CHP+

Child Health Plan *Plus*

Fiscal Year 2018–2019 Site Review Report

for

Rocky Mountain Health Plans

April 2019

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

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with provisions of the Code of Federal Regulations (CFR), Title 42—federal Medicaid managed care regulations published May 6, 2016. Revisions to federal Medicaid managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to evaluate the CHP+ health plans' compliance with new federal managed care regulations published May 2016, the Department determined that the review period for fiscal year (FY) 2018–2019 was July 1, 2018, through December 31, 2018. This report documents results of the FY 2018–2019 site review activities for **Rocky Mountain Health Plans** (**RMHP**). For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2018–2019 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2017–2018 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, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2018–2019 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) final protocol.

Summary of Results

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

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

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	10	10	8	2	0	0	80%
IV. Member Rights and Protections	8	8	7	1	0	0	88%
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%
X. Quality Assessment and Performance Improvement	18	18	15	3	0	0	83%
Totals	**68**	**68**	**62**	**6**	**0**	**0**	**91%**

*The overall score is calculated by adding the total number of Met elements and dividing by the total number of applicable elements

Table 1-2 presents the scores for **RMHP** 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	91	91	0	9	100%
Recredentialing	90	86	86	0	4	100%
Totals	**190**	**177**	**177**	**0**	**13**	**100%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

RMHP's Care Coordination policy and procedure defined a comprehensive care management program to assist members with access to needed services, including: coordinating with the members' providers; assisting in referrals to specialists and community-based organizations; providing complex care coordination for members receiving services from multiple providers and agencies; involving members and family members in treatment and service planning and consent to treatment; and providing continuity of care for newly enrolled members. Staff members stated that care coordination policies and processes applied to all lines of business. PCP contracts also outlined provider responsibilities for ongoing coordination of services for members. **RMHP** used available data and information from intake screenings and comprehensive needs assessments to categorize all members into four levels of potential care coordination interventions as follows: Tier 1—Healthy members/health promotion and prevention; Tier 2—Mitigating emerging risks; Tier 3—Managing outcomes across multiple care settings; and Tier 4—Managing multiple chronic illnesses. Stratification methodologies considered medical, behavioral, and social support needs of members. **RMHP**'s Utilization Management (UM), Care Coordination, and Customer Service staff were well-integrated within the organizational structure. In addition, 10 integrated care coordination teams (ICCTs) were distributed regionwide to provide care coordination of services in local communities. All documentation of member-specific care management information, including health needs assessments and service plans, was entered and maintained in the Essette care management software (Essette), which enabled secure sharing of care coordination files among 14 designated health entities, including all Community Mental Health Centers (CMHCs), all partner ICCTs, public health departments, large primary care clinics, and others. Staff members confirmed that **RMHP** had a business associate agreement with each participating care coordination partner to protect confidentiality of member information.

RMHP's Customer Service staff conducted outreach welcome calls to all newly enrolled members within 30 to 45 days of enrollment to explain the benefits of the plan, encourage and assist members with selecting a PCP, conduct initial intake screenings related to member needs, and identify any continuity of care needs for members with special health care needs (SHCN). In addition, staff members stated that providers contact **RMHP** when continuity-of-care needs are identified for newly enrolled members. When Customer Service is unable to directly contact a member through the welcome call, a written welcome letter is sent encouraging the member to contact **RMHP** for any care coordination or other assistance needs. If intake screening indicated that a member may be included in Tiers 2 through 4 (including members with SHCN) or identified that a member had continuity-of-care needs, Customer Service staff referred the member to Care Management staff for follow-up and further assessment. Results of intake screenings were entered into Essette. Customer Service staff also retained ongoing responsibility for coordinating referrals and assisting members identified as Tier 1. **RMHP** policies and procedures described processes for ensuring that select members' continuity-of-care needs were met; ensuring that transitions of care between settings were identified and facilitated; and identifying and coordinating with services received from other managed care plans, fee-for-service (FFS) providers, and community agencies and organizations. **RMHP** Care Coordination staff assumed the lead coordinator

role for all members with complex needs and personally informed members of the care coordinator's contact information. Care Coordination staff share assessments and care plans with other providers or organizations involved with the member, either through Essette or by outreaching providers and organizations and offering to share such information upon request. The Physician Medical Services Agreement required providers to maintain and share medical records with other providers, and the provider manual outlined requirements for maintaining and sharing medical records in a confidential manner in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations. **RMHP** also demonstrated mechanisms for maintaining secure exchange of confidential member information through security clearance processes and encrypted email communications. **RMHP**'s comprehensive care coordination program and integrated staff and procedures ensured that all CHP+ members had access to an active level of care coordination services appropriate to their needs and in compliance with most requirements.

Summary of Findings Resulting in Opportunities for Improvement

In order to preserve member choice in selecting a PCP, **RMHP** does not auto-assign members to a PCP. **RMHP** demonstrated efforts to connect members to an ongoing source of care—i.e., PCPs—through Customer Service or Care Coordination staff contacts with members as well as via written communications such as new member welcome letters, the member handbook, and the online provider directory. Nevertheless, HSAG encourages **RMHP** to consider additional mechanisms to ensure that each member has a PCP as an ongoing source of care.

While **RMHP** required that providers share medical records with all other providers involved in the member's care, HSAG observed during on-site reviews that providers do not always promptly respond to medical record requests from other providers, thereby risking gaps in continuity of care. HSAG recommended that **RMHP** enhance provider requirements to include responding to medical records requests "in a timely manner."

RMHP's People with SHCN policy described procedures applicable to Medicaid members, not CHP+—although staff members stated that the policy applied to all lines of business. If the SHCN policy applies to all lines of business, **RMHP** should clearly designate in written policy that it is applicable to CHP+ members as well as Medicaid members.

Summary of Required Actions

RMHP demonstrated having a combination of member communications intended to ensure that each member selects a PCP; however, **RMHP** did not have a routine mechanism to inform a member of how to contact his or her designated PCP. **RMHP** must implement a mechanism to inform each member how to contact his or her PCP for ongoing coordination of healthcare services accessed by the member.

RMHP demonstrated mechanisms to attempt to conduct an initial intake screening of all new members within 30 to 45 days of enrollment to identify any special healthcare needs. The intake screening assessment included documentation of the member's language and screening for high-risk medical

conditions. Call staff were also instructed to discuss immunizations, well-child visits, and special health care needs. At the time of on-site review, **RMHP** provided documentation demonstrating having developed an expanded version of the intake screening questions; however, the intake screening implemented during the compliance review period did not include assessment for behavioral health needs, functional problems, or other complex health needs as required by the Department. **RMHP** must implement an expanded intake assessment that addresses all required elements of the health screening defined by the Department.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

RMHP maintained written policies on member rights. Within its policies, **RMHP** delineated the rights and responsibilities for its members and included methods for the distribution of these rights to members and providers. Members received information about their rights, including a list of rights and responsibilities, in the CHP+ member booklet. HSAG identified the full list of member rights within this publication. **RMHP** required, through a stipulation within its provider contracts, that providers adhere to these member rights. **RMHP** included within its member newsletter instructions for accessing member rights and responsibilities online.

RMHP ensured, primarily through a review of Customer Service interactions with members, that employees and providers afford members their rights. Staff members described the process for monitoring calls received via the Customer Service phone line. Member calls describing any issue of dissatisfaction that could possibly be related to a rights issue were flagged for further review. During the on-site review, **RMHP** staff provided HSAG with a documented summary of member calls categorized as potential rights issues. **RMHP** reviewed these summaries periodically to evaluate and determine whether the issues were actually related to member rights and then responded as needed.

RMHP delineated advance directive information within its policies, the CHP+ Benefits Booklet, and the **RMHP** provider manual.

Through policies, **RMHP** addressed compliance with federal and State laws that pertain to member rights. **RMHP** evidenced compliance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E—HIPAA through its policies, staff procedures, and mandatory in-service trainings. During on-site interviews, staff members described methods used to safeguard protected health information (PHI), including secured printers and secured emails.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

HSAG found that **RMHP** did not have provisions for community education regarding advance directives. In the past, **RMHP** had relied on the **RMHP** Foundation to provide advance directive education to the community; however, the Foundation did not conduct this activity during the review period and would not likely be providing this function going forward. **RMHP** did provide an education session to health care providers; however, there was no education provided to the community at large. **RMHP** must develop provisions for community education regarding advance directives, including what constitutes an advance directive; emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment; and description of applicable State law concerning advance directives.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

HSAG reviewed **RMHP**'s policies and procedures related to the initial credentialing and recredentialing of providers and the credentialing of organizations. The policies were well-organized, thorough, and compliant with National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines.

During the interview and through the record review, **RMHP** demonstrated that staff were credentialing and recredentialing providers and health delivery organizations (HDOs) in a manner consistent with the written procedures. Credentialing and recredentialing files included an application with required attestations, documentation that staff verified licensure, Drug Enforcement Agency (DEA) certification (as applicable), board certification status (as applicable), education and training, work history, and current malpractice insurance. Files also included documentation that **RMHP** queried the National Practitioner Data Bank (NPDB) for history of professional liability claims and to ensure that the provider had not been excluded from federal participation. **RMHP** staff members described the process for the monthly review of Office of Inspector General (OIG) and Systems of Award Management (SAM) queries and provided HSAG with evidence of ongoing searches.

RMHP contracted with hundreds of HDOs during the period in review. **RMHP** provided HSAG with its hospital facility site evaluation tool and assessment survey recently used to evaluate a new HDO (a critical access hospital) that had not yet had a State site survey and was not currently accredited. Through use of the tool, **RMHP** assessed and scored the hospital in four general areas: physical accessibility and appearance, services, general, and medical record-keeping and filing. **RMHP** used the tool and survey to ensure that various requirements of the contract were met and that the hospital's overall score was above a set threshold of 80 percent.

RMHP delegated credentialing and recredentialing to several contracted organizations. HSAG reviewed delegation agreements which described the activities, responsibilities, and reporting requirements.

RMHP retained the right to approve, suspend, or terminate providers approved by any delegated entities. Within the contracts, **RMHP** delineated available remedies should the delegate fall short of its obligations. **RMHP** also provided HSAG with a sample of recent audit reports conducted of its delegated providers.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

RMHP's corporate *Quality Improvement Program (QIP) Description* and 2017 corporate *QIP Impact Analysis/Annual Report* demonstrated that **RMHP** has in place a comprehensive quality assessment and performance improvement (QAPI) program. The **RMHP** Board of Directors maintains ultimate accountability for the program, supported by three primary oversight committees— Quality Improvement Committee (QIC), Medical Advisory Council (MAC), Member Experience Advisory Council (MEAC)—and numerous subcommittees with designated areas of responsibility. The program description, corporate QI work plan, and monthly committee meeting minutes demonstrated a multidisciplinary, multidepartmental, active engagement process with routine reporting; analysis of results; and planned interventions for quality improvement initiatives. The scope of the program was defined to focus on the following (applicable to all lines of business):

- Clinical care quality
- Patient safety
- Physician access and availability
- Member satisfaction
- Continuity and coordination of care
- Care management
- Pharmacy management
- Member rights and responsibilities

During on-site interviews, **RMHP** staff members also described the Practice Transformation Program—offered to all CHP+ and Medicaid practices in **RMHP**'s service area—which was designed to coach and assist providers in improving quality of care and performance within individual practices.

The annual QIP impact analysis report documented thorough and comprehensive reporting and analysis of all areas of QI activity, including achievements and continued improvements needed within each area. Components of the QIP program included performance improvement projects (PIPs) and Healthcare Effectiveness Data and Information Set (HEDIS®)[2-1] and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2-2] measures for CHP+, with required reporting of each to the Department. The PIP met the required design parameters (previously evaluated by HSAG). Grievance and appeal data were trended and analyzed quarterly, results of previously processed quality of care concerns (QOCCs) were reviewed semi-annually by the MAC, and both were reported in the annual impact analysis report. The annual report also included an assessment of quality improvement effectiveness within each major area of activity, noting areas of success and areas of continued challenge.

RMHP adopted clinical practice guidelines in compliance with requirements and had practice guidelines in place for all specific health conditions required by the Department. **RMHP** distributed clinical practice guidelines to providers and members through the **RMHP** website. **RMHP** demonstrated, through provider newsletters, that providers were notified of available clinical practice guidelines and how to access them. Staff members also noted that select practice guidelines were distributed to individual practices through the Practice Transformation Program.

RMHP submitted health information system (HIS) architecture and flow chart documents which demonstrated that **RMHP** maintained a highly integrated multi-component data system for collecting, processing, and reporting claims as well as clinical and operational information. Core system components included:

- FACETS—member enrollment data from the State, provider claims processing, provider network profiles, and reporting of encounter data to the Department.
- Essette—UM, care coordination files, and external provider and health information exchange inputs.
- Member services platform—Customer Service communications as well as grievances and appeals.
- Business Intelligence Data Hub (data warehouse)—information received from all system components, data reporting, and analytics.

RMHP provided samples of multiple dashboard and routine reports which demonstrated collection of and access to utilization, claims, grievances and appeals, and data reported from external providers and organizations. **RMHP** collected information from providers in standardized formats, including claims data in the standard ANSI 837 format. Claims data were collected and electronically transferred to **RMHP** through secure data exchange mechanisms. Staff members stated that approximately 10 percent of claims were manually submitted and entered into the data system, where they were subject to the same system edits and claims payment processes as were electronic claims. **RMHP** demonstrated that the encounter data system collected member and provider demographics and services furnished to members by the rendering provider. Claims data received from providers were verified for completeness

[2-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[2-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

and accuracy—including member and provider eligibility, diagnosis codes, service coding rules, and clinical edits—through three separate and increasingly detailed electronic editing applications within the system. If necessary, the system sent claims to a queue for manual review prior to final adjudication. **RMHP'**s policies and procedures described the process and procedures for monthly batch submission—to the Department—of paid, denied, and adjusted medical and pharmacy claims using the required ANSI X12N 837 and National Council for Prescription Drug Programs (NCPDP) file formats.

Summary of Findings Resulting in Opportunities for Improvement

RMHP provided sample reports of utilization measures calculated and communicated to individual providers but not reviewed and analyzed as a component of the QAPI program in the context of detecting over- or under-utilization of services. HSAG recommended that **RMHP** consider elevating periodic review of some of the provider-profiling utilization data or other available utilization trending measures to the QAPI Committee level and implementing analysis focused on detecting underutilization or overutilization of services.

The *Quality Improvement Program Description 2017–2018* and **RMHP** staff members described mechanisms in place to manage the care needed by members with SHCN through the complex case management, care coordination, and continuity-of-care program activities. While these activities are designed to "identify and reduce barriers to services for members with complex health conditions, which may include members with multiple chronic conditions as well as members with physical or developmental disabilities," the intent of these activities was not to assess the quality of care for members with SHCN. HSAG recommended that **RMHP** consider using its adopted clinical care guidelines applicable to members with SHCN as a basis for evaluating the quality of care being delivered to these members or to a sub-population of members with SHCN.

Summary of Required Actions

While **RMHP** demonstrated having program-specific interventions to manage potential under- or over-utilization of services by individual members, and also demonstrated that it provided a variety of utilization measures to individual provider practices, neither these nor other utilization trending measures were reviewed and analyzed as a component of the QAPI program in the context of detecting under- or over-utilization of services. **RMHP** must define and implement mechanisms to systematically detect and determine, as a component of its QAPI program, concerns regarding both underutilization and overutilization of services by CHP+ members.

While **RMHP** described complex case management, care coordination, and continuity-of-care program activities mechanisms in place to manage the care needed by individual members with SHCN, the intent of these activities was not to assess the quality of care for members with SHCN. **RMHP** must develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care furnished to members with SHCN.

Staff members stated that because the approval process for UM guidelines and covered service decisions—as outlined in the *Clinical Criteria for UM Decisions* policy and procedure—paralleled the approval process for clinical practice guidelines, **RMHP** could ensure that UM decisions were consistent with adopted clinical practice guidelines. However, written procedures and processes did not articulate the accountability of the MAC to ensure consistency of UM guidelines with clinical practice guidelines; nor was a process outlined to ensure that member education materials or other operational activities were consistent with applicable clinical practice guidelines. **RMHP** must enhance internal procedures and defined accountabilities to ensure that decisions for UM, member education, coverage of services, and other areas to which clinical practice guidelines apply are consistent with adopted guidelines.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

For the FY 2018–2019 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 III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and related 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 health plan's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-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 CHP+ credentialing and recredentialing.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements effective July 2018. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the samples from all CHP+ credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018. For the record review, the health plan received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-3] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2018–2019 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 V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Objective of the Site Review

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

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

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2018.

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

FY 2017–2018 Corrective Action Methodology

As a follow-up to the FY 2017–2018 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP** until it completed each of the required actions from the FY 2017–2018 compliance monitoring site review.

Summary of FY 2017–2018 Required Actions

For FY 2017–2018, HSAG reviewed Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

For the Grievance System standard, **RMHP** was required to:

- Ensure that members receive written acknowledgement of each grievance within two working days of the health plan's receipt of the grievance.
- Ensure that appeals are resolved and members receive written notice of appeal resolution within 10 working days from date of receipt.
- Resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance.
- Ensure that written acknowledgement of each appeal is sent to the member within two working days of receipt, unless the member or designated client representative requests an expedited resolution.

For the Member Information standard, **RMHP** had no required actions.

For the Provider Participation and Program Integrity standard, **RMHP** was required to have a method to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members.

HSAG scored all requirements for subcontracts and delegation as not applicable for CHP+ health plans due to an effective date, for new federal regulations, of July 1, 2018. As such, HSAG identified no required actions for this standard.

Summary of Corrective Action/Document Review

RMHP submitted a proposed CAP in April 2018. HSAG and the Department reviewed and approved the proposed plan and responded to **RMHP**. In October 2018, **RMHP** submitted documents as evidence of completion of its proposed interventions. HSAG and the Department reviewed and approved **RMHP**'s evidence of completion of the required actions and responded to **RMHP** in January 2019.

Summary of Continued Required Actions

RMHP successfully completed the 2017–2018 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3, 10.5.3.5, 10.5.3.6	*Bullet #1* *III_CM_Care Coordination Policy and Procedure* Page 1, *Policy*, the 4th bullet states that RMHP receives referrals and prioritizes follow-up in a timely manner. Page 11, *Referrals* indicates that all referrals are sent to the respective RMHP or ICCT Care Coordination team and responded to within 7 days or as urgently as the situation requires. Page 16, last paragraph, *Care Plan Development*, indicates that care planning identifies services that a member receives from another RAE, FFS Medicaid, Community or support providers and any other entity that is involved in the member's plan. Bullet #2 *III_CM_Care Coordination Policy and Procedure* Pages 2-3 describe RMHP Stratification. Pages 3-5 describe Clinical Event Management. Pages 5-10 describe RMHP response to members with specific needs. These provisions demonstrate that RMHP provides care coordination to Members who require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet #3 *III_CM_Care Coordination Policy and Procedure* Page 19, 3rd bullet, *Care Plan Development,* indicates that RMHP ensures that the Members authorized family Members or guardians are involved in treatment planning and consent to the medical treatment when appropriate. *III_CM_People w SHCN Policy* Page 4, Section 3 b. states that RMHP will ensure involvement of all Members and or family Members or guardians as applicable in the care planning, establishment of goals and consent for care. *Bullet #4* *III_CM_Care Coordination Policy and Procedure* Page 1, 4th bullet, establishes RMHP's commitment to receive referrals and prioritize follow-up in a timely manner as well as to coordinate with outside partners as needed. Page 18, 1st and 3rd bullets, *Care Plan Development*, demonstrate that care plan interventions include coordination of appropriate resources for care by specialist, subspecialist and community-based organizations, including a follow-up process to determine whether the members act on referrals. *Bullet #5* *III_CM_Continuity & Coordination of Care 2018*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 4, *Medicaid and CHP+ Members*, documents the policy and process to ensure continuity of care when new members are enrolled to prevent disruption in the provision of medically necessary services. *III_CM_Care Coordination Policy and Procedure* Page 5, *Special Populations*, describes Customer Service Welcome calls to all newly enrolled members. These calls provide a mechanism to quickly identify an individual in need of assistance to assure continuity of services when transitioning from one system to another. *III_CM_ Referral Campaign Workflow* This document shows RMHP's referral workflow process. The documents listed below demonstrate procedures to deliver care to and coordinate services for all members. *III_CM_Care Plan Workflow v3* *III_CM_Essette Care Plan Example* *III CM_Essette Documentation* *III_CM_PM ER Follow Up Campaign Workflow-30 Day FU v6* *III_CM_Continuity & Coordination of Care 2018*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B—1.1.79, 7.11.1.2	*III_CM_Care Coordination Policy and Procedure* Page 15, 3rd paragraph, *Initial Care Coordination Outreach and Screening*, indicates that for Members identified as Persons with Special Health Care Needs, an assessment will be initiated within 30 days to identify any ongoing special conditions that require a course of treatment or regular monitoring. Page 20, 6th bullet, *Active Care Plan Maintenance and Follow-up* shows that RMHP ensures that each member has an ongoing source of care appropriate to his or her needs by providing the Member with ongoing information about choices of settings, providers, treatment option and resources as needed and appropriate. Page 11, *Integrated Community Care Coordination Teams*, states that RMHP is exclusively responsible for ensuring that appropriate care coordination is provided for all Medicaid and CHP+ members. Page 18, 1st paragraph, *Care Plan Development*, indicates that the care plan should identify a lead care coordinator who is formally designated as primarily responsible for coordinating covered services furnished to the member. Page 14, 2nd paragraph, *Access to Care Coordination*, states that once a member is engaged	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	with their local Care Coordinator the member is provided with the direct contact information for the Care Coordinator. *III_CM_People w SHCN Policy* *Pages 4-5, Section 4, Case Management Coordination Specific to Children with Special Health Care Needs,* indicates that RMHP enters into agreements with selected County Health Departments for the case management of Children with Special Health Care Needs. This section describes the responsibilities of the County Health Departments in managing these cases. *III_CS_CHP+ Adult Welcome Call Script* *Pages 3-4, Medical Conditions*, sets forth the script informing members with medical conditions how to access a care coordinator. *III_CS_CHP+ Child Welcome Call Script* *Page 4, Medical Conditions*, sets forth the script informing members with medical conditions how to access a care coordinator. *RMHP CHP+ Benefits Booklet_1018_508* Pages 17–18 describe the care coordination program and how to contact a care coordinator.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: Documents submitted and on-site interviews confirmed that, within 30 to 45 days of enrollment, newly enrolled CHP+ members receive an outreach call from Customer Service (CS) staff to explain benefits of the program, assist members with identifying a primary care provider (PCP), and conduct initial intake screenings related to member needs. CS staff members identify themselves to the member and provide contact information for CS availability to assist members with needs and provide ongoing care coordination for Tier 1—Healthy members/health promotion and prevention—i.e., members with a low risk level of stratified needs. Other members are referred to the Care Coordination Team for follow-up. Each care coordinator involved with a member provides his or her contact information to the member. When CS is unable to contact a new member, a welcome letter is sent to the member encouraging the member to select a provider from the online provider directory or to call Customer Service for assistance. The RMHP CHP+ Benefits Booklet also informs members of how to select a provider and how to contact an RMHP care coordinator. RMHP does not auto-assign members to PCPs. The combination of these member communications intends to ensure that each member has an ongoing source of care; however, RMHP does not have a routine mechanism to inform each member of how to contact his or her designated PCP.		
Required Actions: RMHP must develop a mechanism to inform a member of how to contact his or her PCP for ongoing coordination of healthcare services accessed by the member.		
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)*	*III_CM_Care Coordination Policy and Procedure* Page 4, *Clinical Event_Management,* states that RMHP care coordinators will provide assistance during care transitions from hospitals or other care institutions to home or community-based settings or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. Page 16, the 4th and 6th paragraphs, *Care Plan Development***,** describe the procedures for coordinating services to Members under the circumstances listed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract—Exhibit B—10.5.3.3.1	*III_CM_People w SHCN Policy* This document describes RMHP's comprehensive policy for serving People and Children with Special Health Care Needs (P/CSHCN), which includes ensuring that members are referred to community based resources and that care coordinators support communication across all members of the health care team. Page 4, Section 4.a.- b.i, describes RMHP's process for coordinating services for children with special healthcare needs with other agencies, and for linking these members with community based services.	
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including subsequent attempts if the initial attempt to contact the member is unsuccessful. • Assessment includes screening for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. *42 CFR 438.208(b)(3)* Contract: Exhibit B—10.5.3.1.1	*III_CM_Care Coordination Policy and Procedure* Pages 13-16, *Screening, Assessment, Care Planning*, describe RMHP's procedures for conducting initial screenings. *III_CS_CHP+ Child Welcome Call Script* *III_CS_CHP+Adult Welcome Call Script* These documents provide the text for welcome call screens for pregnancy, mental health, Special Health Care Needs, and social determinants of health (SDoH). *III_CS_Welcome Call PP* This Policy indicates that the CHP+ Welcome Calls (screens) are attempted within 90 days of enrollment.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_CS_CHP+ Welcome Letter ENG SP This letter is a subsequent attempt to reach CHP+ Members when the initial attempt is unsuccessful. This letter is sent to all new CHP+ enrollees, even those who are reached through the Welcome call screens. *III_CM_People w SHCN Policy* Page 3, section 1 describes the procedure for initial screening of newly enrolled members.	
Findings: RMHP demonstrated mechanisms for attempting to conduct initial intake screenings of all new members within 30 to 45 days of enrollment to identify any special healthcare needs. Any member with identified need(s) is referred to care management for a more comprehensive follow-up assessment. The intake screening assessment included documentation of the member's language and screening for high-risk medical conditions; and call staff were instructed to discuss immunizations, well-child visits, and special healthcare needs. At the time of on-site review, RMHP provided documentation demonstrating having in development an expanded version of the intake screening questions, However, the intake screening applicable to the review period did not include assessment for behavioral health needs, functional problems, or other complex health needs, as required by the Department.		
Required Actions: RMHP must implement an expanded intake assessment that addresses all required elements of the health screening defined by the Department.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—10.6.1	*III_CM_Care Coordination Policy and Procedure* Page 2 explains that RMHP utilizes a care management system platform named Essette to achieve distribution of all of the members identified by stratification, ADT alerts, Special Populations and Referrals to RMHP. Screening, assessment, care planning, and follow up are all managed through Essette. The sharing and integration of Essette allows coordination of the many entities that may be providing care/services to a members resulting in better member outcomes and less duplication of care and services. Page 18, *Care Plan Development***,** last bullet, explains that the RMHP care coordinator shares the results of assessment and identified needs of the member with other providers serving the member with special healthcare needs in order to prevent duplication of those activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B—14.1.6.6–7	*2018-19 Provider Manual* Pages 101-102 describe PCP responsibilities for maintaining and sharing records with specialty physicians and Consultants. Member confidentiality is described at the bottom of page 102. Pages 103-105 details all aspects of *Medical Records* maintenance, including *Release of Information and Transfer of Records*. Detailed information about what office records should include is provided. Providers are responsible for	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the maintenance of adequate medical records, which are to be secure, complete, legible, accurate, accessible, organized, and maintained in a format that facilitates retrieval of information. *III_PNM_Physician(s) Medical Services Agreement* Page 10, section 2.L. (7), requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law.	
7. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B—10.5.1.1	*III_CM_Care Coordination Policy and Procedure* Page 19, *Care Plan Development*, provides that "[a]ny communication with a non-member representative will require the appropriate Appointment of Representative/HIPAA paperwork to be filled out." *CM_HIPAA Consent Form 0918* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR requirements to assure member privacy is protected. RMHP uses this *Authorization to Use or Disclose Specific Information* (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *III_CM_Confidentiality and Retention of Member Records* Page 1, section I, states that employees of Rocky Mountain have a moral and legal obligation and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	responsibility to protect the privacy of our members. All information obtained in an official capacity is confidential and staff will comply with HIPAA Privacy Regulations.	
8. The Contractor implements mechanisms to comprehensively assess each Medicaid member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *42 CFR 438.208(c)(2)* Contract: Exhibit B—10.6.2	*III_CM_Care Coordination Policy and Procedure* RMHP conducts comprehensive assessments of Members identified as having special health care needs regardless of how they are identified. Page 11 lists *Examples of referral sources,* which includes FFS Medicaid. Page 15, *Assessment* lists the elements of the comprehensive assessment. *III_CM_Comprehensive Needs Assessment* This screenshot from Essette illustrates RMHP's comprehensive needs assessment that is utilized with all members regardless of how they are identified. *III_CM_People w SHCN Policy* Pages 2-3 of *Assessment and Needs Identification* describe how RMHP Care Managers proactively assess individuals with special healthcare needs for conditions that require ongoing treatment and monitoring. RMHP will assess the member with special healthcare needs within 30 days of the referral to the Care Management team.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the enrollee. • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards. • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—10.5.3.2.1–4	*III_CM_Care Coordination Policy and Procedure* 1st Bullet Page 16, 1st paragraph of *Care Plan Development,* states that an individualized care plan is developed collaboratively with the member, providers, community partners, and caregivers (if applicable). Care plans will be communicated to primary care providers and specialists. 2nd Bullet Approval by RMHP is not required. 3rd Bullet Page 16, *Care Plan Development* indicates that RMHP care plans use the SMART goal method for creating care plan goals, which means each goal should be: Specific, Measurable, Attainable, Realistic and Timely. Any services specified in the care plan would comport with any applicable limits or standards established by the State, if any. 4th Bullet Page 19, *Active Care Plan Maintenance and Follow-up* states that Care Coordinators must assign a reasonable timeframe for re-evaluation to facilitate a progressive plan of care. The Care Coordinator will document a schedule for follow-up and communication with the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 2-3, *Stratification*, indicates the various timeframes for outreach/reassessment of functional need (at least biannually).	
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—10.5.3.5; 10.6.3	*III_CM_Care Coordination Policy and Procedure* Page 15, 3rd paragraph of *Initial Care Coordination Outreach and Screening* provides that if the member has been identified as a Person with Special Health Care Needs, an assessment will be initiated within thirty (30) days to identify any ongoing special conditions that require a course of treatment or regular monitoring. NOTE: RMHP does not require referrals to any contracted provider. Members have direct access to specialists. *III_CM_People w SHCN Policy* Pages 3-4, *Continuation of Care*, explain the process for providing continuity of care and minimizing disruptions for newly enrolled members with special health care needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	8
			Total Score ÷ Total Applicable			=	80%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B—14.1.1.2	*IV_CS_Prime RAE CHP+ Member Rights & Responsibilities* This *Policy and Procedure* documents RMHP's written policy regarding a Prime, RAE, or CHP+ Member's Rights and Responsibilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract: Exhibit B—14.1.1.1	*2018-19 Provider Manual* Page 107-108 of the Provider Manual describes Member rights to network providers. *IV_PNM_LawExhibit to Provider Agreements* See Page 7-8, Section 5 for *Medicaid Recipient Rights*. Page 8, Section 6 lists the federal and State laws with which RMHP, providers and subcontractor shall comply. *IV_Compliance Plan_Corp_Mission and Values* Page 2 of the *Compliance Plan* illustrates RMHP's Mission and Values. RMHP's value statement confirms that "We honor the rights of physicians and patients in medical decision-making."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	*IV_CS_Prime RAE CHP+ Member Rights & Responsibilities* Page 2, Section 6 Member rights as specified in state and federal regulation. *Member Newsletter_Fall 2018* Page 3, *RMHP Helpful Resources* advises Members how to find information online to learn	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B—14.1.1.2.1–5; 14.1.1.3	more about their Member rights and responsibilities.	
4. The Contractor ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the State Medicaid agency treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B—14.1.1.2.6	*IV_CS_Prime RAE CHP+ Member Rights & Responsibilities* Page 2, bullet #8 indicates that the Member is able to exercise their rights without being treated differently. *2018-19 Provider Manual* Page 107 indicates that Members are able to freely exercise their rights without being treated differently. *RMHP CHP+ Benefits Booklet_1018_508* Page 18, bullet #9 indicates to Members that they are able to exercise their rights without being treated differently.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IV_PNM_LawExhibit to Provider Agreements Page 7-8, Section 5, *Medicaid Recipient Rights*, which states that "Contractor shall ensure that Medicaid Recipients have the rights set forth in 42 C.F.R. section 438.100(b)(2), including but not limited to the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, consistent with 42 C.F.R., section 438.100.(b)(2)(v)."	
5. Member's rights and responsibilities are included in the member handbook and provided to all enrolled members. *42 CFR 438.10(2)(ix)* Contract: Exhibit B—14.1.3.10	*RMHP CHP+ Benefits Booklet_1018_508* Page 18-19 delineates CHP+ *Member Rights & Responsibilities.* The Benefits Booklet is available to Members on the RMHP.org website. Enrolled Members are advised how to access the Benefits Booklet when they first enroll (through the *Getting Started Guide*) and annually (through the *Member Newsletter*).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor complies with any other federal and State laws that pertain to member rights, including Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract: 21.A	*IV_Screen Shot_#5_Federal and State Laws* Information about federal and State laws that pertain to Member rights is posted on the RMHP.org website. It is also posted in prominent locations in RMHP physical office locations. *2018-19 Provider Manual* Page 106 informs providers of the RMHP Equal Opportunity Policy Statement. *IV_HR_ Law Exhibit_Non-Prov_Ind Contractor_1018*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This Law Exhibit is attached to all non-provider contracts that are executed with RMHP. See pages 3-4, #11 for a list of statutes and regulations that RMHP requires the Contractor and any subcontractor to comply. *IV_PNM_LawExhibit to Provider Agreements* Law Exhibit, page 1, Sections I.1. and I.2. present the *Non-Discrimination* and *Equal Opportunity* language found in provider contracts. Page 8, Section III.6 references other federal and state laws that pertain to Member rights.	
7. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: Exhibit B—14.1.6.7	*CM_HIPAA Consent Form 0918* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this *Authorization to Use or Disclose Specific Information* (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *CM_Confidentiality and Retention of Member Records* Page 1, Section I states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of Members. All information obtained in an official capacity is confidential and will comply with HIPAA Privacy Regulations. Section II describes how RMHP protects the confidentiality of all Member records.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to adult members receiving care by or through the Contractor. Advance directives policies and procedures include: • A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provisions that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive and that members are not discriminated against based on whether they have executed an advance directive.	*RMHP CHP+ Benefits Booklet_1018_508* Pages 19-21 provides written information to Members about advance directives. *2018-19 Provider Manual* Pages 93-94 provides written information to providers about advance directives. 1st bullet RMHP does not impose any limitations with respect to implementing advance directives as a matter of conscience, therefore no statement to this effect is included in written information to individuals. 2nd, 3rd and 4th bullets *IV_RMHMO Medicare Medicaid Advance Directives _PP* This policy implements advance directives. Page 2, item 3, specifies that the provider's obligations with respect to advance directions must comply with 42 CFR 489, Subpart I and, at a minimum, do the following. • Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians. • Identify the state legal authority permitting such objection.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for educating staff concerning policies and procedures about advance directives. • Provisions for community education regarding advance directives, to include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract: Exhibit B—14.1.9.1	• Describe the range of medical conditions or procedures affected by the conscientious objection. *2018-19 Provider Manual* Page 94 explains practitioner responsibilities around advance directives, including the policies they must have in place to provide information to Members about their rights under state law to create an advance directive, and the policies of their organization to respect implementation of those rights (including any limitations because of conscientious objections). 5th and 6th bullets *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 1 under "Process," paragraphs 1.c. and d. provide that Members rights include that advance directive information is given to the Member's family if he or she is incapacitated at the time of enrollment. Once the Member is no longer incapacitated, the information is given to the individual directly. Page 1, under "Procedure," paragraph 1 requires providers to have and comply with written policies and procedures for advance directives, including requirements in 42 CFR 489.102. Subsection (e) of this regulation sets forth the timing of the	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	provision of advance directive information when the Member is incapacitated. *IV_PR_ Advance Directives PP* Page 2, third bullet, practitioners must provide advance directive information to incapacitated Members once they are no longer incapacitated. 7th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 1. Item 4, and page 2, item 2.b sets forth the Member's right to have an advance directive recorded in the medical record. Page 2, item 4 provides that when chart audits occur they will include a review for the presence or absence of advance directives in the medical record. *V_PR_ Advance Directives PP* Page 1, under "Key Components," a practitioner is required to include a Member's advance directive in the medical record. *2018-19 Provider Manual* Page 94 provides that a practitioner must include a Member's advance directive in the medical record. 8th bullet *RMHP CHP+ Benefits Booklet_1018_508*	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 20, *Know the Law*, informs Members that they will not be denied services, treatment or admission to a health care facility if the Member does not sign an advance directive. *IV_PR_ Advance Directives PP* Under "Purpose" on page 1 of the policy, providers are prohibited from discriminating against Members based on whether the Member has executed an advance directive. Under "Key Components" a practitioner may not condition the provision health or medical care based on whether the Member has signed an advance directive. *2018-19 Provider Manual* Page 94 provides that a practitioner may not condition the provision of health or medical care based on whether or not the Member has signed an advance directive. 9th bullet *RMHP CHP+ Benefits Booklet_1018_508* To ensure compliance with state laws regarding advance directives, page 21 provides information to Members about how to complain if an advance directive is not followed. 10th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP*	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2, item 2.a. provides that Members will be informed of changes in state law concerning advance directives no later than 90 days following the change in law. 11th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 2, item 5.c. provides that RMHP will train staff on policies and procedures on advance directives. 12th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 2, item 5.d. provides that RMHP will provide community education on advance directives, including issues that the education will address.	
Findings: RMHP did not have provisions for community education regarding advance directives. In the past, RMHP had relied on the RMHP Foundation to provide advance directive education to the community; however, the Foundation did not conduct this activity during the review period and would not likely be providing this function going forward. RMHP did provide an education session to healthcare providers; however, there was no education provided to the community at large.		
Required Actions: RMHP must develop provisions for community education regarding advance directives including what constitutes an advance directive, emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and description of applicable State law concerning advance directives.		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	7
			Total Score ÷ Total Applicable			=	88%

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's credentialing program complies with the standards of the National Committee on Quality Assurance (NCQA) for initial credentialing and re-credentialing of participating providers. *42 CFR 438.214(a)* Contract: Exhibit B—14.2.1.3	*VIII_QI_Credentialing Criteria and Process* *VIII_QI_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.	☒ 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: • The types of practitioners it credentials and recredentials. This includes all physicians and non-physician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavioral health provider.) NCQA CR1—Element A1	*VIII_QI_Credentialing Criteria and Process* Section B *VIII_QI_Recredentialing Process* Section C The tables on pages 4-5 and 3-5, respectively, outline the types of practitioners that RMHP credentials and recredentials.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's written policies and procedures for the selection and retention of providers specify: • The verification sources it uses. NCQA CR1—Element A2	*VIII_QI_Credentialing Criteria and Process* Section B, pages 7-9 *VIII_QI_Recredentialing Process* Section C, pages 8-9 These sections (Source Verification) outline the sources used to verify practitioner credentials (approved credentialing verification sources).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's written policies and procedures for the selection and retention of providers specify: • The criteria for credentialing and recredentialing. NCQA CR1—Element A3	*VIII_QI_Credentialing Criteria and Process* Sections A-B, pages 2-6 *VIII_QI_Recredentialing Process* Section A-C, pages 2-6 These sections outline the criteria used for credentialing and recredentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	*VIII_QI_Credentialing Criteria and Process* Sections C-D., pages 9-11 *VIII_QI_Recredentialing Process* Sections D-E., pages 9-11 *VIII_QI_Credentialing and Recredentialing Approval Workflow 2018* The sections Review and Determination, Final Decision and Notifications, and the Approval Workflow diagram describe RMHP's process for making credentialing and recredentialing decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor's written policies and procedures for the selection and retention of providers specify: ▪ The process for managing credentialing and recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	*VIII_QI_Credentialing Criteria and Process* Section C, pages 9-10 *VIII_QI_Recredentialing Process* Section D., pages 9-11 These sections describe the process for managing credentialing and recredentialing files according to RMHP's criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	*VIII_QI_Delegated Credentialing & Recredentialing* This document outlines the process for delegation of credentialing and recredentialing activities, and establishes uniform guidelines regarding delegated activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic or national identity, gender, age, sexual orientation, or patient type in which the practitioner specializes). NCQA CR1—Element A7	*VIII_QI_Nondiscriminatory Credentialing* This policy establishes the steps that RMHP takes during credentialing processes to monitor and prevent discriminatory practices.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information provided to the Contractor. NCQA CR1—Element A8	*VIII_QI_Credentialing Criteria and Process* Section B., page 7, paragraph 3 *VIII_QI_Recredentialing Process* Section C., page 8, paragraph 4 This section provides the process that RMHP follows for notifying practitioners if information obtained from sources varies substantially from that provided on the application	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	*VIII_QI_Credentialing Criteria and Process* Section D., page 11 *VIII_QI_Recredentialing Process* Section E, page 11 These sections indicate when a determination has been made by Medical Direction or the 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 PNM013* The *Policy* section on page 1 and the *Credentialing Approved* section on page 4 indicate that approval notification is sent to providers and groups within 30 days.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor's written policies and procedures for the selection and retention of providers specify: • The medical director's or other designated physician's direct responsibility and participation in the credentialing/recredentialing program. NCQA CR1—Element A10	*VIII_QI_Credentialing Criteria and Process* See Policy on Page 1 *VIII_QI_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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor's written policies and procedures for the selection and retention of providers specify: • The process for ensuring the confidentiality of all information obtained in the credentialing/recredentialing process. NCQA CR1—Element A11	*VIII_QI_Credentialing Criteria and Process* Section F, page 11-12 *VIII_QI_Recredentialing Process* Section G, pages 11-12 These sections delineate the RMHP process for ensuring the confidentiality of information obtained in the credentialing and recredentialing process.	☒ 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 written policies and procedures for the selection and retention of providers specify: • The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	*VIII_QI_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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contactor notifies practitioners about their rights: • To review information submitted to support their credentialing or recredentialing application. • To correct erroneous information. • To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B	*VIII_QI_Credentialing Criteria and Process* *VIII_QI_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	☒ 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_QI_CHCP_Credentials_Application* Page 23, item 12 also explains these rights *VIII_QI_Screen Shot_Join RMHP Providers* See screen shot of RMHP.org website that explains practitioners' rights related to the provider application process.	
15. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee uses participating practitioners to provide advice and expertise for credentialing decisions. NCQA CR2—Element A1	*VIII_QI_Credentialing Committee* This policy describes the Credentialing committee structure and function. *VIII_QI_MPRC Member List* This Medical Practice Review Committee (MPRC) listing shows the range of specialties participating in each regional credentialing committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Credentialing Committee: ▪ Reviews credentials for practitioners who do not meet established thresholds. ▪ Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A2 and A3	*VIII_QI_Credentialing Criteria and Process* Section C, pages 9-10 *VIII_QI_Recredentialing Process* Section D, pages 9-11 These sections, *Review and Determination*, 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 8-15-18* This is a sample of the credentialing committee meeting minutes where practitioners who do not meet established thresholds were reviewed. *VIII_QI_Medical Director Review of Clean Files* This documents how a Medical Director reviews and approves a weekly list of files that meet established criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
17. The Contractor verifies credentialing and recredentialing information through primary sources to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: • A current, valid license to practice (verification time limit=180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit=prior to the credentialing decision).	*VIII_QI_Credentialing Criteria and Process* Section B, pages 7-9 *VIII_QI_Recredentialing Process* Section C, pages 8-9 The Sections *Source Verification* indicate that RMHP verifies all required elements for credentialing and recredentialling within 180 days prior to Medical Direction or credentialing committee review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Education and training—highest level obtained—e.g., medical/ professional school graduate; residency (verification time limit=prior to the credentialing decision). Required at initial credentialing only. • Board certification—if the practitioner states on the application that he or she is board certified (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 curriculum vitae (CV) (verification time limit=365 calendar days). Required at initial credentialing only. • History of malpractice settlements—most recent five years (verification time limit=180 calendar days). NCQA CR3—Element A	*VIII_QI_State Licensing Verification Letters* These are primary source verification letters for training that are collected annually from the State for specific specialties.	
18. 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	*VIII_QI_Credentialing Criteria and Process* Section B., pages 7-9 *VIII_QI_Recredentialing Process* Section C, pages 8-9 The sections *Source Verification* 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_QI_National Practitioner Databank* This policy establishes the written guidelines for accessing the NPDB to verify sanctions, license limitations, and malpractice history for all new	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	applicants and all currently contracted practitioners as part of the recredentialing process. *VIII_PR_Initial Credentialing Process PNM013* This policy describes the process that Provider Relations (PR) Representatives follow to initiate credentialing for prospective practitioners. If a practitioner is found in any of the databases, credentialing is not initiated.	
19. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a signed attestation (attestation verification time limit=365 days). The application addresses the following: • Reasons for inability to perform the essential functions of the position. • 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 or professional liability insurance coverage (minimums=physician—0.5mil/1.5mil; facility—0.5mil/3mil). • Attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	*VIII_QI_Credentialing Criteria and Process* *VIII_QI_Recredentialing Process* Pages 3, 6-7 These pages/sections indicate that RMHP utilizes the Department of Public Health & Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentialing Application. *VIII_QI_CHCP_Credentials_Application* • Page 26 ability to perform essential functions of the position • Page 25: attestation regarding illegal drug use • Page 19-20: attestations regarding loss of license and felony convictions • Page 19-20: attestation regarding loss or limitation of privileges or disciplinary actions • Page 16: attestation of current malpractice or professional liability insurance coverage	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Page 21: attestation confirming correctness and completeness of the 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)	
20. The Contractor formally recredentials practitioners at least every 36 months. NCQA CR4	*VIII_QI_Recredentialing Process* Last sentence page 1 states that recredentialing will occur at least every three years.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
21. The Contractor has and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies issues related to poor quality. Monitoring includes: • 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.	*VIII_QI_Midcycle Credentialing* Sections A-D, pages 2-3 explain the RMHP process for reviewing provider status updates related to sanctions or limitations on licensure, adverse events and instances of poor quality. *VIII_QI_Ongoing Monitoring Sample Reports 2018* A sample of a monthly report collected and reviewed for sanctions will be available onsite. *VIII_QI_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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR5—Element A	*VIII_QI_QA Case Review Diagram* This flowchart illustrates the RMHP Quality Assurance case review process *VIII_QI_MPRC Minutes 10-11-18* These Medical Practice Review Committee (MPRC) minutes illustrate examples of interventions when instances of poor quality are identified.	
22. The Contractor has policies and procedures for taking action against a practitioner for quality reasons, reporting the action to the appropriate authorities, and offering the practitioner a formal appeal process. Policies and procedures address: • The range of actions available to the Contractor to improve practitioner performance before termination. • Procedures for reporting to National Practitioner Data Bank (NPDB), State agency, or other regulatory body, as appropriate. NCQA CR6—Element A1 and A2	*VIII_QI MPRC_ Reduction, Suspension or Termination RC.04* This policy describes the procedures for taking action against a practitioner for quality reasons. Section 1.a., pages 2-4 and Section 1.c. page 5 describes the formal appeal process offered to the practitioner. Section 1, page 2 describes the range of actions available to RMHP, including mentoring, increased oversight or other proposed professional review action. Section 4, page 6 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. When taking action against a practitioner for quality reasons, the Contractor offers the practitioner a formal appeal process. Policies and procedures address: • A well-defined practitioner appeal process, including: – Written notification when a professional review action has been brought against a practitioner, reasons for the action, and a summary of the appeal rights and process. – Allowing practitioners to request a hearing and the specific time period for submitting the request. – Allowing at least 30 calendar days, after notification for practitioners, to request a hearing. – Allowing practitioners to be represented by an attorney or another person of their choice. – Appointing a hearing officer or a panel of individuals to review the appeal. – Notifying practitioners of the appeal decision in writing, including specific reasons for the decision. • Making the appeal process known to practitioners. NCQA CR6—Element A3 and A4	*VIII_QI MPRC_ Reduction Suspension or Termination RC.04* This policy describes the procedures for taking action against a practitioner for quality reasons. Section 1.a., pages 2-4 and Section 1.c. 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. Section 1.e. page 5 describes the process for notifying the practitioner of the decision, including the reasons supporting it. *VII_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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* providers with which it contracts, which include: • The Contractor confirms—initially and at least every three years—that the 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. NCQA CR7—Element A1	*VIII_QI_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Section C, page 6 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. Section B, pages 2-3 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. Section D., page 5 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
25. The Contractor confirms, initially and at least every three years, provider review and approval by an accrediting body. • Policies specify the sources used to confirm—which may only include applicable State or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies	*VIII_QI_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Section B, pages 2-3 lists the documentation that must be submitted by all organizational providers to demonstrate that they are in good standing with regulatory or	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
of credentials—e.g., licensure, accreditation report or letter—from the provider. NCQA CR7—Element A2	accrediting bodies. The accrediting bodies recognized by RMHP are listed in Section C, page 3-4. Section D, page 5 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.	
26. The Contractor conducts, initially and at least every three years, an on-site quality assessment if the provider is not accredited. • Polices include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that 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. NCQA CR7—Element A3	*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_QI_Health Delivery Organizations* Section D, page 5 indicates that CMS or state quality reviews substituted for a site visit are no more than three years old.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor's organizational provider assessment policies and processes include assessment of at least the following medical providers: • Hospitals • Home health agencies • Skilled nursing facilities • Freestanding surgical centers NCQA CR7—Element B	*VIII_QI_Health Delivery Organizations* See *Policy* on Page 1, first paragraph lists the organizational providers defined for the purposes of this policy, including hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers and others.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers. NCQA CR7—Element D	*VIII_QI_Ogranizational Providers 7-1-18 thru 12-31-18* This file represents RMHP contracted organizational providers (Health Delivery Organizations) that have been reviewed since July 1, 2018. This universe is located in the Record Review folder. *VIII_QI_SAMPLE - Accred Medical HDO* This is a sample credentialing record of an accredited organizational provider (Health Delivery Organization) credentialed by RMHP. *VIII_QI_SAMPLE - Non-Accred Medical HDO* This is a sample credentialing record of a non-accredited organizational provider (Health Delivery Organization) credentialed by RMHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. If the Contractor delegates any NCQA-required credentialing or recredentialing 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. • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, or terminate individual practitioners, providers, and sites—even if the organization delegates decision making. • Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill obligations. NCQA CR8—Element A	*VIII_QI_Delegated Credentialing Audit Activities* Section B, page 2 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_QI 2017 U of Utah delegated audit* *VIII_QI 2017 Vail delegated audit* *VIII_QI 2018 CU Medicine delegated audit* *VIII_QI 2018 HealthOne delegated audit* *VIII_QI 2018 National Jewish delegated audit* *VIII_QI 2018 Montrose delegated audit* These completed audit tools provide evidence of RMHP oversight of delegated credentialing activities. *VIII_QI_Delegated Credentialing & Recredentialing* Paragraph 1, page 2 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. Section D, page 5 indicates that the specific elements delegated to each entity are outlined in the Delegated Credentialing Addendum attached to each contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_QI Delegated Credentialing Agmt (10-2018) template For each bulleted item, see notes on pages 1, 2, 3, 5, Exhibit A.	
30. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions: • The allowed uses of PHI. • A description of delegate safeguards to protect the information from inappropriate use or further disclosure. • A stipulation that the delegate will ensure that subdelegates have similar safeguards. • A stipulation that the delegate will provide members with access to their PHI. • A stipulation that the delegate will inform the Contractor if inappropriate use of information occurs. • A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR8—Element B	*VIII_QI Delegated Credentialing Agmt (10-2018) template* Member specific PHI is not shared or included in any of RMHP's delegated arrangements, however, our delegated agreement template addresses any potential PHI in Exhibit B, sections II, IV and V.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. For new delegation agreements in effect fewer than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. NCQA CR8—Element C	*VIII_QI_Delegated Credentialing & Recredentialing* Page 3, Section B 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_QI_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_QI Pre-Delegation Evaluation SCL 2018 questionnaire* This is a form completed by a potential delegate to determine ability to fulfill delegation requirements. *VIII_QI Pre-Delegation SCL 2018* This delegate is the only agreement that came into effect in the past 12 months in the Medicaid/CHP+ service area. The packet contains the Policies and Procedures, file review tool, and policy and procedure evaluation tool	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	used to determine compliance with RMHP and NCQA Standards for Credentialing.	
32. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegates' credentialing policies and procedures. • Annually audits credentialing and recredentialing files against NCQA standards for each year that delegation has been in effect. • Annually evaluates delegate performance against NCQA standards for delegated activities. • Semiannually evaluates delegate reports specified in the written delegation agreement. • At least once in each of the past two years, identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Elements D and E	*VII_QI_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_QI_Delegate Annual Oversight Tracking Tool* This tracking tool illustrates current RMHP activity to audit delegated credentialing files. *VIII_QI 2018 Centura delegated audit – NCQA* This delegate is NCQA certified, therefore, only an annual review of Policies and Procedures is required. *VIII_QI 2017 U of Utah delegated audit* *VIII_QI 2017 Vail delegated audit* *VIII_QI 2018 CU Medicine delegated audit* *VIII_QI 2018 HealthOne delegated audit* *VIII_QI 2018 National Jewish delegated audit* *VIII_QI 2018 Montrose 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_QI_Delegate Semi-Annual Report Tracking Tool Demonstrates RMHP activity to evaluate credentialing reports from Delegates semiannually. *VIII_QI Samples Of Semiannual Reports* Examples of self-identifying and reporting improvement activities on the Semi-Annual Credentialing Submission Form.	

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	=	0
Total Applicable		=	32	**Total Score**		=	32
Total Score ÷ Total Applicable						=	100%

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)* Contract: Exhibit B—12.1	*X_QI_Corporate QI Program Description 2017-18* *X_QI_Corporate QI Work Plan 2018* *X_QI_Corporate Quality Program Annual Report 2017* *X_QI_2018 QI Intervention Team Work Plan*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department 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. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B—12.3.1, 12 3.2, 12.3.4	*X_QI_Corporate QI Work Plan 2018* Page 8, Section J.1.a and J.1.b. show contractual requirements for CHP+. *X_QI_Corporate Quality Program Annual Report 2017* Pages 66-67 describes the CHP+ PIP: *Transition of Care for Children with Asthma Aging out of the CHP+ Plan*, including the process followed, and barriers and opportunities identified. *X_QI_CHP+ PIP Conclusion Report 2018* This is the final PIP report that was submitted in April of 2018 to the Department. The PIP for 2018-19 was submitted to HSAG for review on 10/31/18. The current PIP Title: Improving Well Child Visit (WCV) Completion Rates for CHP+ Members Ages 15-18."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B—12.4.1, 12.4.2	*X_QI_Corporate QI Work Plan 2018* Page 2, Section B.1.a.describes RMHP activity in HEDIS data collection and reporting. *X_QI_Corporate Quality Program Annual Report 2017* Page 15, 1a: HEDIS data submitted to the State.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B—12.4.4	*X_QI_Corporate Quality Program Annual Report 2017* Page 40, Section 7a describes RMHP activity to identify and decrease emergency room visits by line of business, including CHP+. Page 52-53, Section G, 1d, describes the Community Health Worker Pilot. This program includes practices in Mesa County, Montrose and Roaring Fork areas that have each been assigned a CHW to engage with patients in efforts to help high-risk patients modify behaviors that prompt inappropriate or ineffective utilization of services. *X_CM_Drug Safety Program* Page 1 describes the basis of the program to ensure safe and appropriate prescribing of high-risk drugs.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2 describes RMHP's process for detecting the target population who may be at risk for negative outcomes due to overutilization. *X_QI_QI126A-Teen Wellness (14-17) Incentive* *X_QI_QI133A Pre Teen Wellness (10-13) Incentive* These incentive programs were developed to address the issue of underutilization of wellness visits in the pre-teen and teen populations. These mailings are sent to Members with a gap in care during their birthday month. *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.	
Findings: RMHP demonstrated having program-specific interventions to identify and assist with management of potential under- or over-utilization of services by individual members. Examples included care management interventions to influence appropriate utilization of services, identifying members through the drug safety program who may be at risk for negative outcomes due to overutilization of high-risk medications, providing incentives to stimulate members to increase use of underutilized well-child visits, and following up with members who use emergency department visits inappropriately. In addition, RMHP provided a sample of utilization measures calculated and communicated to individual providers for potential analysis and intervention by individual provider practices. However, none of these data were routinely reviewed or analyzed in the context of determining under- or over-utilization of services within the QAPI program. HSAG recommended that RMHP consider elevating periodic review of some of the provider profiling utilization data or other available utilization trending measures to the QAPI committee level and implement analysis focused on detecting underutilization or overutilization of services.		
Required Actions: RMHP must define and implement mechanisms to systematically detect and determine, as a component of its QAPI program, concerns regarding both underutilization and overutilization of services by CHP+ members.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor's QAPI program includes investigation of any alleged quality of care concerns. Contract: Exhibit B—12.4.5.1	*X_QI.QMI.06.18 - Retrospective Quality Case Review Process* 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.	☒ 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 means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g., medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	*X_QI_Corporate QI Work Plan 2018* Page 2, Section A.1.h: Complex Health Needs Assessment Page 4, Section B.5: Complex Case Management Page 5, Section C: Continuity and Coordination of Medical Care and Between Medical and Behavioral Healthcare *X_QI_Corporate QI Program Description 2017-18* Page 11, A.1.c: Complex Health Needs Page 11, A.1.d: Collaboration on Continuity and Coordination of Care Page 12, a: Complex Case Management Program	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: The *Quality Improvement Program Description 2017–2018* and RMHP staff members described mechanisms in place to manage the care needed by members with SHCN through the complex case management, care coordination, and continuity-of-care program activities. While these activities are designed to "identify and reduce barriers to services for members with complex health conditions, which may include members with multiple chronic conditions as well as members with physical or developmental disabilities," the intent is not to *assess* the quality of care for members with SHCN. HSAG recommended that RMHP consider using its adopted clinical care guidelines applicable to members with SHCN as a basis for evaluating the quality of care being delivered to these members or to a subpopulation of members with SHCN.		
Required Actions: RMHP must develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care furnished to members with SHCN.		
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B—12.4.7.1	*X_QI_Corporate Quality Program Annual Report 2017* Pages 3-4 indicate that program activities are structured around an ongoing process of quality monitoring, reporting, and evaluation. 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. 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 participating providers. • Are reviewed and updated at least every two years.	*X_QI.QMI.07.18 - Clinical Practice Guidelines* Page 3, Section 1.c: Guidelines will be reviewed and adopted directly from a recognized source (a national organization that develops evidence based clinical practice guidelines). Page 3, Section 1.e: Includes an analysis of the relevancy of the guideline to the RMHP population.	☒ 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 438.236(b) Contract: Exhibit B—12.2.1.2	Page 3, Section 1.a: Annually and when new scientific evidence and/or national standards warrant a review, guidelines are reviewed for updates or changes to current clinical practice initially by the Quality Improvement Department with subsequent consultation by other internal clinical staff as necessary (e.g. Medical Directors and pharmacists). Page 2 indicates that the Medical Director reviews each guideline annually and proposes changes to current guidelines when necessary, and provides approval of final guidelines on an annual basis. *X_CM_ Clinical Criteria for UM Decisions* Section I and II, page 1 and 2 describes the process used to apply written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services. Section III, page 3 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 Section II. E, page 2 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.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_CM_Template_for_Practitioner_Review_Letter This letter template is used for the purpose of obtaining practitioner input on the development and adoption of RMHP criteria.	
9. The Contractor develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. Contract: Exhibit B—12.2.1.1	*X_QI_Bright Futures Periodicity Schedule* Recommendations for Preventive Pediatric well-child care. *X_QI.QMI.07.18 - Clinical Practice Guidelines* Outlines RMHP's process for reviewing, approving, and distributing clinical guidelines. RMHP adopts both Medical and Behavioral Health Guidelines to support quality and clinical activities at RMHP. *X_QI_Perinatal Care Guideline* Outlines RMHP's Perinatal Care Guideline. *X_QI_Special Health Care Needs Adults* *X_QI_Special Health Care Needs Children* These documents represent RMHP's Clinical Practice Guidelines for Children and Adults with Special Health Care Needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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, members, non-members, and the public—at no cost. *42 CFR 438.236(c)* Contract: Exhibit B—12.2.1.3	*X_CM_ Clinical Criteria for UM Decisions* Section VI page 5 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. *X_Screen Shot_#10_Disseminate Clinical Guidelines and Tools* RMHP disseminates information on its public website regarding current clinical practice guidelines, provider tools and Member self-management tools. *X_PNM_Provider Newsletter_Spring 2018* Page 7 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. *X_PNM_Provider Newsletter_Summer 2018* Page 6 indicates the criteria used to make a decision are available upon request at no cost to the Member or provider. *2018-19 Provider Manual*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 80-81 explains *Review Criteria.* Criteria used in decision-making are available, free of charge, to Physicians, Practitioners, facilities, and Members upon request to RMHP.	
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)* Contract: Exhibit B—12.2.1.4decsions	*X_CM_ Clinical Criteria for UM Decisions* Section VII, page 5 describes how RMHP assesses at least annually the consistency with which physician and non-physician reviewers apply UM criteria in decision-making. *2018-19 Provider Manual* The Care Management section starting on page 74 addresses many aspects of the Care Management Program. It describes the organizational structure that is in place to support correct and consistent development and application of guidelines. The first two full paragraphs at the top of page 82 describe how consistency is maintained including inter-rater reliability testing, audits, and utilization clinical rounds.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
RMHP submitted documents that explained the internal processes applied to maintaining decisions that are consistent with the application of UM clinical guidelines. The intent of the federal requirement is to ensure that UM decisions, coverage of services, member education materials, and other operational areas are consistent with clinical practice guidelines—i.e., treatment guidelines—adopted by RMHP. The Clinical Criteria for UM Decisions policy and procedures did describe an approval process for UM criteria that included input from multidisciplinary physicians, medical directors, and the New Technology Assessment and Guidelines Committee—which considers investigational or experimental procedures and emerging technologies for coverage of service determinations. In addition, all guidelines—whether clinical practice guidelines or UM guidelines—were approved by the Medical Advisory Committee (MAC). RMHP staff members explained that the similar review and approval processes applied to both the adoption of clinical practice guidelines and UM guidelines, with ultimate reporting to the MAC ensuring

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
that UM and coverage of service decisions are consistent with clinical practice guidelines. Nevertheless, written procedures and processes did not articulate the accountability for the MAC to ensure consistency of UM guidelines with clinical practice guidelines; nor was a process outlined to ensure that member education materials or other operational activities were consistent with applicable clinical practice guidelines.		
Required Actions: RMHP must enhance internal procedures and defined accountabilities to ensure that decisions for UM, member education, coverage of services, and other areas to which clinical practice guidelines apply are consistent with adopted guidelines.		
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	*X_RMHP Health Information Systems_v1.6* 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. *RMHP CHP MCO Combined Report SFY 2017-18* This report, which tracks grievances and appeals, will be made available onsite. *X_PT_Referrals_Med Nghbrhd_ Peds* *X_PT_Engaging in the Med Nghbrhd* 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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	emergency room triggers a notification to the patient's PCP, e.g., page 6 of *Engaging in the Medical Neighborhood.*	
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract: Exhibit B—12.4.10.1	*X_RMHP Health Information Systems_v1.6* This flowchart indicates the various reporting and analytics that are done in the areas of utilization, claims, grievances and appeals, etc. (RMHP does not disenroll CHP+ Members.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
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)* Contract: Exhibit B—18.2.1	*X_CL_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). *X_CL_Medicaid CHP+_Pharmacy Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Pharmacy Claim Encounter Data to 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	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	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. See also #16 below.	
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)* Contract: Exhibit B—12.4.10.2	*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* Page 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.	☒ 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 used for Medicaid quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B—12.4.10.3.1	*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_IA_Annual Audit Plan 2018* These documents describe RMHP audit activities to verify accuracy and timeliness of reported data;	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	screening data for completeness, logic and consistency; and collecting information in standardized formats. See page 4: • Claims Financial and Transaction Accuracy Audit. Additional information in X_*IA-003 Procedure _Claims Accuracy Reporting* and X_*IA-007 Claims Auditing Manual.* • Hospital Bill and Chart Review Audits. CAS audit software review, 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 in X_*IA-207 Correct Coding for E&M Mgt Code (CCP).* • DME Invoices and Rentals. Audit 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_IA-003 Procedure for Claims Accuracy Reporting* and *X_ IA-007 Claims Auditing Manual* RMHP performs Claims Financial and Transaction Accuracy audits monthly. This document describes the claims accuracy reviews.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_IA-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.	
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, NCPDP, and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B—18.2.6; 18.2.7, 18.2.8	*X_CL_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). *X_CL_Medicaid CHP+_Pharmacy Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Pharmacy Claim Encounter Data to HCPF.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Enrollment and disenrollment information. Contract: Exhibit B—12.4.3.2	*X_QI_Corporate Quality Program Annual Report 2017* Pages 54-63: describes various Member satisfaction survey tools, results, and analyses Page 61: CHP+ CAHPS analysis Page 62: Statewide practitioner survey to evaluate Member experience of PCP and specialist visits. Pages 64-65: RMHP performs quarterly and annual evaluations of Member complaints and appeals. Results and opportunities for improvement are presented to the Member Experience Advisory Council for review and discussion. *RMHP CHP MCO Combined Report SFY 2017-18* This report, which tracks grievances and appeals, will be made available onsite.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	83%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Credentialing Record Review Tool
for Rocky Mountain Health Plans

Review Period:	July 1–December 31, 2018
Date of Review:	January 29, 2019
Reviewer:	Katherine Bartilotta and Gina Stepuncik
Health Plan Participant:	Judy Narenkivicius and Erin Nipper

Sample #	1	2	3	4	5
Provider ID	Remove	***	Remove	Remove	***
Credentialing Date	07/12/18	07/26/18	08/03/18	08/09/18	08/23/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☐ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☒ N ☐ NA ☐
3. Education and training	Y ☐ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☒ N ☐ NA ☐
5. Work history (most recent 5 years or from time of initial licensure)	Y ☐ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☐ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☐ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☐ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☒ N ☐
9. Signed application and attestation	Y ☐ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☐ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☒ N ☐
Number of applicable elements		**8**			**10**
Number of compliant elements		**8**			**10**
Percentage compliant		**100%**			**100%**

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

Comments:

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Credentialing Record Review Tool
for Rocky Mountain Health Plans

Sample #	6	7	8	9	10
Provider ID	Remove	***	***	***	***
Credentialing Date	09/20/18	09/28/18	10/25/18	11/08/18	12/14/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☐ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒
3. Education and training	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☐ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒
5. Work history (most recent 5 years or from time of initial licensure)	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Signed application and attestation	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements		**10**	**9**	**9**	**8**
Number of compliant elements		**10**	**9**	**9**	**8**
Percentage compliant		**100%**	**100%**	**100%**	**100%**

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

Comments:

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Credentialing Record Review Tool
for Rocky Mountain Health Plans

Sample #	OS1	OS2	OS3	OS4	OS5
Provider ID	***	***	***	***	***
Credentialing Date	08/30/18	09/07/18	10/04/18	10/31/18	11/29/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☐
3. Education and training	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
4. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☐
5. Work history (most recent 5 years or from time of initial licensure)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
6. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
7. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
8. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
9. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
10. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
Number of applicable elements	**8**	**10**	**9**	**10**	
Number of compliant elements	**8**	**10**	**9**	**10**	
Percentage compliant	**100%**	**100%**	**100%**	**100%**	

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

Comments:

Total number of applicable elements	**91**
Total number of compliant elements	**91**
Overall percentage compliant	**100%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Recredentialing Record Review Tool
for Rocky Mountain Health Plans

Review Period:	July 1–December 31, 2018
Date of Review:	January 29, 2019
Reviewer:	Gina Stepuncik
Health Plan Participant:	Judy Narenkivicius and Erin Nipper

Sample #	1	2	3	4	5
Provider ID	***	***	***	***	***
Prior Credentialing or Recredentialing Date	08/12/15	08/20/15	08/26/15	08/20/15	09/17/18
Current Recredentialing Date	07/12/18	07/19/18	08/03/18	08/09/18	08/30/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐ NA ☐
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Number of applicable elements	**9**	**7**	**9**	**7**	**9**
Number of compliant elements	**9**	**7**	**9**	**7**	**9**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**

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

Comments:

Sample #	6	7	8	9	10
Provider ID	***	Remove	***	***	Remove
Prior Credentialing or Recredentialing Date	10/14/15		10/28/15	01/27/16	
Current Recredentialing Date	09/13/18	10/4/18	10/12/18	11/29/18	12/20/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☐
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☐ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐
Number of applicable elements	**9**		**9**	**9**	
Number of compliant elements	**9**		**9**	**9**	
Percentage compliant	**100%**		**100%**	**100%**	

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

Comments:

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2018–2019 Recredentialing Record Review Tool
for Rocky Mountain Health Plans

Sample #	OS1	OS2	OS3	OS4	OS5
Provider ID	***	***	***	***	***
Prior Credentialing or Recredentialing Date	08/26/15	08/14/15	10/14/15	11/11/15	12/23/15
Current Recredentialing Date	07/26/18	08/23/18	09/20/18	10/25/18	11/14/18
The Contractor, using primary sources, verifies that the following are present:					
1. A current, valid license to practice with verification that no State sanctions exist	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
2. A valid DEA or CDS certificate (if applicable)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐
3. Board certification (if the practitioner states on the application that he or she is board certified)	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐	Y ☐ N ☐ NA ☐
4. History of malpractice settlements (most recent 5 years)	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
5. Current malpractice insurance in required amount (physicians: 0.5mil/1.5mil)	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
6. Verification that the provider has not been excluded from participation in federal programs	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
7. Signed application and attestation	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
8. Verification was within the allowed time limits (verification time limits are included below).	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
9. Provider was recredentialed within 36 months of previous approval date.	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐
Number of applicable elements	**9**	**9**			
Number of compliant elements	**9**	**9**			
Percentage compliant	**100%**	**100%**			

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

Comments:

Total number of applicable elements	**86**
Total number of compliant elements	**86**
Overall percentage compliant	**100%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2018–2019 site review of **RMHP**.

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

HSAG Review Team	Title
Katherine Bartilotta	Associate Director
Gina Stepuncik	Senior Project Manager
RMHP Participants	**Title**
Alex Hulst	Integrated Behavioral Health Advisor
Amber Davis	Claims Supervisor
Amy Rowan	Outreach Coordinator, Tri County Health
Angela Nottingham	QI Intervention Developer
Anne Wilburn	RN Mountain Family Health Center
Ashley Painter	Communications Specialist
Audrey Oldright	Care Management Outreach Coordinator
Brett Teuscher	Senior Manager, Internal Audit
Carrie Calabro	Projects and Compliance Specialist
Carol Ann Hendrikse	Manager, RN Accountable Care Collaborative Clinical Programs
Cheryl Koch	Compliance Assistant
Christian Perez	Case Manager, Plan de Salud
Christy Hunt	Claims Production Manager
Cynthia Mattingley	QI Practice Transformation
Dale Renzi	Director, Provider Network Management
David Mok-Lamme	Senior Community Research Analyst
Debbie Breitkreuz	QI Intervention Developer
Erin Nipper	Credentialing Coordinator
Eve Presler	Special Populations and Training Manager
Greg Coren	Western Slope Provider Relations Manager and Provider Network Manager
Griffin Day	Community Health Worker, Mountain Family Health Center
Heather Cochrane	Supervisor, Claims Financial Reconciliation
Jay Puhler	Medicaid/Medicare Claims Reconciliation Specialist
Jerry Spomer	Director—Internal Audit, Member Benefit Administration, and Member Enrollment and Billing

RMHP Participants	Title
Jill Bystol	Quality Assurance Compliance Coordinator
Judy Narenkivicius	Supervisor, Credentialing and Quality Improvement
Karen Ramirez	CAC II Social Worker—UC Health, Ft. Collins
Kendra Peters	RAE Program Operation Support and Provider Training Administrator
Laurel Walters	Chief Operating Officer
Leanne Hart	Director, Marketing and Communications
Liz Bullock	West Region, Clinical Program Manager
Lori Stephenson	Director, Clinical Program Development and Evaluation
Marci O'Gara	Director, Customer Service
Matthew Cook	Director, Claims
Maura Cameron	Director, Quality Improvement
Meg Taylor	RAE Program Officer, Region 1
Mike Huotari	Vice President, Legal and Government Affairs
Molly Siegel	RAE Clinical Services Director
Nancy Soltero	RN, Mountain Family Health Center
Nicole Konkoly	RAE Network Relations Manager
Patrick Gordon	Vice President, RMHP
Paul Jackson	Director, Business Operations and Colorado Sales and Service
Pauline Casey	Senior Program Operations Leader
Rhonda Michaelson	Supervisor, Customer Service
Sandy Dowd	Director, Utilization Management
Sarah Weltzer	Behavioral Health Outreach Coordinator
Sheila Worth	Medical Strategic Initiatives Administrator
Sienna Hunter	Care Coordinator, La Plata Integrated Health, Axis Health Systems
Stephen Thompson	Manager of Care Team, UC Health, Fort Collins
Steven Robinson	Behavioral Health Compliance
Tim Sherman	Director, Regulatory Affairs
Department Observers	**Title**
Emily Berry	RAE 1 Program Specialist
Troy Peck	Prime Program Specialist
Murielle Romine	RAE 1 Program Administrator
Russ Kennedy	Quality and Compliance Specialist
Teresa Craig	Contract and Program Manager, CHP+ MCO and SMCN
Gina Robinson	EPSDT Program Administrator

Appendix D. Corrective Action Plan Template for FY 2018–2019

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

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan 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 health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the health plan to proceed with implementation, or • Instruct the health plan 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 health plan has received Department approval of the CAP, the health plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The health plan 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 health plan 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 health plan within the intervening time frame.) If the health plan 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 health plan'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 health plan's discretion at any time the health plan 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 health plan 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 health plan until all required actions are satisfactorily completed.

The CAP template follows.

Table D-2—FY 2018–2019 Corrective Action Plan for RMHP

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
2. The Contractor ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B—1.1.79, 7.11.1.2	Documents submitted and on-site interviews confirmed that RMHP has mechanisms to inform the member of contact information for care coordinators involved with the member and has a combination of member communications intended to ensure that each member has an ongoing source of care; however, RMHP does not have a routine mechanism to inform each member of how to contact his or her designated PCP.	RMHP must develop a mechanism to inform a member of how to contact his or her PCP for ongoing coordination of healthcare services accessed by the member.
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 III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including subsequent attempts if the initial attempt to contact the member is unsuccessful. • Assessment includes screening for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. *42 CFR 438.208(b)(3)* Contract: Exhibit B—10.5.3.1.1	RMHP demonstrated mechanisms for attempting to conduct initial intake screenings of all new members within 30 to 45 days of enrollment to identify any special healthcare needs. Any member with identified need(s) is referred to care management for a more comprehensive follow-up assessment. The intake screening assessment included documentation of the member's language and screening for high-risk medical conditions; and call staff were instructed to discuss immunizations, well-child visits, and special healthcare needs. The intake screening applicable to the review period did not include assessment for behavioral health needs, functional problems, or other complex health needs, as required by the Department.	RMHP must implement an expanded intake assessment that addresses all required elements of the health screening defined by the Department.
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 IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
8. The Contractor maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to adult members receiving care by or through the Contractor. Advance directives policies and procedures address [numerous provisions] including: • Provisions for community education regarding advance directives, to include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract: Exhibit B—14.1.9.1	RMHP did not have provisions for community education regarding advance directives. RMHP did provide an education session to healthcare providers; however, there was no education provided to the community at large.	RMHP must develop provisions for community education regarding advance directives including what constitutes an advance directive, emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and description of applicable State law concerning advance directives.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B—12.4.4	RMHP demonstrated having program-specific interventions to identify and assist with management of potential under- or over-utilization of services by individual members. In addition, RMHP provided a sample of utilization measures calculated and communicated to individual providers for potential analysis and intervention by individual provider practices. However, none of these data were routinely reviewed or analyzed in the context of determining under- or over-utilization of services within the QAPI program.	RMHP must define and implement mechanisms to systematically detect and determine, as a component of its QAPI program, concerns regarding both underutilization and overutilization of services by CHP+ members.
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 X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
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 means persons with ongoing heath conditions that: have lasted or are expected to last for at least one year; produce significant limitations in physical, cognitive, emotions, or—in the case of children—social growth or developmental function; or produce dependency on medical or assistive devices; or—in the case of children—unusual need for psychological, educational, or medical services or ongoing special treatments (e.g., medications, special diets, accommodations at home or at school).* *42 CFR 438.330(b)(4)* Contract: Exhibit B—None	The *Quality Improvement Program Description 2017–2018* and RMHP staff members described mechanisms in place to manage the care needed by members with SHCN through the complex case management, care coordination, and continuity-of-care program activities. While these activities are designed to "identify and reduce barriers to services for members with complex health conditions", the intent is not to *assess* the quality of care for members with SHCN.	RMHP must develop and implement mechanisms within its QAPI program to demonstrate assessment of the quality and appropriateness of care furnished to members with SHCN.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
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)* Contract: Exhibit B—12.2.1.4decsions	The Clinical Criteria for UM Decisions policy and procedures did describe an approval process for UM criteria that included input from multidisciplinary physicians, medical directors, and the New Technology Assessment and Guidelines Committee. In addition, all guidelines—whether clinical practice guidelines or UM guidelines—were approved by the Medical Advisory Committee (MAC). RMHP staff members explained that this process ensures that UM and coverage of service decisions are consistent with clinical practice guidelines. Nevertheless, written procedures and processes did not articulate the accountability for the MAC to ensure consistency of UM guidelines with clinical practice guidelines; nor was a process outlined to ensure that member education materials or other operational activities were consistent with applicable clinical practice guidelines.	RMHP must enhance internal procedures and defined accountabilities to ensure that decisions for UM, member education, coverage of services, and other areas to which clinical practice guidelines apply are consistent with adopted guidelines.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Findings**	**Required Action**
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 CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

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 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, on-site 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 plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all credentialing and recredentialing records that occurred between July 1, 2018, and December 31, 2018 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to credentialing and recredentialing of providers. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2018–2019 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the health plan and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the health plan and the Department.