, 17.3.1.2.4.4	**RAE:** *VII_PM&A-210_ Process for Monitoring, Investigating and Reporting Fraud, Waste and Abuse* Page 2, Section 2- Reporting, Paragraph C describes the process to report semi-annually to the State on recoveries of overpayments. *2020 Provider Manual* Page 49, Refunding Rocky Mountain Health Plans: Instructions are given to providers for reporting overpayments no later than 60 days after the overpayment is identified. Providers are instructed to include a written statement of the reason for the overpayment.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* RAE Contract Amendment #4: Exhibit B-4—14.14.1-2, 17.14.2-4 Prime MCO Contract Amendment #4: Exhibit M-4—17.14.2.4, 14.12.1-2	**RAE:** *VII_PNM_Physicians Medical Services Agreement* Page 12, Paragraph S, No Recourse Against Medicaid Recipients, sections (1), (2), (3): Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. *VII_PNM_Professional Services Agreement* Page 12, Paragraph O, No Recourse Against Medicaid Recipients, sections (1), (2), and (3): Provider contracts state that Members are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.	**RAE** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_PNM_Hospital Services Agreement Page, 15 Paragraph U No Recourse Against Medicaid Recipients, sections (1), (2), and (3): Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. **RAE-specific:** N/A **Prime-specific:** N/A *2020 Provider Manual* Pg. 36 Cost Share Collection RMHP Prime Members: The Member may not be balance billed for any costs not covered by either RMHP or the State.	
Findings: The *Professional Services Agreement*, *Physicians Medical Services Agreement*, and *BH Provider Manual* all provided accurate information regarding member liability for covered services. However, in the provider manual, the information regarding member liability was included under a heading titled "Cost Sharing" with the subheading "RMHP Prime Members" that was not entirely accurate for RAE members. The paragraph included a citation (CRS. 25.5-4-301[1]), which was not entirely accurate in regard to all PH services as there are some instances in which members are required to pay a copay and/or prescription costs.		
Required Actions: RMHP must update the member liability language in the provider manual to accurately address the various lines of business that may have variations in copay and liabilities. HSAG recommends using 42 CFR 438.106 language as a basis, with additional consideration to the individual contract language.		

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	15
Total Score ÷ Total Applicable						=	94%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and re-credentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 RAE Contract Amendment #4: Exhibit B-4- 9.3.4.2.1 Prime MCO Contract Amendment #4: Exhibit M-4—9.2.4	**RAE:** Note: These are NCQA MBHO and NCQA HP requirements available at the time of drafting this tool (6/2020). **RAE:** *VIII_PNM_Credentialing Criteria and Process* *VIII_PNM_Recredentialing Process* These two documents define RMHP's credentialing and recredentialing processes for evaluating and selecting licensed independent practitioners to provide care to our Members. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.*	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Section B, tables on pages 3-5 outline the types of practitioners *VIII_PNM_Recredentialing Process* Section C, tables on pages 3-5 outline the types of practitioners **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Examples of HP practitioners include medical doctors, chiropractors, osteopaths, podiatrists, NPs, etc. *42 CFR 438.214(a)* NCQA CR1—Element A1		
2.B. The verification sources it uses. NCQA CR1—Element A2	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Section B, pages 7-9 *VIII_PNM_Recredentialing Process* Section C, pages 8-9 These sections (Source Verification) outline the sources used to verify practitioner credentials (approved credentialing verification sources). **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Sections A-B, pages 2-6 *VIII_PNM_Recredentialing Process* Section A-C, pages 2-6 These sections outline the criteria used for credentialing and recredentialing.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**RAE:** *VIII_PNM_Recredentialing Process* Pages 9-11, Sections D-E, "Review and Determination, Final Decision and Notifications" *VIII_PNM_Initial Credentialing Workflow 2020* *VIII_PNM_Recredentialing Workflow 2020* These sections, and the workflow diagrams describe RMHP's process for making credentialing and recredentialing decisions. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Pages 9-10, Section C, Review and Determination *VIII_PNM_Recredentialing Process* Pages 9-11 Section D, Review and Determination These sections describe the process for managing credentialing and recredentialing files according to RMHP's criteria. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	**RAE:** *VIII_PNM_Nondiscriminatory Credentialing* This policy establishes the steps that RMHP takes during credentialing processes to monitor and prevent discriminatory practices. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Page, 7, Section B, "Source Verification," Paragraph 3 *VIII_PNM_Recredentialing Process* Page 8, Section C, "Source Verification," Paragraph 4 These sections provide the process that RMHP follows for notifying practitioners if information obtained from sources varies substantially from that provided on the application. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Page 11, Section D, "Final Decision and Notifications" *VIII_PNM_Recredentialing Process* Page 11, Section E, "Final Decision and Notifications" These sections indicate when a determination has been made by Medical Direction or the Medical Practice Review Committee (MPRC), the practitioner are notified of accepted status via letter from the Professional Relations Representative within 60 days. Practitioners are notified of denial via letter from Chief Medical Officer within 20 days. *VIII_PR_Initial Credentialing Process PNM016* Page 1, "Policy" section and Page 3, "Approved Credentialing", Paragraph A, bullet 5, indicates that approval notification is sent to providers and groups within 30 days. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	**RAE:** *VIII_PNM_Credentialing Criteria and Process* See Policy on Page 1 *VIII_PNM_Recredentialing Process* See Policy on Page 1 This paragraph indicates that the RMHMO Board of Directors (BOD) has delegated the responsibility for the credentialing function, review and approval authority for the credentialing policies and procedures and determination as to panel acceptance to the RMHP Chief Medical Officer, and that any Associate Medical Directors may cover for the RMHP Chief Medical Officer for credentialing purposes. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Pages 11-12, Section F, "Records" *VIII_PNM_Recredentialing Process* Pages 11-12, Section G, "Records" These sections delineate the RMHP process for ensuring the confidentiality of information obtained in the credentialing and recredentialing process	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	**RAE:** *VIII_PNM_Practitioner Specialties* This document delineates the process for ensuring that listings in practitioner directories are accurate. *VIII_PR_Physician and Hospital Directory Updates* This policy outlines how RMHP validates physician and hospital information for updates to the printed and web-based directories. *VIII_PR_Provider Relations Validation Letters* This policy describes the quarterly process for evaluating provider directory information by contacting providers and asking them to validate their information. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The contractor is not required to make references, recommendations, and peer-review protected information available.*	**RAE:** *VIII_PNM_Credentialing Criteria and Process* *VIII_PNM_Recredentialing Process* Procedure sections, both on page 6 of these policies, explain that RMHP utilizes the Colorado Health Care Professional Credentials Application (CHCPCA). Through use of this state mandated application, the applicant is informed of their rights:	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR1—Element B1	• To review information submitted to support their credentialing or re-credentialing application. • To correct erroneous information that varies substantially from information provided. • To receive the status of their credentialing or re-credentialing application, upon request. *VIII_PNM_CHCP_Credentials_Application* Page 23, item 12 also explains these rights *VIII_PNM_Screen Shot_Join RMHP Providers* Screen shot of RMHP.org website provides explanation of practitioners' rights related to the provider application **RAE-specific:** N/A **Prime-specific:** N/A	
3.B. To correct erroneous information. NCQA CR1—Element B2	**RAE:** *VIII_PNM_Credentialing Criteria and Process* *VIII_PNM_Recredentialing Process* Procedure sections, both on page 6 of these policies, explain that RMHP utilizes the Colorado Health Care Professional Credentials Application (CHCPCA). Through use of this state mandated application, the applicant is informed of their rights: • To review information submitted to support their credentialing or re-credentialing application.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• To correct erroneous information that varies substantially from information provided. • To receive the status of their credentialing or re-credentialing application, upon request. *VIII_PNM_CHCP_Credentials_Application* Page 23, item 12 also explains these rights. *VIII_PNM_Screen Shot_Join RMHP Providers* Screen shot of RMHP.org website provides explanation of practitioners' rights related to the provider application. **RAE-specific:** N/A **Prime-specific:** N/A	
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**RAE:** *VIII_PNM_Credentialing Criteria and Process* *VIII_PNM_Recredentialing Process* Procedure sections, both on page 6 of these policies, explain that RMHP utilizes the Colorado Health Care Professional Credentials Application (CHCPCA). Through use of this state mandated application, the applicant is informed of their rights: • To review information submitted to support their credentialing or re-credentialing application.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• To correct erroneous information that varies substantially from information provided. • To receive the status of their credentialing or re-credentialing application, upon request. *VIII_PNM_CHCP_Credentials_Application* Page 23, item 12 also explains these rights. *VIII_PNM_Screen Shot_Join RMHP Providers* Screen shot of RMHP.org website provides explanation of practitioners' rights related to the provider application. **RAE-specific:** N/A **Prime-specific:** N/A	
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	**RAE:** *VIII_PNM_Credentialing Committee* This policy describes the Credentialing committee structure and function. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A	**RAE:** *VIII_QI_MPRC Member List* This Medical Practice Review Committee (MPRC) listing shows the range of specialties participating in each regional credentialing committee. *VIII_PNM_Credentialing Criteria and Process* Pages 9-10, Section C, "Review and Determination" *VIII_PNM_Recredentialing Process* Pages 9-11, Section D, "Review and Determination" These sections describe the various levels of review/response by the Medical Director or credentialing committee based on the status of the applicant's file. *VIII_QI_MPRC Minutes 10-21-2020* This is a sample of the credentialing committee meeting minutes where practitioners who do not meet established thresholds were reviewed. *VIII_PNM_Medical Director Review of Clean Files* This documents how a Medical Director reviews and approves a weekly list of files that meet established criteria. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days.) • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply*	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Pages 7-9, Section B, "Source Verification" *VIII_PNM_Recredentialing Process* Pages 8-9, Section C, "Source Verification" The sections indicate that RMHP verifies all required elements for credentialing and recredentialling within 180 days prior to Medical Direction or credentialing committee review. *VIII_PNM_State Licensing Verification Letters* These are primary source verification letters for training that are collected annually from the State for specific specialties. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member. NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Pages 7-9, Section B, "Source Verification" *VIII_PNM_Recredentialing Process* Pages 8-9, Section C, "Source Verification" These sections outline the process for initial credentialing and recredentialing, including license sanction status (State Board of Medical Examiners, NPDB, HIPDB) and Medicare/Medicaid sanction status (Office of Inspector General Debarment Report). *VIII_PNM_National Practitioner Databank* This policy establishes the written guidelines for accessing the NPDB to verify sanctions, license limitations, and malpractice history for all new applicants and all currently contracted practitioners as part of the recredentialing process. *VIII_PR_Initial Credentialing Process PNM016* This policy describes the process that Provider Relations (PR) Representatives follow to initiate credentialing for prospective practitioners. If a	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	practitioner is found in any of the databases, credentialing is not initiated **RAE-specific:** N/A **Prime-specific:** N/A	
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Page 6, "Procedure" *VIII_PNM_Recredentialing Process* Page 6, "Procedure" These pages indicate that RMHP utilizes the Department of Public Health & Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentialing Application. *VIII_PNM_CHCP_Credentials_Application* RMHP utilizes the Department of Public Health and Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentials Application (CHCPCA), or Council for Affordable Quality Healthcare's (CAQH) Universal Provider Database (which also utilizes Colorado's state mandated CHCPCA) • Page 26, Question 3, ability to perform essential functions of the position • Page 25, Question 3, attestation regarding illegal drug use	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Pages 19-20, Paragraphs A-I, attestations regarding loss of license and felony convictions • Page 19-20 Paragraphs A-I, attestation regarding loss or limitation of privileges or disciplinary actions • Page 16, Section X, attestation of current malpractice or professional liability insurance coverage • Page 21, Section XIII, attestation confirming correctness and completeness of the application **RAE-specific:** N/A **Prime-specific:** N/A	
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**RAE:** *VIII_PNM_Recredentialing Process* Page 1, Policy Section, last sentence states that recredentialing will occur at least every three years. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	**RAE:** *VIII_PNM_Midcycle Credentialing* Pages 2-3, Sections A-D, explain the RMHP process for reviewing provider status updates related to sanctions or limitations on licensure, adverse events and instances of poor quality. *VIII_PNM_Ongoing Monitoring Sample Reports 2020* A sample of a monthly report collected and reviewed for sanctions will be available onsite. *VIII_PNM_Complaints Log* The log of complaints that were collected and reviewed will be available at site review. There were no office site complaints during this review period. *VIII_QI_QA Case Review Diagram* This flowchart illustrates the RMHP Quality Assurance case review process *VIII_QI_MPRC Minutes 10-21-2020* These Medical Practice Review Committee (MPRC) minutes illustrate examples of interventions when instances of poor quality are identified. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	**RAE:** *VIII_PNM MPRC_ Reduction, Suspension or Termination RC.04* This policy describes the procedures for taking action against a practitioner for quality reasons. Pages 2-4, Section 1.a and Section 1.c. on page 5 describes the formal appeal process offered to the practitioner. Page 2, Section 1, describes the range of actions available to RMHP, including mentoring, increased oversight or other proposed professional review action. Page 6, Section 4, indicates that the RMHP Chief Medical Officer shall report any sanction, suspension or termination of a health care provider due to quality of care issues to the state licensing agency, Colorado Board of Medical Examiners (CBME) and NPDB/HIPDB, as applicable. **Bullet 2 -** *VIII_PNM MPRC_ Reduction, Suspension or Termination RC.04* This policy describes the procedures for taking action against a practitioner for quality reasons. Pages 2-4, Section 1.a and Section 1.c. on page 5 describes the formal appeal process offered to the practitioner including the right to request a hearing within 30 days and the right to have an attorney or other person of their choice represent them.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 5, Section 1.e. describes the process for notifying the practitioner of the decision, including the reasons supporting it. *VIII_QI_Hearing Panel Notice Template* This notice of MPRC Hearing provides details of the Hearing and lists the Hearing panel members. *VIII_QI_Initial Denial Letter template* *VIII_QI_Recredential Denial Letter template* These denial letters provide written notification that a professional review action has been brought against a practitioner, provides reason for the action, and includes appeal process, including the right to be represented by an attorney or another person of their choice, and timeframe for requesting a hearing. When a letter is drafted, Medical Direction and/or Regulatory Affairs staff include specific reason(s) for each case decision as appropriate. **RAE-specific:** N/A **Prime-specific:** N/A	
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter:	**RAE:** *VIII_PNM_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Page 6, Section C, states that each organizational provider with which RMHP contracts will be assessed	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm—which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable.* NCQA CR7—Element A1	by the credentialing staff for continued compliance with the Standards for Participation every two (2) years for the duration of the contract. Pages 2-3, Section B, lists the documentation that must be submitted by all organizational providers to demonstrate that they are in good standing with regulatory or accrediting bodies. The accrediting bodies recognized by RMHP are listed in Section C, pages 3-4. Page 5, Section D indicates that a non-accredited organization must provide a copy of the State/CMS Survey report, including the cover letter and correction of deficiencies statement or a letter from CMS or the applicable state agency which shows the organization was reviewed and indicates that it passed inspection. **RAE-specific:** N/A **Prime-specific:** N/A	
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable.*	**RAE:** *VIII_PNM_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Pages 2-3, Section B, lists the documentation that must be submitted by all organizational providers to demonstrate that they are in good standing with regulatory or accrediting bodies.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR7—Element A2	The accrediting bodies recognized by RMHP are listed in Section C, page 3-4. Page 5, Section D, indicates that a non-accredited organization must provide a copy of the State/CMS Survey report, including the cover letter and correction of deficiencies statement or a letter from CMS or the applicable state agency which shows the organization was reviewed and indicates that it passed inspection. **RAE-specific:** N/A **Prime-specific:** N/A	
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	**RAE:** *VIII_QI Mechanism for Evaluation per State Operations Manual* This document describes how RMHP will accept the standards set forth in the State Operations Manual for RMHP credentialed Health Delivery Organizations (HDO) facilities in lieu of performing site visits internally. Page 2 indicates that the RMHP Credentialing Lead and Manager verify that the survey process evaluates the facilities procedures for the credentialing of medical staff providing services to Members. *VIII_PNM_Health Delivery Organizations* Page 5, Section D, "Non-accredited Organizational Providers" indicates that CMS or state quality reviews substituted for a site visit are no more than three years old.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA MBHO CR7—Element B NCQA HP CR7-Elements B&C	**RAE:** *VIII_PNM_Health Delivery Organizations* Page 1, "Policy" first paragraph lists the organizational providers defined for the purposes of this policy, including hospitals, home health agencies, skilled nursing facilities, and free-standing surgical centers; and behavioral health facilities providing mental health or substance abuse services in inpatient, residential, or ambulatory settings. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses behavioral health (RAE) and physical health (Prime) providers every 36 months. NCQA MBHO CR7—Element C NCQA HP CR7-Elements D&E	**RAE:** See below **RAE-specific:** *VIII_PNM_SAMPLE - Accred Behavioral Health HDO* This is a sample credentialing record of an accredited organizational provider (Health Delivery Organization) credentialed by RMHP.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_PNM_SAMPLE - Non-Accred Behavioral Health HDO This is a sample credentialing record of a non-accredited organizational provider (Health Delivery Organization) credentialed by RMHP. *VIII_PNM_RAE_Ogranizational Providers CY2020* This file represents RMHP contracted RAE organizational providers (Health Delivery Organizations) that have been reviewed since January 1, 2020. **Prime-specific:** *VIII_PNM_Prime_Ogranizational Providers CY2020* This file represents RMHP contracted organizational providers (Health Delivery Organizations) that have been reviewed since January 1, 2020. *VIII_PNM_SAMPLE - Accred Medical HDO* This is a sample credentialing record of an accredited organizational provider (Health Delivery Organization) credentialed by RMHP. *VIII_PNM_SAMPLE - Non-Accred Medical HDO* This is a sample credentialing record of a non-accredited organizational provider (Health Delivery Organization) credentialed by RMHP.	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. If the Contractor delegates credentialing/re-credentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	**RAE:** *VIII_PNM_Delegated Credentialing Audit Activities* Page 2, Section B, "Annual Audit" of this policy describes RMHP's oversight of delegated activities. Each delegated credentialing entity is audited on at least an annual basis by RMHP for compliance with RMHP standards. *VIII_PNM 2020 BVIPA Delegated Audit* *VIII_PNM 2020 SCL Health Delegated Audit* *VIII_PNM 2020 UPI Delegated Audit* These completed audit tools provide evidence of RMHP oversight of delegated credentialing activities. *VIII_PNM_Delegated Credentialing & Recredentialing* Page 2, Paragraph 1, states that each delegated entity and RMHP enter into a mutually agreed upon Delegated Credentialing Agreement prior to the entity performing any portion of the credentialing process on behalf of RMHP. Page 5, Section D, indicates that the specific elements delegated to each entity are outlined in the Delegated Credentialing Addendum attached to each contract. *VIII_PNM Delegated Credentialing Agmt* For each bulleted item, see notes on pages 1, 2, 3, 5, Exhibit A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**RAE:** *VIII_PNM_Delegated Credentialing & Recredentialing* Page 3, Section B, Paragraph 2 states that each prospective delegated entity will complete the Pre-contractual Delegation Evaluation Form. The form will be evaluated by RMHP credentialing staff. *VIII_PNM_Delegated Credentialing Audit Activities Policy* page 1, states that each prospective delegated credentialing entity will be evaluated for delegation capacity prior to extension of a Delegated Credentialing Agreement. The evaluation will consist of a Pre-contractual Delegation Evaluation Form, file audit and a review of the entity's Credentialing Policy and Procedures. *VIII_PNM Pre-Delegation Evaluation Concentra 2020 Questionnaire* This is a form completed by a potential delegate to determine ability to fulfill delegation requirements. *VIII_PNM Pre-Delegation Concentra 2020* This delegate is the only agreement that came into effect in the past 12 months. The packet contains the Policies and Procedures, file review tool, and policy and procedure evaluation tool used to determine	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	compliance with RMHP and NCQA Standards for Credentialing. **RAE-specific:** N/A **Prime-specific:** N/A	
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	**RAE:** *VIII_PNM_Delegated Credentialing Audit Activities* Page 1, under "Policy," it is noted that RMHP annually audits credentialing delegates for compliance with RMHP and NCQA standards. *VIII_PNM_Delegate Annual Oversight Tracking Tool* This tracking tool illustrates current RMHP activity to audit delegated credentialing files. *VIII_PNM 2020 BVIPA Delegated Audit* *VIII_PNM 2020 SCL Health Delegated Audit* *VIII_PNM 2020 UPI Delegated Audit* These delegated credentialing audits illustrate how RMHP annually audits each delegate against RMHP and NCQA Credentialing Standards. Included are review of policies and procedures and files. *VIII_PNM_Delegate Semi-Annual Report Tracking Tool* Demonstrates RMHP activity to evaluate credentialing reports from Delegates semiannually.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_PNM Samples Of Semiannual Reports Examples of self-identifying and reporting improvement activities on the Semi-Annual Credentialing Submission Form. **RAE-specific:** N/A **Prime-specific:** N/A	
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**RAE:** *VIII_PNM_2019 Davita Delegated Audit* *VIII_PNM_2019 Davita Delegated Audit Follow-up* This is the only recent delegated audit that RMHP found opportunities for improvement. This shows that we followed up with the delegate after the issues were identified. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	32
				Total Score ÷ Total Applicable		=	100%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* CHP+ Contract: Exhibit B1—5.5.3.3	*IX_PNM_Pre-Delegation Instructions* Describes the process RMHP follows to evaluate whether a prospective delegate is capable of performing delegated credentialing activities. *IX_PNM_Pre-Contractual Delegation Evaluation* This questionnaire completed by the potential delegate is reviewed by RMHP (in accordance with the pre-delegation instructions) to determine whether the delegate can perform credentialing activities in compliance with government regulations and NCQA standards. *IX_PNM_Delegated Pre Audit Tracking Sheet* This document is used internally to track the information and documents requested from the delegate prior to audit. *IX_PNM_Delegated Cred Audit Activities Policy DEL.2.20* Describes policy and procedure to conduct pre-delegation and annual delegation audits, including issuance of findings, identification of areas for improvement and monitoring of implementation of audit recommendations. *IX PNM_Semi-Annual Report* Delegates are required to complete this reporting template that identifies practitioners approved, site	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	visits for complaint monitoring, and any improvement activities. *IX_UM_Delegated Utilization Management* The Delegated Utilization Management policy describes the oversight process for delegated Utilization Management (UM) activities. Page 2, Section 3.2 and page 5, Section 6.1 describes pre-delegation activities undertaken to evaluate the prospective subcontractor's ability to perform UM activities. Page 2, Section 3.2, provides the process for monitoring and evaluating the delegated entity's performance. Pages 4-7, Section 6.0, sets forth the procedure for oversight. *IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 2, Section 2.2 RMHO Control and Oversight, explains that RMHP shall maintain oversight and monitor services for quality assurance in conformity with applicable state law and other regulatory requirements. Page 18, Section 3.1 Utilization Management and/or Complex Case Management, explains that the Vendor is delegated for Utilization Management and/or complex case management and maintain a utilization management and/or complex case	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	management program and that the Vendor's process shall comply with the applicable requirements of the NCQA or Accrediting Agency and for Medicare, Medicaid and any other government business and any additional requirements under federal and state law. Page 9, Section 6.4 Delegation of Activities; Oversight, explains that to the extent applicable to any Covered Services, in compliance with the delegation and oversite obligations imposed on RMHP, including the applicable state or under its contracts with any state and/or federal regulatory agencies, RMHP (a) shall conduct at least an annual audit of Vendor's performance or such delegated activities. Pages 5-6, Section 5.4 Corrective Action Plans, describes the corrective action plan process. Page 18, Exhibit B, describes that to the extent required by a regulatory or accrediting agency, the parties have documented in Exhibit F, the level of specificity required by applicable government authorities and/or RMHO's accreditation agencies the activities related to the services that have been delegated with timeframes required. Page 43, Exhibit F, Delegated Activities Grid, displays the delegation functions that shall be in accordance with the provisions of the Agreement.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_UM_UBH dba Optum Pre-Delegation Review This document provides the results of RMHP's pre-delegation audit of and is an example of the type of pre-delegation RMHP undertakes before entering into a contract that involves a delegation of duties. **Note:** The following documents are for CY2019 as the CY2020 reports were not complete at the time of submission. *IX_UM_eviCore Annual Delegation Oversight ReportCY2019* *IX_UM_eviCore Annual Delegation Oversight ReportCY2019_XLS* *IX_UM_Optum Annual Delegation Oversight ReportCY 2019* *IX_UM_Optum Annual Delegation Oversight ReportCY 2019_XLS* These report provide a summary of the oversight activities of these delegated entities. *IX_PH_UHC Pharmacy Delegated Entity Oversight Policy* RMHP is a party to the Inter-segment agreement between UnitedHealthcare and OptumRx. United performs the function of oversight of the PBM, per the UHC Pharmacy Delegated Entity Oversight Policy.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_UM_CCN Contract_CareCore National_ Redacted (CareCore National, LLC d/b/a eviCore healthcare) Page 4-6, Paragraph 2.4, "Oversight" specifies that the delegated entity agrees to allow RMHP to maintain reasonable oversight and what that includes. Page 45, Exhibit 3, in its entirety sets forth the Table of performance standards and monitoring that will occur under the agreement.	
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)*	*IX_ PNM_ Delegated Credentialing Agmt* Page 2, Paragraph 2.A., and Exhibit A describe the delegated credentialing activities. Page 2, Paragraph 2.D., describes the reporting responsibilities of the delegate. Page 1 sets forth the delegate's agreement to perform the delegated credentialing activities and reporting responsibilities. Pages 5-6, Paragraph 4, Revocation/termination of delegated activities is addressed *IX_UM_Delegated Utilization Management* Page 1, Section 3.1, provides that a written agreement between the parties will describe the delegated activities. Page 2, Section 3.1.6, provides that the written agreement will describe the remedies available if	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B1—2.3	the delegate does not fulfill its oblations, including the circumstances that would cause revocation. **Obligations and reporting responsibilities in written delegation agreements** *IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 18, Section 3.1 Utilization Management and/or Complex Case Management, explains that the Vendor is delegated for Utilization Management and/or complex case management and maintain a utilization management and/or complex case management program and that the Vendor's process shall comply with the applicable requirements of the NCQA or Accrediting Agency and for Medicare, Medicaid and any other government business and any additional requirements under federal and state law. Page 18, Exhibit B, describes that to the extent required by a regulatory or accrediting agency, the parties have documented in Exhibit F, the level of specificity required by applicable government authorities and/or RMHO's accreditation agencies the activities related to the services that have been delegated with timeframes required. Page 43, Exhibit F, Delegated Activities Grid, displays the delegation functions that shall be in accordance with the provisions of the Agreement.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 19-20, Section 6, Other Services, 6.1 General Services (a) (i)-(ii), describes the Vendor's reporting responsibilities. **Provisions for revoking or other remedies in delegated agreements** *IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 9, Section 6.4 Delegation of Activities; Oversight, explains that to the extent applicable to any Covered Services, in compliance with the delegation and oversite obligations imposed on RMHP, including the applicable state or under its contracts with any state and/or federal regulatory agencies, RMHP (a) shall conduct at least an annual audit of Vendor's performance or such delegated activities. Pages 5-6, Section 5.4 Corrective Action Plans, describes the corrective action plan process. Page 9, Section 6.4 Delegation of Activities; Oversight, item(b) states that RMHO has the right to revoke any functions or activities delegated to the Vendor under the Agreement, if in RMHO's reasonable judgement, Vendor's performance under the agreement does not comply with RMHO's obligations.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 9-10. Section 7.1 Term and Termination, items (d)(e), describe specified circumstances for immediate termination of delegated functions. *IX_PH_OptumRX_ISA12012020-Full Contract_redacted* Page 25, Section 15, G,(5) Delegation and Oversight. RMHMO reserves the right to revoke functions or activities delegated to the PBM in the event of non-compliance. **Obligations and reporting responsibilities in written delegation agreements** *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Pages 26-30, Exhibit 1, describes the delegated activities. Pages 27-28, Section 1.E, Reporting Requirements, describe the delegated entity's reporting responsibilities. **Provisions for revoking or other remedies in delegated agreements** *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 9, Paragraph 3.6.1 Evaluation of Delegated Entity Services, provides that in the event of a	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	deficiency, the delegated entity shall implement and submit a corrective action plan within 15 business days of notification of the deficiency. Page 21, Paragraph 10.3, "Termination or Suspension Upon Notice," provides for termination or suspension upon notice if the delegated entity is not performing UM activities in compliance with NCQA requirements or applicable law.	
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract: Exhibit B1—20.B	*IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 123, Section 11.2 Amendment, explains that the Agreement may be amended in compliance with any and all notice and/or approval requirements of the insurance laws in the state in which RMHO is domiciled. Page 18, Section 3.1 Utilization Management and/or Complex Case Management, explains that the Vendor is delegated for Utilization Management and/or complex case management and maintain a utilization management and/or complex case management program and that the Vendor's process shall comply with the applicable requirements of the NCQA or Accrediting Agency and for Medicare, Medicaid and any other government business and any additional requirements under federal and state law.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_PNM_Law Exhibit Template_Provider Page 11, Section III, Paragraph 8, demonstrates the credentialing delegation agreement contains the required language regarding compliance with all applicable Medicaid Laws and regulations as stated in this element. *IX_LRA_Law Exhibit_Non-Provider 12-19* Page 9, Paragraph 23, demonstrates the credentialing delegation agreement contains the required language regarding compliance with all applicable Medicaid Laws and regulations as stated in this element. *IX_PH_OptumRX_ISA12012020-Full Contract_redacted* Page 27, Paragraph 23, "State Contracts." Contractor agrees to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and the requirements of Rocky's CHP+ and Medicaid contract. *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 7, Paragraph 3.1.4, specifies that the delegated entity agrees to meet or exceed RMHP standards, policies and procedures, NCQA standards and federal and state statutory or regulatory provisions. Further, if any accrediting organization standards,	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	federal or state regulatory provisions are changed or revised, the delegated entity agrees to comply with or implement any such change as may be required by applicable law. This provision incorporates the applicable regulatory language in this requirement that is contained in RMHP's contracts with HCPF.	
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to CHP+ enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	*IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 25, Section 4.7 Records, (b) Government access to Records, (i)-(ii) describes that the Vendor acknowledges and agrees that Secretary of HHS, the Comptroller General or their designee shall have the right to audit, evaluation and inspect any pertinent books, contracts, computer or other electronic system (including medical records), patient care documentation and other records and information belonging to the Vendor that involve transactions related to the CMS contract. Page 25, Section 4.7 Records, (b), Paragraph 2, describes that the Vendor shall make available its premises, physical facilities and equipment, records related to the services performed pursuant to the Agreement. Page 5, Section 5.1 Maintaining Records, describes provisions for recording keeping and access to records for the purposes of inspection Pages 34-36, Section II, related to Federal Health Care Programs, Sections 1-7 describe that CMS	**RAE** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.230(c)(3) CHP+ Contract: Exhibit B1—2.3	may inspect, evaluate and audit a Contractor at any time id determined there is a possibility of fraud or similar fault. *IX_PNM_Law Exhibit Template_Provider* Page 7, Section III, Paragraph 2, "Records and Audits" is part of the credentialing delegation agreement and contains the required language as stated in this element. *IX_LRA_Law Exhibit_Non-Provider 12-19* Page 4, Paragraph 11, "Medicaid and CHP+ Records and Audits" is part of the credentialing delegation agreement and contains the required language as stated in this element. *IX_PH_OptumRX_ISA12012020-Full Contract_redacted* Page 22, Section 1, "Medicaid and CHP+ Records and Audits," provides that OptumRx shall maintain records and permit inspection, evaluation and audit as described in this requirement. *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 5, Paragraph 2.4.5, grants permission for federal, state and local governmental authorities to audit any and all documents and materials related to services under the agreement at the delegated	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	entity's place of business Page 6, Paragraph 2.4.10, provides that the period for retaining all data, information, records and documentation related to is performance of delegated entity services for the period required by law.	
Findings: While many of the RMHP subcontracts included language to grant the HHS-OIG, Comptroller General, or other designees the right to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years, some of the delegated credentialing agreements failed to include this information and the other specific language used in the federal rule.		
Required Actions: RMHP must update the delegated credentialing agreements that do not include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	3
Total Score ÷ Total Applicable						=	75%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* RAE Contract Amendment #4: Exhibit B-4—16.1.1 Prime MCO Contract Amendment #4: Exhibit M-4—16.1.1	**RAE:** The following documents describe the ongoing comprehensive Quality Assessment and Performance Improvement Program for services provided to our Members. *X_QI_RMHP QI Program Description 2020* *X_QI_RMHP QI Work Plan 2020* *X_QI_RMHP Annual Evaluation_Quality Assessment Report CY 2019* *X_CI_R1_QualityRpt_FY20-21* *X-CI_R1_QualityImprovePln_FY20-21* **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement.	**RAE:** *X_QI_ RMHP QI Work Plan 2020* Page 11, rows 86-88: PIP reporting to RMHP's Quality Improvement Committee *X_CI_CO2019-20_MCD_TechRpt_F1 for RAE&Prime PIPs* Pages 71-74, 204-206, 241-242, and page 269, describes the PIPs conducted during this review period. Activities include: measurement, implementation, and evaluation of the focused areas.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
For RAEs two PIPs are required, one for physical health and one for behavioral health. *42 CFR 438.330(b)(1) and (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—16.3.1, 16.3.5, 16.3.8 Prime MCO Contract Amendment #4: Exhibit M-4—16.2.1.1, 16.3.5, 16.3.8	**RAE-specific:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 115-117 describe the PIP titled "Improving Well Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members & Child Health Plan Plus (CHP+) Members Ages 15-18; Mountain Family Health Center" Pages 115-117 describe the PIP titled "Increase the number of depression screenings completed for RAE Members ages 11 and older; Colorado Mountain Medical" **Prime-specific:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 115-117 describe the PIP titled "Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older; Foresight Family Practice."	
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities.	**RAE:** *X_QI_ RMHP QI Work Plan 2020* Page 4, rows 32-34, describes RMHP activity in HEDIS data collection and reporting. *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Page 24: HEDIS data is collected, validated, and submitted as required.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.330(b)(2) and (c) RAE Contract Amendment #4: Exhibit B-4—16.4.1, 16.4.4 Prime MCO Contract Amendment #4: Exhibit M-4—16.4.1, 16.4.3, 16.4.7	**RAE-specific:** N/A **Prime-specific:** N/A	
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* RAE Contract Amendment #4: Exhibit B-4—16.6.1 Prime MCO Contract Amendment #4: Exhibit M-4—16.2.1.3, 16.6.1	**RAE:** *X_QI_RMHP QI Program Description 2020* Pages 25-26 describes the overutilization and underutilization monitoring activities included in the QI program. *X_QI_ RMHP QI Work Plan 2020* The overutilization and underutilization reports reviewed by the Utilization Management Committee are listed on page 7 (row 59), page 8 (row 61), page 9 (rows 69-72), and page 10 (row 73). *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Beginning on page 74, the Utilization Management Program section describes activities to detect and impact overutilization and underutilization. Page 74, section B, and page 124: establishment of the Utilization Management Committee in 2019 Pages 74-76, section B: over and underutilization for behavioral health Pages 84-89, section G: Member and provider outreach for gaps in care	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_QI_Pfizer_CO_Postcard_MissedDose *X_QI_Welltok Missed Dose Reminder Script* *X_QI_Pfizer_CO_Postcard_WellVisit* *X_QI_Welltok Well Visit Reminder Phone Script* These materials were used in an outreach campaign in 2020 to address underutilization of immunizations and well child visits. The campaign included a postcard and follow-up phone call. The target population was children who missed an immunization between six months and 18 months of age and children identified as due for a 12-month well child visit. *Note: RMHP Tracking of Hospital Readmissions* In the course of doing business, RMHP tracks readmissions within 30 days for all lines of business as a means of tracking inappropriate utilization. *X_UM_Program Description_2020-21* Pages 32-33, Over & Underutilization Monitoring, describes how RMHP monitors over and underutilization of service to ensure Members receive the necessary and appropriate care. **RAE-specific:** N/A **Prime-specific:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 76-78, section C: over and underutilization of physical health	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 78-80, section D: overutilization of hospital readmissions within 30 days of discharge Pages 80-81, section E: Preauthorizations to detect over and underutilization Pages 81-84, section F: Provider Attribution Reports to detect over and underutilization *X_QI_QI126C_TeenWellness2020 Incentive* *X_QI_QI133C_PreteenWellness Incentive* *X_QI_QI83C_Diabetes2020 Incentive* *X_QI_QI132C_BreastCancer Incentive* *X_QI_QI134C_CervicalCancer2020 Incentive* These are examples of Member mailings for gaps in care in 2020. The incentive programs were developed to address underutilization of wellness visits in the teen and pre-teen population, underutilization of preventive care screenings, and underutilization of chronic care management. The brochures are mailed to Members identified as having a gap in care. *X-PH15_Drug Safety and Drug Medication Adherence* The Drug Safety and Medication Adherence Program Description defines RMHP's strategy for managing appropriate and effective utilization of drug and medication therapies. Page 1 gives an overview of the program.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2 and following describes how RMHP identifies the population who may be at risk for negative outcomes due to under and overutilization and the programs used to address and manage associated risks.	
5. The Contractor's QAPI program includes mechanisms for identifying, investigating, analyzing, tracking, trending and resolving any alleged quality of care concerns. RAE Contract Amendment #4: Exhibit B-4—16.7.1.1, 16.7.2 Prime MCO Contract Amendment #4: Exhibit M-4—16.7.1.1, 16.7.2	**RAE:** *X_QI_Retrospective Quality Case Review* This Policy and Procedure describes the process undertaken to investigate any potential quality of care issues identified by Members, providers and others. Page 3 indicates that upon request, a letter will be submitted to HCPF (within 10 business days) that includes a brief description of the quality of care issue, the efforts taken to investigate the issue, the outcome of the review, and any action RMHP intends to take with the providers involved. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to*	**RAE:** *X_QI_ RMHP QI Program Description 2020* Pages 23-24, Section: Collaboration on Continuity and Coordination of Care, describes how RMHP works to facilitate and promote continuity and coordination of care between medical practitioners and between medical and behavioral health practitioners. Pages 24-25, Section: Complex Health Needs, describes that	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school. *42 CFR 438.330(b)(4)* RAE Contract Amendment #4: Exhibit B-4—16.2.1.4 Prime MCO Contract Amendment #4: Exhibit M-4—16.2.1.4, 16.5.5 10 C.C.R. 2505-10, 8.205.9	Members with complex health needs are referred to the Complex Care Management Program. Eligible Members are offered comprehensive and enhanced coordination of care to assist with their needs across a continuum of settings. *X_QI_2019 AAP Psychosocial Factors in CYSHN and their Families* *X_QI_Bright Futures Guidelines- Promoting Health for CYSHN* *X_QI_Adults with Special Healthcare Needs Guidelines_RMHP* These are the clinical practice guidelines RMHP has adopted relating to children and adults with special health care needs. The guidelines are available on the website and upon request. *X_CM_Complex Outreach Workflow* This workflow is an example of how RMHP's targeted outreach to adult and pediatric members who are identified as Complex or have Special Health Care Needs. Assessment and care plans are developed to help Members overcome barriers and achieve specific treatment goals. **RAE-specific:** N/A	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: *X_QI_ RMHP QI Work Plan 2020* Page 11, row 81: The Special Health Care Needs audit is reviewed by the Medical Advisory Council. *X_QI_SHCN Prime Q3 2020 Analysis Report 10.9.20* This report was completed in October of 2020, summarizing the 3rd quarter 2020 assessment of the quality of care for people with special health care needs. *Note: the Q4 report will be available on site for review if needed.* *X_QI_Assessing Quality of Care for People with SHCN* This describes the process for assessing the quality of care for people with special health care needs.	
7. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • CAHPS survey • ECHO survey (RAE only) RAE Contract Amendment #4: Exhibit B-4—16.5.1-2, 16.5.6 Prime MCO Contract Amendment #4: Exhibit M-4—16.5.1-3, 16.5.7	**RAE:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 89-112 describe various Member satisfaction survey tools, results, and analyses. Pages 90-92: Complaints, appeals, and grievances Page 93-95: Statewide survey to evaluate Member experience of PCP and specialist visits Page 95-97: Appointment wait time Member survey Page 97: Net Promoter Score Page 104-107: Medicaid CAHPS survey	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_CI_R1_GrieveAppealRpt_Q1FY20-21 This report, provides identified trends regarding timely response and completion of grievances and appeals, and any actions taken. The Appeals and Grievance team shares Members perception on access and availability of services with appropriate department for follow up. Note: Grievance and Appeal approved template with Q1FY20-21 data will be available on site. *X_CS_MEAC Quarterly Report* This report is presented quarterly to the Member Experience Advisory Committee (MEAC) to report the number of appeals and grievances received as well as the categories which include member perception to access, attitude/service, billing/financial, and quality of practitioner office site. **RAE-specific:** N/A **Prime-specific:** N/A	
8. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* RAE Contract Amendment #4: Exhibit B-4—16.2.5 Prime MCO Contract Amendment #4: Exhibit M-4—16.2.5	**RAE:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 6-9 describe that program activities are structured around an ongoing process of quality monitoring, reporting, and assessment. A detailed evaluation of the Quality Improvement Program and its activities is conducted annually. This report is a formal	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	summary of the annual evaluation of quality improvement activities. **RAE-specific:** N/A **Prime-specific:** N/A	
9. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate. *42 CFR 438.236(b)* RAE Contract Amendment #4: Exhibit B-4—14.8.8.1-3 Prime MCO Contract Amendment #4: Exhibit M-4—14.6.7.1-3	RAE contract—practice guidelines apply to BH services. Prime contract—practice guidelines apply to PH services. **RAE:** *X_QI_Clinical Practice Guidelines* Page 2, Section 1.b: Guidelines address physical and behavioral health care. Page 2, Section 1.b: Guidelines will be reviewed and adopted directly from a recognized source (a national organization that develops evidence based clinical practice guidelines). Page 2, Section 1.c: When evidence based guidelines are not available, guidelines may be developed from a consensus of Health Care Professionals in a particular field. Page 4, Section 4.a: Includes an analysis of the relevancy of the guideline to the RMHP population. Page 2, Section 1.a: Annually and when new scientific evidence and/or national standards warrant, guidelines are reviewed for updates or changes to current clinical practice by the Quality Improvement Department with	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	subsequent consultation by other internal clinical staff as necessary (e.g. Medical Directors and pharmacists). *X_UM_ Clinical Criteria for UM Decisions* Page 1-2, Sections I and II, describes the process used to apply written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services. Page 3, Section III, indicates that throughout the process of making a determination, RMHP considers many sources of clinical information, individual Member needs and characteristics of the local delivery system Page 2, Section II, Paragraph E indicates that practitioners with professional knowledge or clinical expertise in the relevant area have an opportunity to give advice or comment on development, review and adoption of UM criteria and on instructions for applying criteria. *X_UM_Template for Specialist Review Letter and Feedback form* This letter template is used for the purpose of obtaining practitioner input on the development and adoption of RMHP criteria. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* RAE Contract Amendment #4: Exhibit B-4—14.8.8 Prime MCO Contract Amendment #4: Exhibit M-4—14.6.7	**RAE:** *X_QI_Clinical Practice Guidelines* Page 3, Section 2.a-d: Providers are notified that approved clinical practice guidelines are on the RMHP website. Guidelines are provided to Members and potential Members upon request. *X_PNM_Provider Newsletter_Winter 2020* Page 3 provides a clinical practice guidelines update. Guidelines listed include Pediatric *Preventive Care, Prenatal Care, and Special Healthcare Needs—Children and Adults*. Providers are advised how to obtain copies of these guidelines. Page 8 indicates the criteria used to make a decision are available upon request at no cost to the Member or provider. *X_CI_Screen Shot of Clinical Practice Guidelines-Website* RMHP disseminates information on its public website regarding current clinical practice guidelines. *X_UM_ Clinical Criteria for UM Decisions* Pages 5-6, Section VI indicates that guidelines used in UM decision-making are available at no cost upon request. Practitioners and Members are notified in writing that they are available.	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	2020 Provider Manual Page 82 explains *Review Criteria.* Criteria used in decision-making are available, free of charge, to Physicians, Practitioners, facilities, and Members upon request to RMHP. **RAE-specific:** N/A **Prime-specific:** N/A	
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* RAE Contract Amendment #4: None Prime MCO Contract Amendment #4: Exhibit M-4—None	**RAE:** *X_QI_Clinical Practice Guidelines* Page 3, Section 1.e: RMHP assesses whether Member materials, benefit configuration, UM decisions, prior authorization list, or other operational functions are consistent with adopted clinical guidelines and/or need to be updated as a result of any changes to the clinical guidelines. *X_UM_ Clinical Criteria for UM Decisions* Page 6, Section VII, describes how RMHP assesses at least annually the consistency with which physician and non-physician reviewers apply UM criteria in decision-making. *2020 Provider Manual* Page 75, Care Management Section, addresses many aspects of the Care Management Program. It describes	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the organizational structure that is in place to support correct and consistent development and application of guidelines. Page 83, last two paragraphs describe how consistency is maintained including inter-rater reliability testing, audits, and utilization clinical rounds. **RAE-specific:** N/A **Prime-specific:** N/A	
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* RAE Contract Amendment #4: Exhibit B-4—15.1.1 Prime MCO Contract Amendment #4: Exhibit M-4—15.1.1	**RAE:** *X_Data_RMHP Health Information Systems_v2* This flowchart illustrates the various health information systems used by RMHP to collect, analyze, integrate and report data. *X_CL_Steps to Process a Medical Claim* Describes the steps the RMHP takes to process electronic and paper claims from providers—includes the processing steps, role of examiners, systems utilized, workflows and queues. *X_CI_R1_GrieveAppealRpt_Q1FY20-21* 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 Q1FY20-21 data will be available on site. *X_PT_Referrals_Med Nghbrhd_ Peds* *X_PT_Engaging in the Med Nghbrhd*	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These two documents are provided as examples of how RMHP helps its provider network use data and health information exchange for purposes of improving the care provided to patients. This includes an example of a workflow using health information exchange when a visit to the emergency room triggers a notification to the patient's PCP, e.g., pages 6-7 of *Engaging in the Medical Neighborhood.* **RAE-specific:** N/A **Prime-specific:** N/A	
13. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* RAE Contract: Exhibit B—15.1.1, 8.1 Prime MCO Contract Amendment #4: Exhibit M-4—15.1.1, 8.1	Note: For RAEs, these elements apply only to BH services. For Prime, these elements apply only to PH services. **RAE:** *X_Data_RMHP Health Information Systems_v2* This flowchart indicates the various reporting and analytics that are done in the areas of utilization, claims, grievances and appeals, etc. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.2 Prime MCO Contract Amendment #4: Exhibit M-4—15.2.3.1, 15.2.3.2	Note: For RAEs, claims/encounter systems relate only to BH capitated services. For Prime, claims/encounter systems apply only to PH capitated services. **RAE:** *X_PRGREC_Medicaid CHP+_Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Medicaid and CHP+ Claim Encounter Data to the Colorado Department of Health Care Policy and Finance (HCPF). ***Claims note regarding Mechanism for verifying accuracy of claims/encounter data:*** All Health Care Professionals must comply with adopted HIPAA standards and all ANSI claims submission requirements for acceptance of their claims. In addition, RMHP utilizes a series of national published correct coding guidelines to ensure Providers are submitting accurate claims. **RAE-specific:** N/A **Prime-specific:** *X_PRGREC_Medicaid CHP+_Pharmacy Claim Encounter Data Submission PP*	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Describes the process and procedure for the submission of Pharmacy Claim Encounter Data to HCPF.	
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.1, 15.2.2.3.2 Prime MCO Contract Amendment #4: Exhibit M-4—15.2.2, 15.2.3	**RAE:** *X_PT_PCP Practice Monthly Report_PHI Removed* This PCP Practice monthly report demonstrates how RMHP collects and uses data on Member and provider characteristics regarding services furnished to Members. The various worksheets provide practice summaries, patient summary, patient detail, Members who are assigned but unattributed, and enrollment and claims data. *X_PT_Engaging in the Med Nghbrhd* Pages 4-5 provides information for providers on tracking utilization in the emergency department and hospital, and on the attribution report (the practice monthly report noted above) and how practices can use it. **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments.	**RAE:** *X_CL_Steps to Process a Medical Claim* Describes the steps the RMHP takes to process electronic and paper claims from providers—includes the processing steps, role of examiners, systems	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. • Making all collected data available to the State and upon request to CMS. *42 CFR 438.242(b)(3) and (4)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.1, 15.2.2.3.5.1 Prime MCO Contract Amendment #4: Exhibit M-4—15.2.3.1, 15.2.3.6.1	utilized, workflows and queues. • Verify accuracy and timeliness examples Page 3: checking of line items Page 4: claims sorted and worked by age Page 4: errors researched and cleared Page 4: duplicates are checked by the system automatically • Completeness, logic and consistency examples Page 2: claim with lack of information or eligibility is rejected Page 3: checking of line items Page 4: claims that do not meet criteria are pended • Service information in standardized formats examples Page 1: claims can be received electronically *X_PM&A-Annual Audit Plan 2020 REVISED 20200429* This annual audit plan describes RMHP audit activities to verify accuracy and timeliness of reported data; screening data for completeness, logic and consistency; and collecting information in standardized formats. Page 4 lists the summary of audits planned. Claims Financial and Transaction Accuracy Audit. Additional information can be found in:	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_PM&A-003 Procedure for Medical Claims Accuracy Reporting *X_PM&A-007 Medical Claims Auditing Manual.* Hospital Bill and Chart Review Audits. Claims Edit Review using Claims Audit Software, which is an electronic review to identify claims and claim combinations that were possibly paid incorrectly or should not have been paid, depending on set criteria. Provider Correct Coding Audit. Additional information can be found in: *X_PM&A-207 Correct Coding for E&M Mgt Code (CCP).* Audits of DME claims to review a sample of claims for DME products and services for transactional accuracy and medical necessity. The review includes medical records request to support billed charges. *X_PM&A-003 Procedure for Medical Claims Accuracy Reporting* *X_PM&A-007 Claims Auditing Manual* RMHP performs Claims Financial and Transaction Accuracy audits monthly. These documents describe the claims accuracy review process. *X_PM&A-207 Correct Coding for E&M Mgt Code (CCP)*	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP conducts post-payment reviews of E&M coding practices to monitor potential upcoding of claims and to improve the accuracy of and consistency of codes submitted by participating providers. **RAE-specific:** *X_Leif_Appendix I. Flat File Specifications HCPF Version 21 Final* *X_Leif_RAE BH Flat File Process 20201211* A general description of what happens between RMHP giving data to Leif (RMHP's data actuary) and Leif providing HCPF (The Department) monthly BH Flat Files. This would be for both FFS and encounter claims. **Prime-specific:** *X_Leif_Appendix I. 2020.08.05 HMO Flat File Specification* *X_Leif_Prime Flat File Process 20201211* A general description of what happens between RMHP giving data to Leif (RMHP's data actuary) and Leif providing HCPF (The Department) monthly BH Flat Files. This would be for both FFS and encounter claims.	
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members.	**RAE:** *X_PRGREC_Medicaid CHP+_Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Medicaid and CHP+ Claim Encounter	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* RAE Contract Amendment #4: Exhibit B—4-15.2.2.3.2-3, 15.2.2.3.5 Prime MCO Contract Amendment #4: Exhibit M-4—15.2.2.1, 15.2.3.2, 15.2.3.4, 15.2.3.6	Data to the Colorado Department of Health Care Policy and Finance (HCPF). **RAE-specific:** **Prime-specific:** *X_PRGREC_Medicaid CHP+_Pharmacy Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Pharmacy Claim Encounter Data to HCPF.	

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	17
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Rocky Mountain Health Plans Region 1 and Prime

Review Period:	January 1 through December 31, 2020
Date of Review:	March 17, 2021
Reviewer:	Sarah Lambie
Health Plan Participant:	Erin Nipper

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: ***** Credentialing Date: 02/20/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #2 Provider ID: ***** Credentialing Date: 04/16/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: **** Credentialing Date: 06/05/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: ***** Credentialing Date: 09/04/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Rocky Mountain Health Plans Region 1 and Prime

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #5 Provider ID: ***** Credentialing Date: 10/26/20	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #6 Provider ID: ***** Credentialing Date: 01/24/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: ***** Credentialing Date: 01/31/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #8 Provider ID: ***** Credentialing Date: 02/20/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: ***** Credentialing Date: 05/08/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Credentialing Record Review Tool
for Rocky Mountain Health Plans Region 1 and Prime

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #10 Provider ID: ***** Credentialing Date: 09/04/20	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**5**	**10**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**5**	**10**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**88**
Total Number of Compliant Elements	**88**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Education/training—the highest of board certification, residency, graduation from medical/professional school
4. Applicable if the practitioner states on the application that he or she is board certified
5. Most recent five years or from time of initial licensure (if less than five years)
6. Malpractice settlements in most recent five years
7. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
8. Verified that provider is not excluded from participation in federal programs

9. Application must be complete (see compliance tool for elements of complete application)

10. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate • Education and training	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation • Work history

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Recredentialing Record Review Tool
for Rocky Mountain Health Plans Region 1 and Prime

Review Period:	January 1 through December 31, 2020
Date of Review:	March 17, 2021
Reviewer:	Sarah Lambie
Health Plan Participant:	Erin Nipper

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: **** Current Recredentialing Date: 01/17/20 Prior Credentialing or Recredentialing Date: 04/13/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: **** Current Recredentialing Date: 04/03/20 Prior Credentialing or Recredentialing Date: 06/21/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #3 Provider ID: **** Current Recredentialing Date: 07/17/20 Prior Credentialing or Recredentialing Date: 07/12/17	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #4 Provider ID: **** Current Recredentialing Date: 11/20/20 Prior Credentialing or Recredentialing Date: 01/04/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments:									
File #5 Provider ID: **** Current Recredentialing Date: 12/23/20 Prior Credentialing or Recredentialing Date: 02/08/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #6 Provider ID: **** Current Recredentialing Date: 01/10/20 Prior Credentialing or Recredentialing Date: 04/13/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #7 Provider ID: **** Current Recredentialing Date: 02/07/20 Prior Credentialing or Recredentialing Date: 04/27/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: Malpractice insurance was verified through self-report.									
File #8 Provider ID: **** Current Recredentialing Date: 05/15/20 Prior Credentialing or Recredentialing Date: 07/12/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Recredentialing Record Review Tool
for Rocky Mountain Health Plans Region 1 and Prime

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #9 Provider ID: **** Current Recredentialing Date: 06/12/20 Prior Credentialing or Recredentialing Date: 08/17/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #10 Provider ID: **** Current Recredentialing Date: 10/29/20 Prior Credentialing or Recredentialing Date: 12/07/17	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
Number of Applicable Elements	**10**	**5**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**5**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**78**
Total Number of Compliant Elements	**78**
Overall Percentage Compliant	**100%**

Key: Y = Yes; N = No; NA = Not Applicable

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)

3. Applicable if the practitioner states on the application that he or she is board certified

4. Malpractice settlements in most recent five years

5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance

6. Verified that provider is not excluded from participation in federal programs

7. Application must be complete (see compliance tool for elements of complete application)

8. Verification time limits:

Prior to Credentialing Decision	180 Calendar Days	365 Calendar Days
• DEA or CDS certificate	• Current, valid license • Board certification status • Malpractice history • Exclusion from federal programs	• Signed application/attestation

9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2020–2021 site review of **RMHP RAE** and **Prime**.

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

HSAG Review Team	Title
Barbara McConnell	Executive Director
Gina Stepuncik	Associate Director
Sarah Lambie	Project Manager III
Erica Arnold-Miller	Project Manager II
RMHP Participants	**Title**
Braden Neptune	Director of Member Enrollment and Billing (MEB) & Program Reconciliation
Brian Burban	Manager, UHC Audit Management
Carrie Baumann	Projects and Compliance Specialist
Cathy Moorehouse	Staff Auditor, Internal Audit
Christy Hunt	Claims Production Manager
Cris Matoush	Crisis Systems Manager
Cynthia Mattingley	Quality Improvement Accreditation and Compliance Manager
Dale Renzi	Vice President of Network Strategies and Operations
David McElfresh	Internal Auditor
David Mok-Lamme	Vice President of Data Analytics and Strategy
Diana Lopez	Customer Service Supervisor
Erin Nipper	Lead Credentialing Coordinator
Greg Coren	Senior Manager, Provider Networks
Heather Cochrane	Manager, Program Reconciliation
Jay Puhler	Medicaid/Medicare Reconciliation
Jeremiah Fluke	Prime Contract Manager & Quality Analyst
Jerry Spomer	Director of Internal Audit, Member Benefit Administration and Member Enrollment and Billing
Jill Bystol	Quality Assurance Compliance Coordinator
Kathryn Jantz	Accountable Health Communities Model Director
Kendra Peters	CHP+ Contract Manager & RAE Program Operation Support
Kim Herek	Director of Clinical Program Development and Evaluation

RMHP Participants	Title
Krista Cavataio	Contract Manager, Behavioral Health Administrative Services Organization
Louisa Wren	RAE Health Neighborhood and Community Program Manager
Marci O'Gara	Senior Director of Business Operations
Margot Gates	Manager of Non-clinical Prescriptions, Optum
Marjorie Champenoy	Community Integration Quality Analyst
Matt Cook	Director Configuration Management
Matt Swanson	Senior Compliance Analyst, UHC Audit Management
Maura Cameron	Director of Quality Improvement
Meg Taylor	Vice President, Community Integration; RAE Program Officer
Melanie Maddocks	Senior Actuarial Analyst
Monika Tuell	Chief Operations Officer
Nacole Johnson	Customer Service Process Analyst
Nicole Konkoly	RAE Network Relations Manager
Patrick Gordon	Chief Executive Officer
Rhonda Michaelson	Supervisor, Appeals and Grievances
Rose Stauffer	Chief Financial Officer
Sandy Dowd	Director, Care Coordination
Sheila Worth	Medical Strategic Initiatives Administrator
Steven Robinson	Senior Analyst, Behavioral Health Compliance
Sue Baker	Manager, Customer Service
Tiffany Kikta	Director, Utilization Management
Todd Lessley	Vice President, Clinical Services
Thomas Cheek	Interim Chief Medical Officer
Zach Kareus	Clinical Pharmacist, Pharmacy Department
Zach Snyder	Digital Analyst, Information Technology
Vikki Watkins	Claims Supervisor
Department Observers	**Title**
Lina Major	ACC Program Specialist
Tyller Kerrigan-Nichols	Managed Care Contract Specialist
Ben Harris	ACC Program Specialist
Russell Kennedy	Quality & Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2020–2021

If applicable, the RAE 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 RAE should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the RAE 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 RAE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer SAFE site, with an email notification to HSAG and the Department. The RAE 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 and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the RAE is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the RAE to proceed with implementation, or • Instruct the RAE to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the RAE has received Department approval of the CAP, the RAE will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The RAE will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the RAE will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the RAE within the intervening time frame.) If the RAE is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

Step	Action
Step 5	**Technical Assistance**
	At the RAE's request, HSAG will schedule an interactive, verbal consultation and technical assistance session during the three-month time frame. The session may be scheduled at the RAE's discretion at any time the RAE 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 RAE 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 completion established by the Department. HSAG will continue to work with the RAE until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2020–2021 Corrective Action Plan for RMHP RAE and Prime

Standard VII—Provider Participation and Program Integrity—Both RAE and Prime		
Requirement	**Findings**	**Required Action**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* RAE Contract Amendment #4: Exhibit B-4—14.14.1-2, 17.14.2-4 Prime MCO Contract Amendment #4: Exhibit M-4—17.14.2.4, 14.12.1-2	The *Professional Services Agreement*, *Physicians Medical Services Agreement*, and *BH Provider Manual* all provided accurate information regarding member liability for covered services. However, in the provider manual, the information regarding member liability was included under a heading titled "Cost Sharing" with the subheading "RMHP Prime Members" that was not entirely accurate for RAE and Prime members. The paragraph included a citation (CRS 25.5-4-301[1]), which was not entirely accurate in regard to all PH services as there are some instances in which members are required to pay a copay and/or prescription costs.	RMHP RAE and Prime must update the member liability language in the provider manual to accurately address the various lines of business that may have variations in copay and liabilities. HSAG recommends using 42 CFR 438.106 language as a basis, with additional consideration to the individual contract language.

Standard VII—Provider Participation and Program Integrity—Both RAE and Prime		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard IX—Subcontractual Relationships and Delegation—Both RAE and Prime		
Requirement	**Findings**	**Required Action**
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to CHP+ enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability	While many of the RMHP RAE and Prime subcontracts included language to grant the HHS-OIG, Comptroller General, or other designees the right to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years, some of the delegated credentialing agreements failed to include this information and the other specific language used in the federal rule.	RMHP RAE and Prime must update the delegated credentialing agreements that do not include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.

Standard IX—Subcontractual Relationships and Delegation—Both RAE and Prime		
Requirement	**Findings**	**Required Action**
of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: Exhibit B1—2.3		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix 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 site 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 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 site reviewers to ensure consistency in scoring across RAEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided RAEs with proposed site review dates, group technical assistance and training, as needed. • HSAG confirmed a primary RAE contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site review, HSAG notified the RAE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and site review activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the desk review and site review consisted of the completed desk review form, the compliance monitoring tool with the RAE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The RAE also submitted a list of all provider credentialing records and all provider recredentialing records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). The RAE submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review.

For this step,	HSAG completed the following activities:
	HSAG notified the RAE five days following receipt of the lists of records regarding the sample records selected. • The HSAG review team reviewed all documentation submitted prior to the site review and prepared a request for further documentation and an interview guide to use during the site review.
Activity 3:	**Conduct RAE Site Review**
	• During the site review, HSAG met with groups of the RAE's key staff members to obtain a complete picture of the RAE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the site review, HSAG provided RAE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2020–2021 Department-approved Site Review Report Template to compile the findings and incorporate information from the pre-site review and site 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 Site Review Report to the RAE and the Department for review and comment. • HSAG incorporated the RAE 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 RAE and the Department.

COLORADO

Department of Health Care Policy & Financing

Appendix F:

Fiscal Year 2020–2021 Site Review Report

for

Rocky Mountain Health Plans

Prime

June 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

Appendxi F: Table of Contents

1. Executive Summary

Introduction

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

This report documents results of the fiscal year (FY) 2020–2021 site review activities for the **RMHP** Region 1 limited managed care initiative—**RMHP Prime**. For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix F1 contains the compliance monitoring tool for the review of the MCO standards.

Summary of Compliance Results

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

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

Table 1-1—Summary of MCO Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	* Score (% of Met Elements)
VII. Provider Participation and Program Integrity	16	16	15	1	0	NA	94%
VIII. Credentialing and Recredentialing	32	32	32	0	0	NA	100%
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
X. Quality Assessment and Performance Improvement	17	17	17	0	0	0	100%
Totals	**69**	**69**	**67**	**2**	**0**	**0**	**97%**

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

Table 1-2 presents the scores for **RMHP RAE** and **RMHP Prime** combined for the credentialing and recredentialing 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)
Credentialing	100	88	88	0	12	100%
Recredentialing	90	78	78	0	12	100%
Totals	**190**	**166**	**166**	**0**	**24**	**100%**

*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 VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

RMHP Prime described a provider network that supported payment models across multiple lines of business. Staff members noted the approach was not "off the shelf" but instead identified service gaps and rewarded high performance providers through a variety of reimbursement strategies and ultimately responded to the unique needs of its members to create choices within **RMHP Prime**'s Medicaid system. Staff members also cited an "any willing provider" and grassroots approach to outreach, which included attending a variety of local community meetings and events to spread the word about **RMHP Prime** and reduce the stigma about Medicaid through "myth busting" informational sessions that outlined the contracting process. However, with a well-established network across a geographically diverse landscape, ongoing outreach needs were fairly minimal. In-person efforts were further reduced by the coronavirus disease 2019 (COVID-19) changes throughout calendar year (CY) 2020. Toward the end of CY 2020, substance use disorder (SUD) providers were the focus of provider contract efforts, specifically for residential, intensive outpatient, step-down, and telehealth services to support the SUD expansion benefit. Staff members also noted efforts to support Grand County, which was heavily impacted due to fires. Single case agreements were reportedly used when necessary.

Internally, the Network Advisory Committee included participants from network management, quality improvement (QI), and other departments and reviewed network adequacy and provider-related reports to monitor overall performance. The software system Facets contained provider configuration information and the Maces software system managed workflow details and captured credentialing information. While credentialing, provider contracting, provider relations, and provider administration were all rolled up through the provider network management department, **RMHP Prime** also operated an independent internal audit department for added oversight and monitoring.

RMHP Prime did not have any moral or religious objections to covered services. Providers with any objections, or members experiencing a provider who would not provide specific services, were directed to contact **RMHP Prime**.

The compliance policies, procedures, and supporting documents submitted demonstrated a robust program integrity system, which was aligned with federal and State regulations. The UnitedHealthcare (UHC) compliance committee included the chief financial officer, chief medical officer (CMO), chief operating officer, clinical services management, and other executives. Participants of this committee reviewed risk assessments and assigned priorities based on compliance and/or business risks. Additionally, a compliance scorecard was generated by UHC. Staff members reported there were minor billing errors noted as trends in CY 2020. Other trends were identified through the utilization management (UM) department. Additionally, the *Member Verification of Services* procedure included claims reports, confidence interval methodology, and sampled both adults and children.

Summary of Findings Resulting in Opportunities for Improvement

The compliance program documents described a robust approach to the establishment of policies and procedures to comply with federal, State, and contract requirements, including the appointment of a compliance officer, compliance committee, and oversight by the chief executive officer and board of directors. Training and education were clearly detailed for staff members and additional specialized trainings were produced for management and supported by an online platform, LearnSource. However, **RMHP Prime** did not supply additional evidence of training and education specific to the compliance officer or compliance leadership. HSAG recommends further detailing credentialing leadership expectations (i.e., credentials, continuing education) within compliance program documents.

Summary of Required Actions

The *Professional Services Agreement*, *Physicians Medical Services Agreement*, and *BH Provider Manual* all provided accurate information regarding member liability for covered services. However, in the provider manual, the information regarding member liability was included under a heading titled "Cost Sharing" with the subheading "RMHP Prime Members" that was not entirely accurate for Prime members. The paragraph included a citation (Colorado Revised Statutes [CRS] 25.5-4-301[1]), which was not entirely accurate in regard to all PH services as there are some instances in which members are required to pay a copay and/or prescription costs. **RMHP Prime** must update the member liability language in the provider manual to accurately address the various lines of business that may have variations in copay and liabilities. HSAG recommends using 42 CFR 438.106 language as a basis, with additional consideration to the individual contract language.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

RMHP Prime compiled a thorough submission which included sample templates, reports, delegate agreements, and corrective action plans (CAPs). The *Credentialing Criteria and Process* document and other credentialing documents followed National Committee for Quality Assurance (NCQA) criteria and included verification of license, certification, hospital clinical privileges, drug enforcement agency or controlled dangerous substance certifications (where applicable, training/board certification), professional liability insurance, malpractice, work history, sanction status, and ability to perform job functions. Procedures were clearly outlined in terms of file management, file review, and notification to the providers.

Staff members highlighted timely turnaround procedures to fast-track providers where gaps in the network may exist, specifically PCPs. Timeliness efforts were further improved through increased focus around communicating with providers throughout the application process, which ensured any small details a provider may have inaccurately entered were easily resolved. Provider rights were clearly stated on the application document as well as the **RMHP Prime** website.

RMHP Prime described a three-tiered category system for review, which included clean files in category one, files with minor issues in category two, and files with significant issues in category three. The CMO or associate CMOs would review the full file if any category two or three issues were identified. The Medical Practice Review Committee also participated in reviewing files and was attended by a variety of specialists. Staff members reported it was common for reviewers to seek additional information prior to making a final decision. Practitioners were notified in a reasonable time frame regarding approval or denial, including details regarding appeal rights if denied.

Based on a review of initial and recredentialing files for individual providers, **RMHP Prime** met 100 percent compliance with all required elements. Additional record review for organizational providers showed that, while **RMHP Prime** did not always adhere to the internal goal of reviewing every two years, files were reviewed within the NCQA three-year standard, with one exception due to a COVID-19 delay, which prevented a timely site visit.

Summary of Findings Resulting in Opportunities for Improvement

While NCQA does not state specific criteria regarding credentialing file management in terms of years, HSAG noted that **RMHP Prime**'s files were kept for seven years. HSAG recommends that **RMHP Prime** align file storage guidelines to be aligned with the 10-year standard (i.e., contract citations 17.10.8.2 and 17.10.9.2).

Summary of Required Actions

HSAG did not identify any opportunities for improvement that resulted in required actions.

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

RMHP Prime maintained a set of policies that described the mechanisms in place for delegation and oversight of delegated activities. **RMHP Prime** completed predelegation assessments for potential delegate organizations and presented the results to the **RMHP Prime** Medical Advisory Committee. **RMHP Prime** provided a comprehensive set of documents that reflected ongoing reporting and oversight activities, which included annual credentialing delegation audit reports. Oversight was provided by the department associated with delegated function, and delegation activities were described in a delegation policy for each functional area. Most delegated activities were related to credentialing and recredentialing; other delegated functions included pharmacy benefit management, behavioral health services, and UM.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

While many of the **RMHP Prime** subcontracts included language to grant the United States Department of Health and Human Services Office of Inspector General (HHS-OIG), Comptroller General, or other designees the right to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years, some of the delegated credentialing agreements failed to include this information and the other specific language used in the federal rule. **RMHP Prime** must update the delegated credentialing agreements that do not include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

RMHP Prime's QI program included an in-depth work plan that contained a list of goals, specific objectives, and a comprehensive mechanism for assessment. The *CY 2019 Annual Evaluation/Quality Assessment* document was very thorough, with a summary of each topic with associated data analysis, and reflected successes, ongoing opportunities, and identified barriers. Information was presented in various formats that ranged from high-level summaries, to tables, graphs, and detailed procedural steps. The *CY 2019 Annual Evaluation/Quality Assessment* contained a graphic of the QI program structure and operation activities that reflected the various councils and committees that functioned within the QI Committee framework. These included the Population Health Management Committee and member, network provider, medical, data and operations councils.

RMHP Prime also produced an *RMHP Annual Evaluation Quality Assessment* report, which contained an informative executive summary and overview of key topics. The QI work plan included barrier analysis and goal setting, which was followed by targeted intervention, and the QI work plan outlined the frequency of monitoring and review of data, performance, and successes.

One of **RMHP Prime**'s priority initiatives over the past year was the meaningful engagement of stakeholders for **RMHP Prime**'s advisory councils. Dashboards summarizing performance on key metrics were well-received by stakeholders over the past year and have been a focal point in community and stakeholder meetings.

In CY 2020, **RMHP Prime** reported 255 quality of care concerns (QOCs) were tracked. While the term "QOC Grievance" was mentioned in procedures, grievances and QOCs were in fact separated and QOCs were addressed through the quality team with a higher degree of clinical oversight, while grievances not involving possible clinical issues were pursued by the member services team.

Member perception of accessibility and adequacy of services were surveyed through traditional means, and **RMHP Prime** implemented an additional randomized survey through which members were outreached telephonically and asked a net promoter score question. **RMHP Prime** conducted the adult and child Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-1] surveys for Prime members.

RMHP Prime adopted clinical practice guidelines (CPGs) based on nationally recognized standards that included the American Academy of Obstetrics, Gynecology or Pediatrics, and other guidelines as approved by the CMO, associate directors, and Medical Advisory Committee. The Member Experience Advisory Council (MEAC) also reviewed the CPGs. The CPGs informed UM practices, care management, and member education materials. Members were informed about CPGs through the member handbook, targeted member educational materials aligned with CPGs, and also through newsletters until discontinued due to COVID-19. Medical chart audits were conducted for Prime members as an additional measure of oversight.

RMHP Prime monitored both over- and underutilization, with a specific focus on care gaps to identify underutilization within the population. To address gaps in care, **RMHP Prime** used the program ELIZA to text appointment and other reminders to members. Prompts and gift cards were used in some circumstances to encourage attendance at medical appointments. Additionally, members with special health care needs (SHCN) were monitored through regular reporting and the Complex Care Management Program, which provided comprehensive coordination for members across a continuum of settings, including referrals to specialists and community programs.

RMHP Prime implemented a performance improvement project (PIP) for Prime members during FY 2019–2020: *Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older*. While the intervention was selected and initiated, the PIP was discontinued early due to COVID-19, and full evaluation of the PIP was incomplete. Initial data indicated a positive trend in performance prior to discontinuation of the PIP.

Member disenrollment data for reasons other than loss of eligibility were monitored through monthly files and reviewed through the reconciliation process. **RMHP Prime** proactively analyzed member satisfaction data to assess potential causes of voluntary enrollment terminations and engaged the MEAC to evaluate disenrollment findings and satisfaction trends.

RMHP Prime submitted a visual map of the health information operating system architecture that displayed integrated Department data, primary care and behavioral health claims, health information exchange information, and the community center analytics system interface. All these data sources were imported to **RMHP Prime**'s systems (Facets, care coordination tools, and other portals and data hubs) and demonstrated the ability to maintain, analyze, and report on key data elements.

The *Medicaid CHP+ Claim Encounter Data Submission* policy detailed a Health Insurance Portability and Accountability Act (HIPAA)-compliant process to generate and submit 837 files using the Facets

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

and NextGen platforms. **RMHP Prime** described the Department acknowledgement report and how it is uploaded to NextGen to perform a variety of data analytic validation and summary functions. The *PCP Practice Monthly Report* demonstrated a usable summary, which informed **RMHP Prime** of member details, including both attribution rates and "assigned but unattributed" details. The summary sheet included total patients, risk adjustment information, and total cost of care. While **RMHP Prime** only recently updated the *Medicaid CHP+ Claim Encounter Data Submission* policy to include the timeline of submitting encounter data to the State within 120 days of the adjudicated claim, **RMHP Prime** described adhering to this timeline in practice during CY 2020 through weekly and monthly procedures, which were in alignment with regulations.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard VII—Provider Participation and Performance Improvement; Standard VIII—Credentialing and Recredentialing; Standard IX—Subcontractual Relationships and Delegation; and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated for the limited managed care initiative (MCO) through review of all four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE managed care initiative contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. 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, 2020, through December 31, 2020. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key MCO personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and site 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 credentialing and recredentialing of providers. While the RAE and MCO managed care requirements were reviewed simultaneously, HSAG delineated results for each product line into individual separate reports. However, required corrective actions for the MCO are the responsibility of the RAE and are incorporated into Appendix D of the RAE Region 1 report.

HSAG reviewed a sample of the RAE and MCO administrative records related to both credentialing and recredentialing to evaluate implementation of applicable 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 six records (to the extent that a sufficient number existed) for each of credentialing and recredentialing. For health plans that were contracted by the Department for administration of both the RAE and MCO for the RAE region, HSAG included five records from each of the RAE and the MCO for a total of 10 records applicable to both the RAE and the MCO. Using a random sampling technique, HSAG selected the samples from all RAE BH and Prime PH credentialing records, and all RAE BH and Prime PH recredentialing records that occurred between January 1, 2020, and December 31, 2020. For the record review, the health plan received a score of M (*Met*), NM (*Not Met*), or NA (*Not Applicable*) for each required element. HSAG separately calculated a record review score for

each record review requirement and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing.

The site review processes were consistent with *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

Objective of the Site Review

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

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

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

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP Prime** until it completed each of the required actions from the FY 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VI—Grievances and Appeals. There were no required actions related to access and availability.

Related to coverage and authorization of services, **RMHP Prime** was required to complete three corrective actions, including:

- Correct UM policies to address the 10-calendar-day time frame for standard authorization decisions.
- Correct UM policies to address 14-calendar-day extensions for both standard and expedited authorization decisions.
- Ensure notices of adverse benefit determination are written in a manner that is easy for a member to understand (i.e., at or below the sixth grade reading level).

Related to Standard VI—Grievances and Appeals, **RMHP Prime** was required to complete five required actions:

- Develop a mechanism to ensure grievances regarding treatment are reviewed by someone with clinical expertise.
- Ensure each grievance is thoroughly addressed.
- Communicate the appeal resolution and reason for the decision in member-friendly language.
- Update policies to accurately reflect continuation of benefits information (two required actions).

Summary of Corrective Action/Document Review

RMHP Prime submitted a proposed CAP in June 2020. HSAG and the Department reviewed and approved the proposed interventions. **RMHP Prime** submitted initial documents as evidence of completion in September 2020 and all required interventions were approved as complete.

Summary of Continued Required Actions

RMHP Prime successfully completed the FY 2019–2020 CAP, resulting in no continued corrective action.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* RAE Contract Amendment #4: Exhibit B-4—9.1.6 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.7	**Prime:** *VII_PNM_CR.01.20 Credentialing Criteria and Process* This P&P defines a consistent credentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for credentialing of its providers. *VII_PNM_RC.01.20 Recredentialing Process* This policy defines a consistent recredentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for recredentialing of its providers. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor ensures that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* RAE Contract Amendment #4: Exhibit B-4—9.3.4.2.1; 9.3.5 Prime MCO Contract Amendment #4: Exhibit M-4—9.2.4	For RAE—applies only to BH providers For Prime—applies only to PH providers **Prime:** *VII_PNM_CR.01.20 Credentialing Criteria and Process* The Contractor complies with NCQA standards and guidelines for credentialing and recredentialing its providers. *VII_PNM_HDO.01.20 Health Delivery Organizations* Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA)	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. **RAE-specific:** N/A **Prime-specific:** N/A	
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.1-2 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.7.1-2	**Prime:** *VII_PNM_CR.14.20 Non Discriminatory Credentialing* This policy describes the process used to monitor for and prevent against discriminatory credentialing practices. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* RAE Contract Amendment #4: Exhibit B-4—9.1.6.4 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.7.3	**Prime:** *VII_PNM_CR.01.20 Credentialing Criteria and Process* Pg. 11 Section D Final Decision and Notifications: This section explains the notification procedure for practitioners applying to the RMHP panel and being denied. *VII_PNM_RC.01.20 Recredentialing Process* Pg. 11, Section E. Final Decision and Notification: This section sets forth the notification procedure for practitioners applying to the RMHP panel. *VII_PNM_RC.04.20 MPRC - Reduction, Suspension or Termination* Pages 2-5, Section 1. This policy outlines the process for notifying a provider of the reduction, suspension or termination of a health care provider's contracting status. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* RAE Contract Amendment #4: Exhibit B-4—9.1.13 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.15	**Prime:** *VII_PNM_Professional Services Agreement* Page, 6 Paragraph HH, "Professional Health Care Services" provides the term "Health Care Professional" who is legally authorized to provide services under Colorado law and under their licensure and or certification. This agreement is used for all behavioral health providers.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_PNM._Physicians Medical Services Agreement Page 4, Paragraph GG, "Participating Physician" Provides that the term "participating physician" means a person who holds a degree of Doctor of Medicine or Doctor of Osteopathy, is licensed by the State of Colorado to practice medicine, has a written agreement directly with RMHP. **RAE-specific:** N/A **Prime-specific:** *VII_PNM_Hospital Services Agreement* Page 4, Paragraph V, "Hospital Services" defines those services which are provided at a Hospital Facility.	
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* RAE Contract Amendment #4: Exhibit B-4—9.1.15, 17.9.4.2.5, 17.10.5.1-2 Prime MCO Contract Amendment #4: Exhibit M-4—9.1.17, 17.9.4.1	**Prime:** *VII_PNM_CR.01.20 Credentialing Criteria and Process* This policy defines the credentialing process for Practitioners applying to the RMHP panel. Pg. 7: If a provider is on the OIG's list of debarred providers, credentialing/contracting will not be initiated. Pg. 8: RMHP's credentialing verification sources include License Sanction Status (#8), and Medicare/Medicaid Sanction Status (#9). *VII_PNM_ PNM-016 Initial Credentialing and Provider Notification of Request Process* Pages 2-3, Section C, Provides that before credentialing	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	can begin, SAM, OFAC and OIG websites must be checked to ensure provider is not excluded from participation in federal healthcare programs. *VII_PNM_CR.05.20 National Practitioner Databank* Page 1, under "Policy," Describes RMHP's process for accessing the NPDB for all new practitioners and all currently contracted practitioners. This serves as primary source verification of sanctions against or limitations on licensure, sanction activity by Medicare and Medicaid, and malpractice history. *VII_Compliance_New Hire and Periodic Employee Sanction Review Policy* This policy describes the process for ensuring that RMHP does not hire, continue to employ or contract with ineligible persons. *VII_Compliance_Prohibition Against Contracting With Any Person Policy* This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* RAE Contract Amendment #4: Exhibit B-4—17.9.4.2.1-4 Prime MCO Contract Amendment #4: Exhibit M-4—17.9.4.2.1-4	**Prime:** *VII_Compliance_New Hire and Periodic Employee Sanction Review Policy* This policy describes the process for ensuring that RMHP does not hire, continue to employ or contract with ineligible persons. *VII_ Compliance_Economic Sanctions and Sanctions Monitoring Policy* Page 2, Section "General," demonstrates that RMHP is prohibited from engaging in activities with, provide goods, insurance or services or employ or contract with individuals or entities prohibited by law. *VII_Compliance_Prohibition Against Contracting With Any Person Policy* This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered.	**Prime:** *VII_PNM._Physicians Medical Services Agreement* Page, 13, Paragraph U, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation, and that RMHP has a	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* RAE Contract Amendment #4: Exhibit B-4—14.7.3 Prime MCO Contract Amendment #4: Exhibit M-4—14.5.2	process for submitting grievances and appeals for Members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with Members and will not penalize providers for such discussions. Page, 13, Paragraph V, "Medicaid Recipients Right to Participation" RMHP recognizes the Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. Page 23, Paragraph G, " Limitations on Adverse Actions" RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with the Member whether covered by the health plan or not. *VII_PNM_Professional Services Agreement* Pages 12-13 Paragraph Q, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with Members and will not penalize providers for such discussions. *VII_PNM_Hospital Services Agreement* Page 16, Paragraph W, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with Members and will not penalize providers for such discussions. Page 16, Paragraph X, "Medicaid Recipients Right to Participation" RMHP recognizes the Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. Page, 26, Paragraph G, "Limitations on Adverse Actions"	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with Member whether covered by the health plan or not. *2020 Provider Manual* Pg. 13 Affirmative Statement RMHP encourages open communication between providers and Members in discussing appropriate treatment alternatives for medically necessary health care services, including medication treatment options, regardless of benefit coverage limitations. Contracted providers are not prohibited or discouraged from protesting or expressing disagreement with a medical decision, medical policy, or medical practice, including, without limitation, medication treatment options, made by RMHP or an entity representing or working for RMHP (e.g., a utilization review company). **RAE-specific:** N/A **Prime-specific:** N/A	
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment.	**Prime:** NOTE: RMHP does not have objections to providing services on moral or religious grounds; therefore this requirement is not applicable. **RAE-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• To members 30 days prior to adopting the policy with respect to any particular service. *42 CFR 438.102(b)* RAE Contract Amendment #4: Exhibit B-4—7.3.6.1.13-14, 14.4.7 Prime MCO Contract Amendment #4: Exhibit M-4—7.1.6.1.13-14	**Prime-specific:** N/A	
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and reports directly to the CEO and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines.	**Prime:** **Bullet 1 -** *VII_Compliance_Compliance Program Document* Page 1, Introduction: Explains that the UHG/RMHP Program Promotes compliance with applicable legal requirements, fosters ethical conduct with the company, and provides guidance to its employees and contractors. Page 1, Introduction: Articulates that as part of the UHG/RMHP Program, the company has adopted a Code of Conduct, which is a guide to acceptable and appropriate business conduct by the company's employees and contractors. Page 3: Key Elements of Compliance/Written Standards, Policies and Procedures: Explains that compliance policies and procedures are posted and accessible online to employees. **Bullet 2 –** *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 1: Compliance Plan and Program Integrity	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* RAE Contract Amendment #4: Exhibit B-4—17.1.3, 17.1.5.1-7 Prime MCO Contract Amendment #4: Exhibit M-4—17.1.3, 17.1.5.1-7	Infrastructure: Notes the designation of an RMHP compliance officer who reports directly to the CEO and Board of Directors; the compliance officer is responsible for developing and implementing policies and procedures designed to ensure compliance with RMHP's contractual obligations. **Bullet 3 –** *VII_Compliance_Compliance Program Document* Page 4: Compliance Committee Structure Describes the Compliance Committee structure. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 1: Key Preventive Structures and Processes/bullet 1, Provides information regarding program governance, including a regulatory compliance oversight committee. **Bullet 4 –** *VII_Compliance_Compliance Program Document* Page 4: Effective Training and Education Describes the annual company training and education requirements for all employees, which includes the Compliance Officer, management, and staff as well as vendors. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 1: Key Prevention Structures and Processes/bullet 3, Discusses training and education topics, training processes and record retention.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet 5 – *VII_Compliance_Compliance Program Document* Pages 5-6: Effective Lines of Communication Explains the various reporting mechanisms and communication mechanisms utilized to achieve effective communication to implement a successful compliance program. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 1: Key Preventive Structures and Processes/bullet 4, Describes communication mechanisms available to employees, Members and others to report issues and concerns to the RMHP Compliance Officer. **Bullet 6 –** *VII_Compliance_Compliance Program Document* Page 7: Enforcement and Disciplinary Guidelines Provides company expectations regarding compliance with laws, regulations and policies; it also notes that the enforcement and disciplinary guides are publicized in the code of conduct (the "Code"). *VII_Compliance_UHC-Code-of-Conduct* Page 4: About the Code of Conduct/Violations of the Code of Conduct and Policies This section explains that violations may result in discipline, up to and including termination and possible legal action, including referral to law enforcement.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet 7 - *VII_Compliance_Compliance Program Document* Page 7, Auditing and Monitoring This section describes RMHP's procedures and system for routine internal monitoring and auditing of compliance risks. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 2: Key Detection Structures and Processes Describes elements of compliance auditing and monitoring. *VII_PM&A-211 FWA Policy and Procedure Hotline Monitoring* Describes the process for daily monitoring of internally and externally reported compliance issues. **Bullet 8 -** *VII_Compliance_Compliance Program Document* Page 8: Responding to Identified Issues Describes internal coordination to respond promptly to suspected misconduct and to ensure appropriate corrective action and reporting. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 2: Key Correction Structures and Processes Describes the program's commitment to prompt	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	response to identified issues and credible allegations and effective corrective action plans. *VII PM&A-203_Medicaid FWA Deterrence & Reporting* Pages 3-4, Section 6, describes the procedure for prompt response to compliance issues as they are raised, including identification of referral, preliminary review, conducting the review, reporting internally and reporting to Regulatory Agencies. **RAE-specific:** N/A **Prime-specific:** N/A	
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12). *42 CFR 438.608(a)(6-8)* RAE Contract Amendment 4: Exhibit B-4—17.1.6, 17.1.5.9, 17.7.1, 17.5.1	**Prime:** **Bullet 1 -** *VII_Compliance_Control FWA Policy* Provides high-level depiction of how RMHP/UHC follow identified guidelines. *VII_Compliance_False Claims Act Compliance Policy RMHP 2020* Provides information regarding fraud, waste and abuse as it relates to the False Claims Act. Page 3, Whistleblower and Whistleblower Protections, describes the prohibition of retaliation when an employee provides any truthful information to a law enforcement officer that is related to any possible federal offense.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Prime MCO Contract Amendment #4: Exhibit M-4—17.1.5.9, 17.1.6, 17.7.1, 17.5.1	**Bullet 2 -** *VII_PM&A-210_ Process for Monitoring, Investigating and Reporting Fraud, Waste and Abuse* Page 2, Section 2 – Reporting, A. and B. describes the process for prompt referral of any potential fraud to State Regulatory Agencies. **Bullet 3 -** *VII PM&A-203_Medicaid FWA Deterrence & Reporting* Page 3, Section 6 Paragraph B, describes the process for suspension of payments for which the State determines any credible allegation of potential fraud. **RAE-specific:** N/A **Prime-specific:** N/A	
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor.	**Prime:** **Bullet 1 -** *VII_PM&A-210_ Process for Monitoring, Investigating and Reporting Fraud, Waste and Abuse* Page 2, Section 2 – Reporting, A. and B. describes the process for prompt referral of any potential fraud to State Regulatory Agencies. **Bullet 2 -** *VII_MEB-PP Notice to State_Enrollee Circumstance Change* This policy and procedure outlines the steps RMHP	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.7.2-5, 17.1.5.7.1, 17.1.5.7.6, 17.3.1.3.2.1, 17.3.1.1.2.3-4, 17.3.1.3.1.1 Prime MCO Contract Amendment #4: Exhibit M-4—17.1.5.6, 17.1.5.8.1.2, 17.1.5.7.1, 17.1.5.7.5, 17.3.1.3.1.1, 17.3.1.3.2.1, 17.3.1.1.2.3-4	takes to notify the State when there is a change in a Member's circumstance which may affect the Member's eligibility. **Bullet 3 -** *VII_CI_Monthly FWA_Provider Term Notification Template* This document is produced monthly and sent to the Department to report FWA activity as well as overpayment recoveries and Provider Termination from the RMHP network. *(This is an example of the template used monthly)* *Note: Actual monthly report will be available on site as it contains PHI.* *VII_CI_Monthly FWA_Provider Term Notification Dec 2020* Email example of notification to the Department of FWA, overpayment recoveries, and provider term notification. **Bullet 4 -** *VII_PM&A-215_Member Verification of Services Process* This document describes the process of verifying services delivered by network providers were received by Members.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
13. The Contractor ensures that all network providers are enrolled with the State as Medicaid providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty days (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty days (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608(b)* RAE Contract Amendment #4: Exhibit B-4—9.2.1.1, 9.3.2, 17.9.2 Prime MCO Contract Amendment #4: Exhibit M-4—17.9.2, 9.2.8.1.1	**Prime:** *VII_PNM_LAW EXHIBIT-Provider* Page 11, Paragraph 8 states that Contractor shall be enrolled with the State of Colorado in accordance with the disclosure, screening, and enrollment requirements of the State of Colorado for Medicaid and CHP+ providers. *VII_PNM_PNM-016 Initial Credentialing and Provider Notification of Request Process* Page 3, Section D (last bullet): RMHP credentialing department validates the providers State Medicaid ID number. If the provider has a valid Medicaid number a CP (Common Practitioner) will be created. If not, the request is returned to the PR Rep who notifies the applicant that a valid Medicaid ID number is required prior to the initiation of credentialing. *VII_PNM_Physicians Medical Services Agreement* Page 8, Paragraph F, "Enrollment Requirements" If the contractor serves Health First Colorado (Colorado Medicaid) or CHP+ Members, then the provider must be enrolled with Health First Colorado consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR Part 455, Subparts B and E and requirements of the State of Colorado. The provider	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	must include in its RMHP enrollment application its Medicaid Identification number and the date of Health First Colorado enrollment or most recent validation. **RAE-specific:** N/A **Prime-specific:** *VII_PNM_RAE_Prime Addendum 2020* This is an addendum to the PCMP contract that is executed by all Prime PCPs. Page 3, Paragraph F Enrollment Requirements, states that provider will be enrolled with State of Colorado in accordance with the disclosure, screening, and enrollment requirements of 42 CFR Part 455, Subparts B and E and the requirements of the State of Colorado for Medicaid and CHP+ providers.	
14. The Contractor has procedures to provide to the State: • Written discosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* RAE Contract Amendment #4: Exhibit B-4—17.3.1.5.1.1, 17.9.4.3, 17.10.2.1	**Prime:** *VII_Compliance_Prohibited Affiliations PP* This policy states that RMHP will disclose to Colorado's Department of Health Care Policy and Finance ("HCPF") any relationship RMHMO has with an individual who is debarred, suspended or otherwise excluded from participating in a federal or state health care program. *VII_Compliance_Prohibition Against Contracting With Any Person Policy*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Prime MCO Contract Amendment #4: Exhibit M-4—17.3.1.5.1.1, 17.9.4.3, 17.10.2.1	This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons. *VII_Compliance_Ownership & Control PP* This policy indicates that RMHP will disclose to HCPF information on ownership and control in a form acceptable to HCPF, and delineates what the disclosures will include. *VII_PRGREC_Reporting Overpayments to State* This describes the procedure to identify and report within 60 calendar days any capitation or other payments in excess of the amounts specified in the contract. **RAE-specific:** N/A **Prime-specific:** N/A	
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments. *42 CFR 438.608 (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—17.1.5.8, 17.3.1.2.4.4 Prime MCO Contract Amendment #4: Exhibit M-4—17.1.5.8, 17.3.1.2.4.4	**Prime:** *VII_PM&A-210_ Process for Monitoring, Investigating and Reporting Fraud, Waste and Abuse* Page 2, Section 2- Reporting, Paragraph C describes the process to report semi-annually to the State on recoveries of overpayments. *2020 Provider Manual* Page 49, Refunding Rocky Mountain Health Plans: Instructions are given to providers for reporting overpayments no later than 60 days after the overpayment is identified. Providers are instructed to	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	include a written statement of the reason for the overpayment. **RAE-specific:** N/A **Prime-specific:** N/A	
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* RAE Contract Amendment #4: Exhibit B-4—14.14.1-2, 17.14.2-4 Prime MCO Contract Amendment #4: Exhibit M-4—17.14.2.4, 14.12.1-2	**Prime:** *VII_PNM_Physicians Medical Services Agreement* Page 12, Paragraph S, No Recourse Against Medicaid Recipients, sections (1), (2), (3): Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. *VII_PNM_Professional Services Agreement* Page 12, Paragraph O, No Recourse Against Medicaid Recipients, sections (1), (2), and (3): Provider contracts state that Members are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_PNM_Hospital Services Agreement Page, 15 Paragraph U No Recourse Against Medicaid Recipients, sections (1), (2), and (3): Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. **RAE-specific:** N/A **Prime-specific:** N/A *2020 Provider Manual* Pg. 36 Cost Share Collection RMHP Prime Members: The Member may not be balance billed for any costs not covered by either RMHP or the State.	
Findings: The *Professional Services Agreement*, *Physicians Medical Services Agreement*, and *BH Provider Manual* all provided accurate information regarding member liability for covered services. However, in the provider manual, the information regarding member liability was included under a heading titled "Cost Sharing" with the subheading "RMHP Prime Members" that was not entirely accurate for Prime members. The paragraph included a citation (CRS 25.5-4-301[1]), which was not entirely accurate in regard to all PH services as there are some instances in which members are required to pay a copay and/or prescription costs.		
Required Actions: RMHP Prime must update the member liability language in the provider manual to accurately address the various lines of business that may have variations in copay and liabilities. HSAG recommends using 42 CFR 438.106 language as a basis, with additional consideration to the individual contract language.		

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	94%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and re-credentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 RAE Contract Amendment #4: Exhibit B-4- 9.3.4.2.1 Prime MCO Contract Amendment #4: Exhibit M-4—9.2.4	**Prime:** Note: These are NCQA MBHO and NCQA HP requirements available at the time of drafting this tool (6/2020). **Prime:** *VIII_PNM_Credentialing Criteria and Process* *VIII_PNM_Recredentialing Process* These two documents define RMHP's credentialing and recredentialing processes for evaluating and selecting licensed independent practitioners to provide care to our Members. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.*	**RAE:** *VIII_PNM_Credentialing Criteria and Process* Section B, tables on pages 3-5 outline the types of practitioners *VIII_PNM_Recredentialing Process* Section C, tables on pages 3-5 outline the types of practitioners **RAE-specific:** N/A **Prime-specific:** N/A	**RAE** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Examples of HP practitioners include medical doctors, chiropractors, osteopaths, podiatrists, NPs, etc. *42 CFR 438.214(a)* NCQA CR1—Element A1		
2.B. The verification sources it uses. NCQA CR1—Element A2	**Prime:** *VIII_PNM_Credentialing Criteria and Process* Section B, pages 7-9 *VIII_PNM_Recredentialing Process* Section C, pages 8-9 These sections (Source Verification) outline the sources used to verify practitioner credentials (approved credentialing verification sources). **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Prime:** *VIII_PNM_Credentialing Criteria and Process* Sections A-B, pages 2-6 *VIII_PNM_Recredentialing Process* Section A-C, pages 2-6 These sections outline the criteria used for credentialing and recredentialing.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Prime:** *VIII_PNM_Recredentialing Process* Pages 9-11, Sections D-E, "Review and Determination, Final Decision and Notifications" *VIII_PNM_Initial Credentialing Workflow 2020* *VIII_PNM_Recredentialing Workflow 2020* These sections, and the workflow diagrams describe RMHP's process for making credentialing and recredentialing decisions. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Prime:** *VIII_PNM_Credentialing Criteria and Process* Pages 9-10, Section C, Review and Determination *VIII_PNM_Recredentialing Process* Pages 9-11 Section D, Review and Determination These sections describe the process for managing credentialing and recredentialing files according to RMHP's criteria. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	**Prime:** *VIII_PNM_Nondiscriminatory Credentialing* This policy establishes the steps that RMHP takes during credentialing processes to monitor and prevent discriminatory practices. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	**Prime:** *VIII_PNM_Credentialing Criteria and Process* Page, 7, Section B, "Source Verification," Paragraph 3 *VIII_PNM_Recredentialing Process* Page 8, Section C, "Source Verification," Paragraph 4 These sections provide the process that RMHP follows for notifying practitioners if information obtained from sources varies substantially from that provided on the application. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	**Prime:** *VIII_PNM_Credentialing Criteria and Process* Page 11, Section D, "Final Decision and Notifications" *VIII_PNM_Recredentialing Process* Page 11, Section E, "Final Decision and Notifications" These sections indicate when a determination has been made by Medical Direction or the Medical Practice Review Committee (MPRC), the practitioner are notified of accepted status via letter from the Professional Relations Representative within 60 days. Practitioners are notified of denial via letter from Chief Medical Officer within 20 days. *VIII_PR_Initial Credentialing Process PNM016* Page 1, "Policy" section and Page 3, "Approved Credentialing", Paragraph A, bullet 5, indicates that approval notification is sent to providers and groups within 30 days. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	**Prime:** *VIII_PNM_Credentialing Criteria and Process* See Policy on Page 1 *VIII_PNM_Recredentialing Process* See Policy on Page 1 This paragraph indicates that the RMHMO Board of Directors (BOD) has delegated the responsibility for the credentialing function, review and approval authority for the credentialing policies and procedures and determination as to panel acceptance to the RMHP Chief Medical Officer, and that any Associate Medical Directors may cover for the RMHP Chief Medical Officer for credentialing purposes. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	**Prime:** *VIII_PNM_Credentialing Criteria and Process* Pages 11-12, Section F, "Records" *VIII_PNM_Recredentialing Process* Pages 11-12, Section G, "Records" These sections delineate the RMHP process for ensuring the confidentiality of information obtained in the credentialing and recredentialing process	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	**Prime:** *VIII_PNM_Practitioner Specialties* This document delineates the process for ensuring that listings in practitioner directories are accurate. *VIII_PR_Physician and Hospital Directory Updates* This policy outlines how RMHP validates physician and hospital information for updates to the printed and web-based directories. *VIII_PR_Provider Relations Validation Letters* This policy describes the quarterly process for evaluating provider directory information by contacting providers and asking them to validate their information. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The contractor is not required to make references, recommendations, and peer-review protected information available.*	**Prime:** *VIII_PNM_Credentialing Criteria and Process* *VIII_PNM_Recredentialing Process* Procedure sections, both on page 6 of these policies, explain that RMHP utilizes the Colorado Health Care Professional Credentials Application (CHCPCA). Through use of this state mandated application, the applicant is informed of their rights:	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR1—Element B1	• To review information submitted to support their credentialing or re-credentialing application. • To correct erroneous information that varies substantially from information provided. • To receive the status of their credentialing or re-credentialing application, upon request. *VIII_PNM_CHCP_Credentials_Application* Page 23, item 12 also explains these rights *VIII_PNM_Screen Shot_Join RMHP Providers* Screen shot of RMHP.org website provides explanation of practitioners' rights related to the provider application **RAE-specific:** N/A **Prime-specific:** N/A	
3.B. To correct erroneous information. NCQA CR1—Element B2	**Prime:** *VIII_PNM_Credentialing Criteria and Process* *VIII_PNM_Recredentialing Process* Procedure sections, both on page 6 of these policies, explain that RMHP utilizes the Colorado Health Care Professional Credentials Application (CHCPCA). Through use of this state mandated application, the applicant is informed of their rights:	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• To review information submitted to support their credentialing or re-credentialing application. • To correct erroneous information that varies substantially from information provided. • To receive the status of their credentialing or re-credentialing application, upon request. *VIII_PNM_CHCP_Credentials_Application* Page 23, item 12 also explains these rights. *VIII_PNM_Screen Shot_Join RMHP Providers* Screen shot of RMHP.org website provides explanation of practitioners' rights related to the provider application. **RAE-specific:** N/A **Prime-specific:** N/A	
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Prime:** *VIII_PNM_Credentialing Criteria and Process* *VIII_PNM_Recredentialing Process* Procedure sections, both on page 6 of these policies, explain that RMHP utilizes the Colorado Health Care Professional Credentials Application (CHCPCA). Through use of this state mandated application, the applicant is informed of their rights:	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• To review information submitted to support their credentialing or re-credentialing application. • To correct erroneous information that varies substantially from information provided. • To receive the status of their credentialing or re-credentialing application, upon request. *VIII_PNM_CHCP_Credentials_Application* Page 23, item 12 also explains these rights. *VIII_PNM_Screen Shot_Join RMHP Providers* Screen shot of RMHP.org website provides explanation of practitioners' rights related to the provider application. **RAE-specific:** N/A **Prime-specific:** N/A	
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	**Prime:** *VIII_PNM_Credentialing Committee* This policy describes the Credentialing committee structure and function. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A	**Prime:** *VIII_QI_MPRC Member List* This Medical Practice Review Committee (MPRC) listing shows the range of specialties participating in each regional credentialing committee. *VIII_PNM_Credentialing Criteria and Process* Pages 9-10, Section C, "Review and Determination" *VIII_PNM_Recredentialing Process* Pages 9-11, Section D, "Review and Determination" These sections describe the various levels of review/response by the Medical Director or credentialing committee based on the status of the applicant's file. *VIII_QI_MPRC Minutes 10-21-2020* This is a sample of the credentialing committee meeting minutes where practitioners who do not meet established thresholds were reviewed. *VIII_PNM_Medical Director Review of Clean Files* This documents how a Medical Director reviews and approves a weekly list of files that meet established criteria. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days.) • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply*	**Prime:** *VIII_PNM_Credentialing Criteria and Process* Pages 7-9, Section B, "Source Verification" *VIII_PNM_Recredentialing Process* Pages 8-9, Section C, "Source Verification" The sections indicate that RMHP verifies all required elements for credentialing and recredentialling within 180 days prior to Medical Direction or credentialing committee review. *VIII_PNM_State Licensing Verification Letters* These are primary source verification letters for training that are collected annually from the State for specific specialties. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member. NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions. NCQA CR3—Element B	**Prime:** *VIII_PNM_Credentialing Criteria and Process* Pages 7-9, Section B, "Source Verification" *VIII_PNM_Recredentialing Process* Pages 8-9, Section C, "Source Verification" These sections outline the process for initial credentialing and recredentialing, including license sanction status (State Board of Medical Examiners, NPDB, HIPDB) and Medicare/Medicaid sanction status (Office of Inspector General Debarment Report). *VIII_PNM_National Practitioner Databank* This policy establishes the written guidelines for accessing the NPDB to verify sanctions, license limitations, and malpractice history for all new applicants and all currently contracted practitioners as part of the recredentialing process. *VIII_PR_Initial Credentialing Process PNM016* This policy describes the process that Provider Relations (PR) Representatives follow to initiate credentialing for prospective practitioners. If a	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	practitioner is found in any of the databases, credentialing is not initiated **RAE-specific:** N/A **Prime-specific:** N/A	
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	**Prime:** *VIII_PNM_Credentialing Criteria and Process* Page 6, "Procedure" *VIII_PNM_Recredentialing Process* Page 6, "Procedure" These pages indicate that RMHP utilizes the Department of Public Health & Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentialing Application. *VIII_PNM_CHCP_Credentials_Application* RMHP utilizes the Department of Public Health and Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentials Application (CHCPCA), or Council for Affordable Quality Healthcare's (CAQH) Universal Provider Database (which also utilizes Colorado's state mandated CHCPCA) • Page 26, Question 3, ability to perform essential functions of the position • Page 25, Question 3, attestation regarding illegal drug use	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Pages 19-20, Paragraphs A-I, attestations regarding loss of license and felony convictions • Page 19-20 Paragraphs A-I, attestation regarding loss or limitation of privileges or disciplinary actions • Page 16, Section X, attestation of current malpractice or professional liability insurance coverage • Page 21, Section XIII, attestation confirming correctness and completeness of the application **RAE-specific:** N/A **Prime-specific:** N/A	
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**Prime:** *VIII_PNM_Recredentialing Process* Page 1, Policy Section, last sentence states that recredentialing will occur at least every three years. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints.	**Prime:** *VIII_PNM_Midcycle Credentialing* Pages 2-3, Sections A-D, explain the RMHP process for reviewing provider status updates related to sanctions or limitations on licensure, adverse events and instances of poor quality.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	*VIII_PNM_Ongoing Monitoring Sample Reports 2020* A sample of a monthly report collected and reviewed for sanctions will be available onsite. *VIII_PNM_Complaints Log* The log of complaints that were collected and reviewed will be available at site review. There were no office site complaints during this review period. *VIII_QI_QA Case Review Diagram* This flowchart illustrates the RMHP Quality Assurance case review process *VIII_QI_MPRC Minutes 10-21-2020* These Medical Practice Review Committee (MPRC) minutes illustrate examples of interventions when instances of poor quality are identified. **RAE-specific:** N/A **Prime-specific:** N/A	
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve*	**Prime:** *VIII_PNM MPRC_ Reduction, Suspension or Termination RC.04* This policy describes the procedures for taking action against a practitioner for quality reasons. Pages 2-4, Section 1.a and Section 1.c. on page 5 describes the formal appeal process offered to the practitioner.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
practitioner performance before termination; reporting actions taken to the appropriate authorities. NCQA CR6—Element A	Page 2, Section 1, describes the range of actions available to RMHP, including mentoring, increased oversight or other proposed professional review action. Page 6, Section 4, indicates that the RMHP Chief Medical Officer shall report any sanction, suspension or termination of a health care provider due to quality of care issues to the state licensing agency, Colorado Board of Medical Examiners (CBME) and NPDB/HIPDB, as applicable. **Bullet 2 -** *VIII_PNM MPRC_ Reduction, Suspension or Termination RC.04* This policy describes the procedures for taking action against a practitioner for quality reasons. Pages 2-4, Section 1.a and Section 1.c. on page 5 describes the formal appeal process offered to the practitioner including the right to request a hearing within 30 days and the right to have an attorney or other person of their choice represent them. Page 5, Section 1.e. describes the process for notifying the practitioner of the decision, including the reasons supporting it. *VIII_QI_Hearing Panel Notice Template* This notice of MPRC Hearing provides details of the Hearing and lists the Hearing panel members.	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_QI_Initial Denial Letter template *VIII_QI_Recredential Denial Letter template* These denial letters provide written notification that a professional review action has been brought against a practitioner, provides reason for the action, and includes appeal process, including the right to be represented by an attorney or another person of their choice, and timeframe for requesting a hearing. When a letter is drafted, Medical Direction and/or Regulatory Affairs staff include specific reason(s) for each case decision as appropriate. **RAE-specific:** N/A **Prime-specific:** N/A	
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm—which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials (e.g., state licensure) from the provider. Attestations are not acceptable.* NCQA CR7—Element A1	**Prime:** *VIII_PNM_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Page 6, Section C, states that each organizational provider with which RMHP contracts will be assessed by the credentialing staff for continued compliance with the Standards for Participation every two (2) years for the duration of the contract. Pages 2-3, Section B, lists the documentation that must be submitted by all organizational providers to demonstrate that they are in good standing with regulatory or accrediting bodies. The accrediting bodies recognized by RMHP are listed in Section C, pages 3-4.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 5, Section D indicates that a non-accredited organization must provide a copy of the State/CMS Survey report, including the cover letter and correction of deficiencies statement or a letter from CMS or the applicable state agency which shows the organization was reviewed and indicates that it passed inspection. **RAE-specific:** N/A **Prime-specific:** N/A	
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	**Prime:** *VIII_PNM_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Pages 2-3, Section B, lists the documentation that must be submitted by all organizational providers to demonstrate that they are in good standing with regulatory or accrediting bodies. The accrediting bodies recognized by RMHP are listed in Section C, page 3-4. Page 5, Section D, indicates that a non-accredited organization must provide a copy of the State/CMS Survey report, including the cover letter and correction of deficiencies statement or a letter from CMS or the applicable state agency which shows the organization was reviewed and indicates that it passed inspection.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	**Prime:** *VIII_QI Mechanism for Evaluation per State Operations Manual* This document describes how RMHP will accept the standards set forth in the State Operations Manual for RMHP credentialed Health Delivery Organizations (HDO) facilities in lieu of performing site visits internally. Page 2 indicates that the RMHP Credentialing Lead and Manager verify that the survey process evaluates the facilities procedures for the credentialing of medical staff providing services to Members. *VIII_PNM_Health Delivery Organizations* Page 5, Section D, "Non-accredited Organizational Providers" indicates that CMS or state quality reviews substituted for a site visit are no more than three years old. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA MBHO CR7—Element B NCQA HP CR7-Elements B&C	**Prime:** *VIII_PNM_Health Delivery Organizations* Page 1, "Policy" first paragraph lists the organizational providers defined for the purposes of this policy, including hospitals, home health agencies, skilled nursing facilities, and free-standing surgical centers; and behavioral health facilities providing mental health or substance abuse services in inpatient, residential, or ambulatory settings. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses physical health (Prime) providers every 36 months. NCQA MBHO CR7—Element C NCQA HP CR7-Elements D&E	**Prime:** See below **Prime-specific:** *VIII_PNM_Prime_Ogranizational Providers CY2020* This file represents RMHP contracted organizational providers (Health Delivery Organizations) that have been reviewed since January 1, 2020.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_PNM_SAMPLE - Accred Medical HDO This is a sample credentialing record of an accredited organizational provider (Health Delivery Organization) credentialed by RMHP. *VIII_PNM_SAMPLE - Non-Accred Medical HDO* This is a sample credentialing record of a non-accredited organizational provider (Health Delivery Organization) credentialed by RMHP.	
15. If the Contractor delegates credentialing/re-credentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement.	**Prime:** *VIII_PNM_Delegated Credentialing Audit Activities* Page 2, Section B, "Annual Audit" of this policy describes RMHP's oversight of delegated activities. Each delegated credentialing entity is audited on at least an annual basis by RMHP for compliance with RMHP standards. *VIII_PNM 2020 BVIPA Delegated Audit* *VIII_PNM 2020 SCL Health Delegated Audit* *VIII_PNM 2020 UPI Delegated Audit* These completed audit tools provide evidence of RMHP oversight of delegated credentialing activities. *VIII_PNM_Delegated Credentialing & Recredentialing* Page 2, Paragraph 1, states that each delegated entity and RMHP enter into a mutually agreed upon Delegated Credentialing Agreement prior to the entity	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR8—Element A	performing any portion of the credentialing process on behalf of RMHP. Page 5, Section D, indicates that the specific elements delegated to each entity are outlined in the Delegated Credentialing Addendum attached to each contract. *VIII_PNM Delegated Credentialing Agmt* For each bulleted item, see notes on pages 1, 2, 3, 5, Exhibit A **RAE-specific:** N/A **Prime-specific:** N/A	
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *NA if the contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**Prime:** *VIII_PNM_Delegated Credentialing & Recredentialing* Page 3, Section B, Paragraph 2 states that each prospective delegated entity will complete the Pre-contractual Delegation Evaluation Form. The form will be evaluated by RMHP credentialing staff. *VIII_PNM_Delegated Credentialing Audit Activities Policy* page 1, states that each prospective delegated credentialing entity will be evaluated for delegation capacity prior to extension of a Delegated Credentialing Agreement. The evaluation will consist of a Pre-contractual Delegation Evaluation Form, file audit and a review of the entity's Credentialing Policy and Procedures.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_PNM Pre-Delegation Evaluation Concentra 2020 Questionnaire This is a form completed by a potential delegate to determine ability to fulfill delegation requirements. *VIII_PNM Pre-Delegation Concentra 2020* This delegate is the only agreement that came into effect in the past 12 months. The packet contains the Policies and Procedures, file review tool, and policy and procedure evaluation tool used to determine compliance with RMHP and NCQA Standards for Credentialing. **RAE-specific:** N/A **Prime-specific:** N/A	
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	**Prime:** *VIII_PNM_Delegated Credentialing Audit Activities* Page 1, under "Policy," it is noted that RMHP annually audits credentialing delegates for compliance with RMHP and NCQA standards. *VIII_PNM_Delegate Annual Oversight Tracking Tool* This tracking tool illustrates current RMHP activity to audit delegated credentialing files. *VIII_PNM 2020 BVIPA Delegated Audit* *VIII_PNM 2020 SCL Health Delegated Audit* *VIII_PNM 2020 UPI Delegated Audit* These delegated credentialing audits illustrate how	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP annually audits each delegate against RMHP and NCQA Credentialing Standards. Included are review of policies and procedures and files. *VIII_PNM_Delegate Semi-Annual Report Tracking Tool* Demonstrates RMHP activity to evaluate credentialing reports from Delegates semiannually. *VIII_PNM Samples Of Semiannual Reports* Examples of self-identifying and reporting improvement activities on the Semi-Annual Credentialing Submission Form. **RAE-specific:** N/A **Prime-specific:** N/A	
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**Prime:** *VIII_PNM_2019 Davita Delegated Audit* *VIII_PNM_2019 Davita Delegated Audit Follow-up* This is the only recent delegated audit that RMHP found opportunities for improvement. This shows that we followed up with the delegate after the issues were identified. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	32
			Total Score ÷ Total Applicable			=	100%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* CHP+ Contract: Exhibit B1—5.5.3.3	*IX_PNM_Pre-Delegation Instructions* Describes the process RMHP follows to evaluate whether a prospective delegate is capable of performing delegated credentialing activities. *IX_PNM_Pre-Contractual Delegation Evaluation* This questionnaire completed by the potential delegate is reviewed by RMHP (in accordance with the pre-delegation instructions) to determine whether the delegate can perform credentialing activities in compliance with government regulations and NCQA standards. *IX_PNM_Delegated Pre Audit Tracking Sheet* This document is used internally to track the information and documents requested from the delegate prior to audit. *IX_PNM_Delegated Cred Audit Activities Policy DEL.2.20* Describes policy and procedure to conduct pre-delegation and annual delegation audits, including issuance of findings, identification of areas for improvement and monitoring of implementation of audit recommendations. *IX PNM_Semi-Annual Report* Delegates are required to complete this reporting template that identifies practitioners approved, site	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	visits for complaint monitoring, and any improvement activities. *IX_UM_Delegated Utilization Management* The Delegated Utilization Management policy describes the oversight process for delegated Utilization Management (UM) activities. Page 2, Section 3.2 and page 5, Section 6.1 describes pre-delegation activities undertaken to evaluate the prospective subcontractor's ability to perform UM activities. Page 2, Section 3.2, provides the process for monitoring and evaluating the delegated entity's performance. Pages 4-7, Section 6.0, sets forth the procedure for oversight. *IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 2, Section 2.2 RMHO Control and Oversight, explains that RMHP shall maintain oversight and monitor services for quality assurance in conformity with applicable state law and other regulatory requirements. Page 18, Section 3.1 Utilization Management and/or Complex Case Management, explains that the Vendor is delegated for Utilization Management and/or complex case management and maintain a utilization management and/or complex case	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	management program and that the Vendor's process shall comply with the applicable requirements of the NCQA or Accrediting Agency and for Medicare, Medicaid and any other government business and any additional requirements under federal and state law. Page 9, Section 6.4 Delegation of Activities; Oversight, explains that to the extent applicable to any Covered Services, in compliance with the delegation and oversite obligations imposed on RMHP, including the applicable state or under its contracts with any state and/or federal regulatory agencies, RMHP (a) shall conduct at least an annual audit of Vendor's performance or such delegated activities. Pages 5-6, Section 5.4 Corrective Action Plans, describes the corrective action plan process. Page 18, Exhibit B, describes that to the extent required by a regulatory or accrediting agency, the parties have documented in Exhibit F, the level of specificity required by applicable government authorities and/or RMHO's accreditation agencies the activities related to the services that have been delegated with timeframes required. Page 43, Exhibit F, Delegated Activities Grid, displays the delegation functions that shall be in accordance with the provisions of the Agreement.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_UM_UBH dba Optum Pre-Delegation Review This document provides the results of RMHP's pre-delegation audit of and is an example of the type of pre-delegation RMHP undertakes before entering into a contract that involves a delegation of duties. **Note:** The following documents are for CY2019 as the CY2020 reports were not complete at the time of submission. *IX_UM_eviCore Annual Delegation Oversight ReportCY2019* *IX_UM_eviCore Annual Delegation Oversight ReportCY2019_XLS* *IX_UM_Optum Annual Delegation Oversight ReportCY 2019* *IX_UM_Optum Annual Delegation Oversight ReportCY 2019_XLS* These report provide a summary of the oversight activities of these delegated entities. *IX_PH_UHC Pharmacy Delegated Entity Oversight Policy* RMHP is a party to the Inter-segment agreement between UnitedHealthcare and OptumRx. United performs the function of oversight of the PBM, per the UHC Pharmacy Delegated Entity Oversight Policy.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_UM_CCN Contract_CareCore National_ Redacted (CareCore National, LLC d/b/a eviCore healthcare) Page 4-6, Paragraph 2.4, "Oversight" specifies that the delegated entity agrees to allow RMHP to maintain reasonable oversight and what that includes. Page 45, Exhibit 3, in its entirety sets forth the Table of performance standards and monitoring that will occur under the agreement.	
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.*	*IX_ PNM_ Delegated Credentialing Agmt* Page 2, Paragraph 2.A., and Exhibit A describe the delegated credentialing activities. Page 2, Paragraph 2.D., describes the reporting responsibilities of the delegate. Page 1 sets forth the delegate's agreement to perform the delegated credentialing activities and reporting responsibilities. Pages 5-6, Paragraph 4, Revocation/termination of delegated activities is addressed *IX_UM_Delegated Utilization Management* Page 1, Section 3.1, provides that a written agreement between the parties will describe the delegated activities.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.230(b)(2) and (c)(1) CHP+ Contract: Exhibit B1—2.3	Page 2, Section 3.1.6, provides that the written agreement will describe the remedies available if the delegate does not fulfill its oblations, including the circumstances that would cause revocation. **Obligations and reporting responsibilities in written delegation agreements** *IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 18, Section 3.1 Utilization Management and/or Complex Case Management, explains that the Vendor is delegated for Utilization Management and/or complex case management and maintain a utilization management and/or complex case management program and that the Vendor's process shall comply with the applicable requirements of the NCQA or Accrediting Agency and for Medicare, Medicaid and any other government business and any additional requirements under federal and state law. Page 18, Exhibit B, describes that to the extent required by a regulatory or accrediting agency, the parties have documented in Exhibit F, the level of specificity required by applicable government authorities and/or RMHO's accreditation agencies the activities related to the services that have been delegated with timeframes required.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 43, Exhibit F, Delegated Activities Grid, displays the delegation functions that shall be in accordance with the provisions of the Agreement. Pages 19-20, Section 6, Other Services, 6.1 General Services (a) (i)-(ii), describes the Vendor's reporting responsibilities. **Provisions for revoking or other remedies in delegated agreements** *IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 9, Section 6.4 Delegation of Activities; Oversight, explains that to the extent applicable to any Covered Services, in compliance with the delegation and oversite obligations imposed on RMHP, including the applicable state or under its contracts with any state and/or federal regulatory agencies, RMHP (a) shall conduct at least an annual audit of Vendor's performance or such delegated activities. Pages 5-6, Section 5.4 Corrective Action Plans, describes the corrective action plan process. Page 9, Section 6.4 Delegation of Activities; Oversight, item(b) states that RMHO has the right to revoke any functions or activities delegated to the Vendor under the Agreement, if in RMHO's	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	reasonable judgement, Vendor's performance under the agreement does not comply with RMHO's obligations. Pages 9-10. Section 7.1 Term and Termination, items (d)(e), describe specified circumstances for immediate termination of delegated functions. *IX_PH_OptumRX_ISA12012020-Full Contract_redacted* Page 25, Section 15, G,(5) Delegation and Oversight. RMHMO reserves the right to revoke functions or activities delegated to the PBM in the event of non-compliance. **Obligations and reporting responsibilities in written delegation agreements** *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Pages 26-30, Exhibit 1, describes the delegated activities. Pages 27-28, Section 1.E, Reporting Requirements, describe the delegated entity's reporting responsibilities. **Provisions for revoking or other remedies in delegated agreements** *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare)	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 9, Paragraph 3.6.1 Evaluation of Delegated Entity Services, provides that in the event of a deficiency, the delegated entity shall implement and submit a corrective action plan within 15 business days of notification of the deficiency. Page 21, Paragraph 10.3, "Termination or Suspension Upon Notice," provides for termination or suspension upon notice if the delegated entity is not performing UM activities in compliance with NCQA requirements or applicable law.	
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract: Exhibit B1—20.B	*IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 123, Section 11.2 Amendment, explains that the Agreement may be amended in compliance with any and all notice and/or approval requirements of the insurance laws in the state in which RMHO is domiciled. Page 18, Section 3.1 Utilization Management and/or Complex Case Management, explains that the Vendor is delegated for Utilization Management and/or complex case management and maintain a utilization management and/or complex case management program and that the Vendor's process shall comply with the applicable requirements of the NCQA or Accrediting Agency and for Medicare, Medicaid and any other government business and any additional requirements under federal and state law.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_PNM_Law Exhibit Template_Provider Page 11, Section III, Paragraph 8, demonstrates the credentialing delegation agreement contains the required language regarding compliance with all applicable Medicaid Laws and regulations as stated in this element. *IX_LRA_Law Exhibit_Non-Provider 12-19* Page 9, Paragraph 23, demonstrates the credentialing delegation agreement contains the required language regarding compliance with all applicable Medicaid Laws and regulations as stated in this element. *IX_PH_OptumRX_ISA12012020-Full Contract_redacted* Page 27, Paragraph 23, "State Contracts." Contractor agrees to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and the requirements of Rocky's CHP+ and Medicaid contract. *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 7, Paragraph 3.1.4, specifies that the delegated entity agrees to meet or exceed RMHP standards, policies and procedures, NCQA standards and federal and state statutory or regulatory provisions.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Further, if any accrediting organization standards, federal or state regulatory provisions are changed or revised, the delegated entity agrees to comply with or implement any such change as may be required by applicable law. This provision incorporates the applicable regulatory language in this requirement that is contained in RMHP's contracts with HCPF.	
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State. – The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to CHP+ enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.	*IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 25, Section 4.7 Records, (b) Government access to Records, (i)-(ii) describes that the Vendor acknowledges and agrees that Secretary of HHS, the Comptroller General or their designee shall have the right to audit, evaluation and inspect any pertinent books, contracts, computer or other electronic system (including medical records), patient care documentation and other records and information belonging to the Vendor that involve transactions related to the CMS contract. Page 25, Section 4.7 Records, (b), Paragraph 2, describes that the Vendor shall make available its premises, physical facilities and equipment, records related to the services performed pursuant to the Agreement. Page 5, Section 5.1 Maintaining Records, describes provisions for recording keeping and access to records for the purposes of inspection Pages 34-36, Section II, related to Federal Health	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.230(c)(3) CHP+ Contract: Exhibit B1—2.3	Care Programs, Sections 1-7 describe that CMS may inspect, evaluate and audit a Contractor at any time id determined there is a possibility of fraud or similar fault. *IX_PNM_Law Exhibit Template_Provider* Page 7, Section III, Paragraph 2, "Records and Audits" is part of the credentialing delegation agreement and contains the required language as stated in this element. *IX_LRA_Law Exhibit_Non-Provider 12-19* Page 4, Paragraph 11, "Medicaid and CHP+ Records and Audits" is part of the credentialing delegation agreement and contains the required language as stated in this element. *IX_PH_OptumRX_ISA12012020-Full Contract_redacted* Page 22, Section 1, "Medicaid and CHP+ Records and Audits," provides that OptumRx shall maintain records and permit inspection, evaluation and audit as described in this requirement. *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 5, Paragraph 2.4.5, grants permission for federal, state and local governmental authorities to audit any and all documents and materials related to	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	services under the agreement at the delegated entity's place of business Page 6, Paragraph 2.4.10, provides that the period for retaining all data, information, records and documentation related to is performance of delegated entity services for the period required by law.	
Findings: While many of the RMHP Prime subcontracts included language to grant the HHS-OIG, Comptroller General, or other designees the right to audit, evaluate, and inspect any books, records, contracts, and computer or other electronic systems of the subcontractor for up to 10 years, some of the delegated credentialing agreements failed to include this information and the other specific language used in the federal rule.		
Required Actions: RMHP Prime must update the delegated credentialing agreements that do not include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	3
				Total Score ÷ Total Applicable		=	75%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)* RAE Contract Amendment #4: Exhibit B-4—16.1.1 Prime MCO Contract Amendment #4: Exhibit M-4—16.1.1	**Prime:** The following documents describe the ongoing comprehensive Quality Assessment and Performance Improvement Program for services provided to our Members. *X_QI_RMHP QI Program Description 2020* *X_QI_RMHP QI Work Plan 2020* *X_QI_RMHP Annual Evaluation_Quality Assessment Report CY 2019* *X_CI_R1_QualityRpt_FY20-21* *X-CI_R1_QualityImprovePln_FY20-21* **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement.	**Prime:** *X_QI_ RMHP QI Work Plan 2020* Page 11, rows 86-88: PIP reporting to RMHP's Quality Improvement Committee *X_CI_CO2019-20_MCD_TechRpt_F1 for RAE&Prime PIPs* Pages 71-74, 204-206, 241-242, and page 269, describes the PIPs conducted during this review period. Activities include: measurement, implementation, and evaluation of the focused areas.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
For RAEs two PIPs are required, one for physical health and one for behavioral health. *42 CFR 438.330(b)(1) and (d)(2) and (3)* RAE Contract Amendment #4: Exhibit B-4—16.3.1, 16.3.5, 16.3.8 Prime MCO Contract Amendment #4: Exhibit M-4—16.2.1.1, 16.3.5, 16.3.8	**RAE-specific:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 115-117 describe the PIP titled "Improving Well Child Visit (WCV) Completion Rates for Regional Accountable Entity (RAE) Members & Child Health Plan Plus (CHP+) Members Ages 15-18; Mountain Family Health Center" Pages 115-117 describe the PIP titled "Increase the number of depression screenings completed for RAE Members ages 11 and older; Colorado Mountain Medical" **Prime-specific:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 115-117 describe the PIP titled "Substance Use Disorder Treatment in Primary Care Settings for Prime Members Age 18 and Older; Foresight Family Practice."	
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enables the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities.	**Prime:** *X_QI_ RMHP QI Work Plan 2020* Page 4, rows 32-34, describes RMHP activity in HEDIS data collection and reporting. *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Page 24: HEDIS data is collected, validated, and submitted as required.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.330(b)(2) and (c) RAE Contract Amendment #4: Exhibit B-4—16.4.1, 16.4.4 Prime MCO Contract Amendment #4: Exhibit M-4—16.4.1, 16.4.3, 16.4.7	**RAE-specific:** N/A **Prime-specific:** N/A	
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* RAE Contract Amendment #4: Exhibit B-4—16.6.1 Prime MCO Contract Amendment #4: Exhibit M-4—16.2.1.3, 16.6.1	**Prime:** *X_QI_RMHP QI Program Description 2020* Pages 25-26 describes the overutilization and underutilization monitoring activities included in the QI program. *X_QI_ RMHP QI Work Plan 2020* The overutilization and underutilization reports reviewed by the Utilization Management Committee are listed on page 7 (row 59), page 8 (row 61), page 9 (rows 69-72), and page 10 (row 73). *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Beginning on page 74, the Utilization Management Program section describes activities to detect and impact overutilization and underutilization. Page 74, section B, and page 124: establishment of the Utilization Management Committee in 2019 Pages 74-76, section B: over and underutilization for behavioral health Pages 84-89, section G: Member and provider outreach for gaps in care	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_QI_Pfizer_CO_Postcard_MissedDose *X_QI_Welltok Missed Dose Reminder Script* *X_QI_Pfizer_CO_Postcard_WellVisit* *X_QI_Welltok Well Visit Reminder Phone Script* These materials were used in an outreach campaign in 2020 to address underutilization of immunizations and well child visits. The campaign included a postcard and follow-up phone call. The target population was children who missed an immunization between six months and 18 months of age and children identified as due for a 12-month well child visit. *Note: RMHP Tracking of Hospital Readmissions* In the course of doing business, RMHP tracks readmissions within 30 days for all lines of business as a means of tracking inappropriate utilization. *X_UM_Program Description_2020-21* Pages 32-33, Over & Underutilization Monitoring, describes how RMHP monitors over and underutilization of service to ensure Members receive the necessary and appropriate care. **RAE-specific:** N/A **Prime-specific:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 76-78, section C: over and underutilization of physical health	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 78-80, section D: overutilization of hospital readmissions within 30 days of discharge Pages 80-81, section E: Preauthorizations to detect over and underutilization Pages 81-84, section F: Provider Attribution Reports to detect over and underutilization *X_QI_QI126C_TeenWellness2020 Incentive* *X_QI_QI133C_PreteenWellness Incentive* *X_QI_QI83C_Diabetes2020 Incentive* *X_QI_QI132C_BreastCancer Incentive* *X_QI_QI134C_CervicalCancer2020 Incentive* These are examples of Member mailings for gaps in care in 2020. The incentive programs were developed to address underutilization of wellness visits in the teen and pre-teen population, underutilization of preventive care screenings, and underutilization of chronic care management. The brochures are mailed to Members identified as having a gap in care. *X-PH15_Drug Safety and Drug Medication Adherence* The Drug Safety and Medication Adherence Program Description defines RMHP's strategy for managing appropriate and effective utilization of drug and medication therapies. Page 1 gives an overview of the program.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2 and following describes how RMHP identifies the population who may be at risk for negative outcomes due to under and overutilization and the programs used to address and manage associated risks.	
5. The Contractor's QAPI program includes mechanisms for identifying, investigating, analyzing, tracking, trending and resolving any alleged quality of care concerns. RAE Contract Amendment #4: Exhibit B-4—16.7.1.1, 16.7.2 Prime MCO Contract Amendment #4: Exhibit M-4—16.7.1.1, 16.7.2	**Prime:** *X_QI_Retrospective Quality Case Review* This Policy and Procedure describes the process undertaken to investigate any potential quality of care issues identified by Members, providers and others. Page 3 indicates that upon request, a letter will be submitted to HCPF (within 10 business days) that includes a brief description of the quality of care issue, the efforts taken to investigate the issue, the outcome of the review, and any action RMHP intends to take with the providers involved. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: 1) a significant limitation in areas of physical, cognitive, or emotional function; 2) dependency on medical or assistive devices to*	**Prime:** *X_QI_ RMHP QI Program Description 2020* Pages 23-24, Section: Collaboration on Continuity and Coordination of Care, describes how RMHP works to facilitate and promote continuity and coordination of care between medical practitioners and between medical and behavioral health practitioners. Pages 24-25, Section: Complex Health Needs, describes that Members with complex health needs are referred to the Complex Care Management Program.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
minimize limitation of function or activities; 3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school. *42 CFR 438.330(b)(4)* RAE Contract Amendment #4: Exhibit B-4—16.2.1.4 Prime MCO Contract Amendment #4: Exhibit M-4—16.2.1.4, 16.5.5 10 C.C.R. 2505-10, 8.205.9	Eligible Members are offered comprehensive and enhanced coordination of care to assist with their needs across a continuum of settings. *X_QI_2019 AAP Psychosocial Factors in CYSHN and their Families* *X_QI_Bright Futures Guidelines- Promoting Health for CYSHN* *X_QI_Adults with Special Healthcare Needs Guidelines_RMHP* These are the clinical practice guidelines RMHP has adopted relating to children and adults with special health care needs. The guidelines are available on the website and upon request. *X_CM_Complex Outreach Workflow* This workflow is an example of how RMHP's targeted outreach to adult and pediatric members who are identified as Complex or have Special Health Care Needs. Assessment and care plans are developed to help Members overcome barriers and achieve specific treatment goals. **RAE-specific:** N/A **Prime-specific:** *X_QI_ RMHP QI Work Plan 2020* Page 11, row 81: The Special Health Care Needs audit is reviewed by the Medical Advisory Council.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_QI_SHCN Prime Q3 2020 Analysis Report 10.9.20 This report was completed in October of 2020, summarizing the 3rd quarter 2020 assessment of the quality of care for people with special health care needs. *Note: the Q4 report will be available on site for review if needed.* *X_QI_Assessing Quality of Care for People with SHCN* This describes the process for assessing the quality of care for people with special health care needs.	
7. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include, at a minimum: • Member surveys • Anecdotal information • Grievance and appeals data • Call center data • CAHPS survey • ECHO survey (RAE only) RAE Contract Amendment #4: Exhibit B-4—16.5.1-2, 16.5.6 Prime MCO Contract Amendment #4: Exhibit M-4—16.5.1-3, 16.5.7	**Prime:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 89-112 describe various Member satisfaction survey tools, results, and analyses. Pages 90-92: Complaints, appeals, and grievances Page 93-95: Statewide survey to evaluate Member experience of PCP and specialist visits Page 95-97: Appointment wait time Member survey Page 97: Net Promoter Score Page 104-107: Medicaid CAHPS survey *X_CI_R1_GrieveAppealRpt_Q1FY20-21* This report, provides identified trends regarding timely response and completion of grievances and appeals, and any actions taken.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Appeals and Grievance team shares Members perception on access and availability of services with appropriate department for follow up. Note: Grievance and Appeal approved template with Q1FY20-21 data will be available on site. *X_CS_MEAC Quarterly Report* This report is presented quarterly to the Member Experience Advisory Committee (MEAC) to report the number of appeals and grievances received as well as the categories which include member perception to access, attitude/service, billing/financial, and quality of practitioner office site. **RAE-specific:** N/A **Prime-specific:** N/A	
8. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. *42 CFR 438.330(e)(2)* RAE Contract Amendment #4: Exhibit B-4—16.2.5 Prime MCO Contract Amendment #4: Exhibit M-4—16.2.5	**Prime:** *X_QI_ RMHP Annual Evaluation_Quality Assessment Report CY 2019* Pages 6-9 describe that program activities are structured around an ongoing process of quality monitoring, reporting, and assessment. A detailed evaluation of the Quality Improvement Program and its activities is conducted annually. This report is a formal summary of the annual evaluation of quality improvement activities. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor adopts practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with contracted health care professionals. • Are reviewed and updated periodically as appropriate. *42 CFR 438.236(b)* RAE Contract Amendment #4: Exhibit B-4—14.8.8.1-3 Prime MCO Contract Amendment #4: Exhibit M-4—14.6.7.1-3	RAE contract—practice guidelines apply to BH services. Prime contract—practice guidelines apply to PH services. **Prime:** *X_QI_Clinical Practice Guidelines* Page 2, Section 1.b: Guidelines address physical and behavioral health care. Page 2, Section 1.b: Guidelines will be reviewed and adopted directly from a recognized source (a national organization that develops evidence based clinical practice guidelines). Page 2, Section 1.c: When evidence based guidelines are not available, guidelines may be developed from a consensus of Health Care Professionals in a particular field. Page 4, Section 4.a: Includes an analysis of the relevancy of the guideline to the RMHP population. Page 2, Section 1.a: Annually and when new scientific evidence and/or national standards warrant, guidelines are reviewed for updates or changes to current clinical practice by the Quality Improvement Department with subsequent consultation by other internal clinical staff as necessary (e.g. Medical Directors and pharmacists). *X_UM_ Clinical Criteria for UM Decisions* Page 1-2, Sections I and II, describes the process used to apply written, evidence-based criteria to evaluate the	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	medical appropriateness of medical and behavioral healthcare services. Page 3, Section III, indicates that throughout the process of making a determination, RMHP considers many sources of clinical information, individual Member needs and characteristics of the local delivery system Page 2, Section II, Paragraph E indicates that practitioners with professional knowledge or clinical expertise in the relevant area have an opportunity to give advice or comment on development, review and adoption of UM criteria and on instructions for applying criteria. *X_UM_Template for Specialist Review Letter and Feedback form* This letter template is used for the purpose of obtaining practitioner input on the development and adoption of RMHP criteria. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members. *42 CFR 438.236(c)* RAE Contract Amendment #4: Exhibit B-4—14.8.8 Prime MCO Contract Amendment #4: Exhibit M-4—14.6.7	**Prime:** *X_QI_Clinical Practice Guidelines* Page 3, Section 2.a-d: Providers are notified that approved clinical practice guidelines are on the RMHP website. Guidelines are provided to Members and potential Members upon request. *X_PNM_Provider Newsletter_Winter 2020* Page 3 provides a clinical practice guidelines update. Guidelines listed include Pediatric *Preventive Care, Prenatal Care, and Special Healthcare Needs—Children and Adults*. Providers are advised how to obtain copies of these guidelines. Page 8 indicates the criteria used to make a decision are available upon request at no cost to the Member or provider. *X_CI_Screen Shot of Clinical Practice Guidelines-Website* RMHP disseminates information on its public website regarding current clinical practice guidelines. *X_UM_ Clinical Criteria for UM Decisions* Pages 5-6, Section VI indicates that guidelines used in UM decision-making are available at no cost upon request. Practitioners and Members are notified in writing that they are available.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	2020 Provider Manual Page 82 explains *Review Criteria.* Criteria used in decision-making are available, free of charge, to Physicians, Practitioners, facilities, and Members upon request to RMHP. **RAE-specific:** N/A **Prime-specific:** N/A	
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* RAE Contract Amendment #4: None Prime MCO Contract Amendment #4: Exhibit M-4—None	**Prime:** *X_QI_Clinical Practice Guidelines* Page 3, Section 1.e: RMHP assesses whether Member materials, benefit configuration, UM decisions, prior authorization list, or other operational functions are consistent with adopted clinical guidelines and/or need to be updated as a result of any changes to the clinical guidelines. *X_UM_ Clinical Criteria for UM Decisions* Page 6, Section VII, describes how RMHP assesses at least annually the consistency with which physician and non-physician reviewers apply UM criteria in decision-making. *2020 Provider Manual* Page 75, Care Management Section, addresses many aspects of the Care Management Program. It describes	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the organizational structure that is in place to support correct and consistent development and application of guidelines. Page 83, last two paragraphs describe how consistency is maintained including inter-rater reliability testing, audits, and utilization clinical rounds. **RAE-specific:** N/A **Prime-specific:** N/A	
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* RAE Contract Amendment #4: Exhibit B-4—15.1.1 Prime MCO Contract Amendment #4: Exhibit M-4—15.1.1	**Prime:** *X_Data_RMHP Health Information Systems_v2* This flowchart illustrates the various health information systems used by RMHP to collect, analyze, integrate and report data. *X_CL_Steps to Process a Medical Claim* Describes the steps the RMHP takes to process electronic and paper claims from providers—includes the processing steps, role of examiners, systems utilized, workflows and queues. *X_CI_R1_GrieveAppealRpt_Q1FY20-21* 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 Q1FY20-21 data will be available on site. *X_PT_Referrals_Med Nghbrhd_ Peds* *X_PT_Engaging in the Med Nghbrhd*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These two documents are provided as examples of how RMHP helps its provider network use data and health information exchange for purposes of improving the care provided to patients. This includes an example of a workflow using health information exchange when a visit to the emergency room triggers a notification to the patient's PCP, e.g., pages 6-7 of *Engaging in the Medical Neighborhood.* **RAE-specific:** N/A **Prime-specific:** N/A	
13. The Contractor's health information system provides information on areas including, but not limited to, utilization, encounters, claims, grievances and appeals, and disenrollment (for reasons other than loss of Medicaid eligibility). *42 CFR 438.242(a)* RAE Contract: Exhibit B—15.1.1, 8.1 Prime MCO Contract Amendment #4: Exhibit M-4—15.1.1, 8.1	Note: For RAEs, these elements apply only to BH services. For Prime, these elements apply only to PH services. **Prime:** *X_Data_RMHP Health Information Systems_v2* This flowchart indicates the various reporting and analytics that are done in the areas of utilization, claims, grievances and appeals, etc. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interchange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.2 Prime MCO Contract Amendment #4: Exhibit M-4—15.2.3.1, 15.2.3.2	Note: For RAEs, claims/encounter systems relate only to BH capitated services. For Prime, claims/encounter systems apply only to PH capitated services. **Prime:** *X_PRGREC_Medicaid CHP+_Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Medicaid and CHP+ Claim Encounter Data to the Colorado Department of Health Care Policy and Finance (HCPF). ***Claims note regarding Mechanism for verifying accuracy of claims/encounter data:*** All Health Care Professionals must comply with adopted HIPAA standards and all ANSI claims submission requirements for acceptance of their claims. In addition, RMHP utilizes a series of national published correct coding guidelines to ensure Providers are submitting accurate claims. **RAE-specific:** N/A **Prime-specific:** *X_PRGREC_Medicaid CHP+_Pharmacy Claim Encounter Data Submission PP*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Describes the process and procedure for the submission of Pharmacy Claim Encounter Data to HCPF.	
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.1, 15.2.2.3.2 Prime MCO Contract Amendment #4: Exhibit M-4—15.2.2, 15.2.3	**Prime:** *X_PT_PCP Practice Monthly Report_PHI Removed* This PCP Practice monthly report demonstrates how RMHP collects and uses data on Member and provider characteristics regarding services furnished to Members. The various worksheets provide practice summaries, patient summary, patient detail, Members who are assigned but unattributed, and enrollment and claims data. *X_PT_Engaging in the Med Nghbrhd* Pages 4-5 provides information for providers on tracking utilization in the emergency department and hospital, and on the attribution report (the practice monthly report noted above) and how practices can use it. **RAE-specific:** N/A **Prime-specific:** N/A	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts. • Making all collected data available to the State and upon request to CMS. *42 CFR 438.242(b)(3) and (4)* RAE Contract Amendment #4: Exhibit B-4—15.2.2.3.1, 15.2.2.3.5.1 Prime MCO Contract Amendment #4: Exhibit M-4—15.2.3.1, 15.2.3.6.1	**Prime:** *X_CL_Steps to Process a Medical Claim* Describes the steps the RMHP takes to process electronic and paper claims from providers—includes the processing steps, role of examiners, systems utilized, workflows and queues. • Verify accuracy and timeliness examples Page 3: checking of line items Page 4: claims sorted and worked by age Page 4: errors researched and cleared Page 4: duplicates are checked by the system automatically • Completeness, logic and consistency examples Page 2: claim with lack of information or eligibility is rejected Page 3: checking of line items Page 4: claims that do not meet criteria are pended • Service information in standardized formats examples Page 1: claims can be received electronically *X_PM&A-Annual Audit Plan 2020 REVISED 20200429* This annual audit plan describes RMHP audit activities to verify accuracy and timeliness of reported data; screening data for completeness, logic and	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	consistency; and collecting information in standardized formats. Page 4 lists the summary of audits planned. Claims Financial and Transaction Accuracy Audit. Additional information can be found in: *X_PM&A-003 Procedure for Medical Claims Accuracy Reporting* *X_PM&A-007 Medical Claims Auditing Manual.* Hospital Bill and Chart Review Audits. Claims Edit Review using Claims Audit Software, which is an electronic review to identify claims and claim combinations that were possibly paid incorrectly or should not have been paid, depending on set criteria. Provider Correct Coding Audit. Additional information can be found in: *X_PM&A-207 Correct Coding for E&M Mgt Code (CCP).* Audits of DME claims to review a sample of claims for DME products and services for transactional accuracy and medical necessity. The review includes medical records request to support billed charges. *X_PM&A-003 Procedure for Medical Claims Accuracy Reporting* *X_PM&A-007 Claims Auditing Manual* RMHP performs Claims Financial and Transaction Accuracy audits monthly. These documents describe the claims accuracy review process.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_PM&A-207 Correct Coding for E&M Mgt Code (CCP) RMHP conducts post-payment reviews of E&M coding practices to monitor potential upcoding of claims and to improve the accuracy of and consistency of codes submitted by participating providers. **RAE-specific:** *X_Leif_Appendix I. Flat File Specifications HCPF Version 21 Final* *X_Leif_RAE BH Flat File Process 20201211* A general description of what happens between RMHP giving data to Leif (RMHP's data actuary) and Leif providing HCPF (The Department) monthly BH Flat Files. This would be for both FFS and encounter claims. **Prime-specific:** *X_Leif_Appendix I. 2020.08.05 HMO Flat File Specification* *X_Leif_Prime Flat File Process 20201211* A general description of what happens between RMHP giving data to Leif (RMHP's data actuary) and Leif providing HCPF (The Department) monthly BH Flat Files. This would be for both FFS and encounter claims.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in standardized ASC X12N 837 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State (within 120 days of an adjudicated provider claim). *42 CFR 438.242(c)* RAE Contract Amendment #4: Exhibit B—4-15.2.2.3.2-3, 15.2.2.3.5 Prime MCO Contract Amendment #4: Exhibit M-4—15.2.2.1, 15.2.3.2, 15.2.3.4, 15.2.3.6	**Prime:** *X_PRGREC_Medicaid CHP+_Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Medicaid and CHP+ Claim Encounter Data to the Colorado Department of Health Care Policy and Finance (HCPF). **RAE-specific:** **Prime-specific:** *X_PRGREC_Medicaid CHP+_Pharmacy Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Pharmacy Claim Encounter Data to HCPF.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	17
				Total Score ÷ Total Applicable		=	100%