CHP+
Child Health Plan *Plus*

Fiscal Year 2019–2020 Site Review Report

for

Rocky Mountain Health Plans

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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

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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 federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2019–2020 was January 1, 2019, through December 31, 2019. This report documents results of the FY 2019–2020 site review activities for **Rocky Mountain Health Plans** (**RMHP**). For each of the standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2018–2019 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 denials of authorization of services (denials) 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 2019–2020 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)
I. Coverage and Authorization of Services	36	32	29	3	0	4	91%
II. Access and Availability	16	16	16	0	0	0	100%
Totals	**52**	**48**	**45**	**3**	**0**	**4**	**94%**

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

Table 1-2 presents the scores for **RMHP** for the denial record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	90	62	60	2	28	97%
Totals	**90**	**62**	**60**	**2**	**28**	**97%**

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

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Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

RMHP submitted a large body of evidence to substantiate compliance with coverage and authorization of services requirements. **RMHP**'s submission included policies, procedures, reports, work plans, tools, manuals, and sample denial and extension letters. HSAG reviewed all submissions and found that the documents illustrated a thorough and comprehensive approach for the review, authorization, and denial of CHP+ covered services.

RMHP delegated utilization management (UM) functions for advanced imaging services, genetic testing, chiropractor, and behavioral health services to two different delegated entities. Policies and procedures addressed **RMHP**'s strategic oversight of all delegated UM activities, including an annual audit and evaluation of all delegated entities and overall performance. The delegation oversight scoring tool and annual oversight report demonstrated monitoring mechanisms and performance compliance for activities such as the initial and continuous prior authorization request process, application of evidence-based criteria, and requesting peer-to-peer review for decisions and review of adverse benefit determinations. Delegated oversight activities also included regular joint operations meetings and required delegate reporting and monitoring of utilization, grievances, and appeals. In instances of substandard performance, **RMHP** had a process to implement a corrective action plan to address and correct areas of concern, including discontinuation of the delegated relationship.

During on-site record reviews, HSAG observed that the notices of adverse benefit determination (NABDs) demonstrated the required content, including the reason for the decision, the member's right to appeal and to request a State review, and the possibility of requesting continued service/benefits pending the resolution of the appeal. **RMHP**'s staff members stated that, in addition to mailing members the NABD, **RMHP** placed a call to each member or the member's designated representative to clearly explain the reason for the adverse benefit determination, to ensure that the decision is clearly understood and to address any corresponding questions.

RMHP's policies and procedures accurately defined "emergency condition," "emergency services," and "post-stabilization services" consistent with regulatory definitions. In addition, the *CHP+ Member Benefit Booklet* clearly defined and explained that both emergency care and post-stabilization care services are covered and do not require a prior authorization. *RMHP's Claims Processing Manual* reiterated that services rendered in an urgent care facility or in the emergency room and all associated services are payable at the claim processor level without review for medical necessity.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

While denial record reviews demonstrated that **RMHP** met all required decision time frames, **RMHP**'s *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies included inaccurate information regarding required time frames for standard prior authorization decisions, as well as extended time frames. **RMHP** must correct information in its UM policies to accurately address:

- The 10-calendar day time frame for making standard authorization decisions.
- The 14-calendar day time frame for extending a standard or expedited authorization decision.

RMHP demonstrated that the CHP+ letter used for UM denials included all of the required content and was available in prevalent non-English language and alternative formats for persons with special needs. However, two of the denial record reviews demonstrated that **RMHP**'s reason for the adverse benefit determination incorporated prior authorization clinical criteria difficult for members with limited reading ability to understand. **RMHP** must ensure that the NABD letter in its entirety is written in language that is easy for a CHP+ member to understand.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

RMHP submitted a large body of evidence to substantiate compliance with access and availability requirements. **RMHP**'s submission included policies, procedures, reports, analytics, strategic plans, tools, manuals, and directories. HSAG reviewed the submission and found that **RMHP** maintained a network of providers sufficient to cover services to its CHP+ members. Within its Network Capacity Report, **RMHP** demonstrated the number of primary care and specialists available in each county, as well as the ratio of physicians to members living in those respective counties. HSAG reviewed the report and found that, while primary care and specialist provider types met network adequacy time and distance standards for most areas, **RMHP** experienced challenges with specialist access in some rural and frontier counties. During the on-site interview, **RMHP** discussed these challenges and strategies to improve access; however, for the most part, any additional providers required to fully meet network adequacy requirements do not exist in these communities. **RMHP** has continued to work to address specific access inadequacies, and has implemented use of telemedicine. **RMHP** reported that use of its CareNow and provider telemedicine modalities for urgent care and psychological therapy services has increased significantly over the short time since implementation and **RMHP** expects this trend to continue.

During the on-site interview, **RMHP** confirmed that members were provided access to women's healthcare specialists and to second opinions without a referral, which aligned with **RMHP** policies. **RMHP** provided evidence in its 2019 Provider Network Strategic Plan and Access Plan that a sufficient ratio of family planning providers were made available to members. In addition, **RMHP** affirmed that out-of-network providers were made available to members at no cost in situations where there was no

qualified provider within the network. **RMHP** stated that eating disorder specialists were the most referred to out-of-network providers.

RMHP had policies in place outlining the State's standards for timely access. **RMHP** also published timely access standards in its 2019 Provider Manual to ensure providers were aware of the requirements. **RMHP** informed providers in its 2019 Provider Manual that they may not limit their hours of operation in a manner which is less than what is offered to members of non-publicly financed programs. **RMHP** provided evidence of a member survey used to monitor providers for timely access. During 2019, **RMHP** evaluated timely access by administering the survey annually. During the on-site interview, **RMHP** stated that it would be conducting the survey quarterly in order to garner more responses and improve the quality of member reporting by reducing the lag between the member's appointment and the survey.

RMHP provided a robust array of policies on cultural competency. Within its policies, **RMHP** included provisions for how it addressed the needs of those members with limited English proficiency, diverse cultural and ethnic backgrounds, physical or mental disabilities, differing sexual orientation, or gender identity. During the interview, **RMHP** discussed its provider education series, which addressed topics such as "Bridges Out of Poverty" training and cultural and generational communications. A future topic planned for the May provider education series is "Best Practices for Providing Integrated Care Services for Latino Families."

Summary of Findings Resulting in Opportunities for Improvement

HSAG reviewed **RMHP**'s cultural competency policies for providing prevention, health education, and treatment for diseases prevalent in specific cultural or ethnic groups. While some policies and provider education existed, HSAG did not find specific processes associated with identifying and addressing prevalent health conditions of specific ethnic or cultural populations in the region. HSAG recommends that **RMHP** review the specific cultures, ethnicities, and identities of its CHP+ member population to determine prevalent healthcare issues that may be overlooked in the general population and enhance its policies and processes for extending prevention, education, and treatment to those populations.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two 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+ denial of authorization.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ denials to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed). Using a random sampling technique, HSAG selected the sample from all CHP+ denial records that occurred between January 1, 2019, and December 31, 2019. 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 I—Coverage and Authorization of Services. HSAG separately calculated a record review score for each record 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.[2-1] Appendix E contains a detailed description of HSAG's site review

[2-1] 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: Aug 5, 2019.

activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievances and Appeals, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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 two 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.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 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 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed 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 (QAPI).

Related to coordination and continuity of care, **RMHP** was required to complete two corrective actions, including:

- Develop a mechanism to inform a member how to contact his or her PCP for ongoing coordination of healthcare services.
- Implement an expanded intake assessment that addresses all required elements of the health screening defined by the Department.

Related to member rights and protections, **RMHP** was required to develop provisions for community education regarding advance directives.

Related to quality assessment and performance improvement, **RMHP** was required to complete three corrective actions, including:

- Implement mechanisms to systematically detect and determine, as a component of its QAPI program, concerns regarding both underutilization and overutilization of services.
- Implement mechanisms to demonstrate assessment of the quality and appropriateness of care furnished to members with special health care needs (SHCN).
- Enhance internal procedures 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.

Summary of Corrective Action/Document Review

RMHP submitted a proposed CAP in May 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **RMHP**. **RMHP** submitted initial documents as evidence of completion in August 2019, and all required actions were found to be successfully completed.

Summary of Continued Required Actions

RMHP successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* Contract: Exhibit B-1—8.3	*I_UM_ Program Description_2019-2020* Page 3, Section II, Paragraph 2: This describes that RMHP's UM Program is designed to ensure that medical services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the Plan. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 22: This describes that as part of its procedure RMHP ensures that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *2019 Provider Manual* Page 89, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the Member. Further, RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Exhibit B-1—8.11	*I_UM_Preauthorization Policy & Procedure* Pages 6-7, Paragraph 24 (a): This describes that RMHP does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *2019 Provider Manual* Page 89, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the State plan (such as medical necessity). • For the purpose of utilization control, provided that: – The services furnished can reasonably achieve their purpose. – Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. – Long-term services and supports (LTSS) supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services. *42 CFR 438.210(a)(4)* Contract: Exhibit B-1—8.15.8.1	*I_UM_Clinical Criteria for UM Decisions* Page 1, Purpose: This describes that RMHP applies objective and evidence-based criteria when determining medical appropriateness (necessity) of health care services. *I_UM_Preauthorization Policy & Procedure* Pages 7-8, Paragraph 24 (e)(i-iv): This describes that RMHP may place appropriate limits on services on the basis of criteria applied under the State (medical necessity) and for the purpose of utilization control, provided that the services furnished can reasonably be expected to achieve their purpose. Family planning services are provided in a manner that enables the member to be free from coercion and choose the method of family planning to be used. Long-term services and supports (LTSS) supporting individuals with ongoing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	or chronic conditions are authorized in a manner that reflects the member's ongoing need for such services. *2019 Provider Manual* Page 89, Pre-authorization Policies and Procedures: This states that RMHP may place appropriate limits on services to be furnished to reasonably be expected to achieve their purpose and are in accordance with the State Plan.	
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or SUD benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3—10-16-104(3)(B)* Contract: Exhibit B-1—8.15.4.1	Inform health plan on-site of forthcoming information from the Department regarding implementation by MCO's. (No desk review documentation from health plan needs to be submitted)	*For Information Only*
5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*	Inform health plan on-site of forthcoming information from the Department regarding implementation by MCO's. (No desk review documentation from health plan needs to be submitted)	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*	Inform health plan on-site of forthcoming information from the Department regarding implementation by MCO's. (No desk review documentation from health plan needs to be submitted)	*For Information Only*
7. The Contractor specifies what constitutes "medically necessary" in a manner that is: • Consistent with the symptom, diagnosis, and treatment of a member's medical condition. • Widely accepted by the practitioner's peer group as effective and reasonably safe based on scientific evidence. • Not experimental, investigational, unproven, unusual, or not customary. • Not solely for cosmetic purposes. • Not solely for the convenience of the member, subscriber, physician, or other provider. • The most appropriate level of care that can be safely provided to the member, and failure to provide the service would adversely affect the member's health. • When applied to inpatient care—medically necessary services cannot be safely provided in an ambulatory setting. Contract: Exhibit B-1—1.1.62.1–8	*I_UM_ Program Description_2019-2020* Page 3, Section II: This describes that RMHP's UM Program is designed to ensure that medical services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the Plan. Pages 24-25, Section XI. UM Criteria This describes RMHP's use of nationally accepted evidence-based guidelines that span the continuum of care, such as MCG Care Guidelines® and other nationally recognized criteria established by organizations such as the American Academy of Obstetrics, Gynecology or Pediatrics. Use of these criteria ensures that RMHP provides services in accordance with professionally recognized standards for healthcare in the United States. *I_UM_Clinical Criteria for UM Decisions* Pages 1-2 Section II: This describes that RMHP applies written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services. Further, this states that RMHP clinical policies are sound and based upon analysis of clear, professionally recognized evidence of effectiveness, and are financially responsible.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_Preauthorization Policy & Procedure Page 2, Definitions: This provides the definition of "Medical Necessity" that comports with 42 CFR 438.210(a)(5). *2019 Provider Manual* Page 66, Paragraph 2: This describes that a "Medically Necessary" health care good or service will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects, of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. Medical necessity means that a good or service: • Is clinically appropriate in terms of type, frequency, extent, site, and duration; • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider; • Is delivered in the most appropriate setting(s) required by the client's condition; • Is not experimental or investigational; and • Is not more costly than other equally effective treatment options.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* Contract: Exhibit B-1—11.1.5	*I_UM_Preauthorization Policy & Procedure* Page 1, Purpose: This policy addresses the processing of requests for initial and continuing authorization of services. *I_UM_2019_Optum_BH_UM_Program Description_Work Plan* Page 6, Scope of the Utilization Management Program: This describes that Optum has a well-structured UM program with a continuum of processes to address requests for initial and continuing authorization of services. *I_UM_eviCore_Delegation_Oversight_Summary_2019* Page 2, UM 1: Utilization Management Structure: This describes that eviCore has a well-structured UM program with policies and promote utilization decisions affecting the health care of Members in a fair, impartial and consistent manner.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor and its subcontractors have in place mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Contract: Exhibit B-1—11.1.6	*I_UM_2019_Optum_BH_UM_Program Description_Work Plan:* Page 32, Clinical Criteria: Demonstrates the use of evidence-based objective criteria that are reviewed at least annually. *I_UM_eviCore_Delegation_Oversight_Summary_2019* Page 2, UM 2: Clinical Criteria for Utilization Management Decisions:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This demonstrates that eviCore uses evidence-based, objective criteria that are reviewed at least annually. *I_UM_Clinical Criteria for UM Decisions* This document demonstrates that RMHP applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Pages 5-6, Section VII: This describes how RMHP annually assesses the consistency with which reviewers apply UM criteria in decision making and acts upon opportunities to improve consistency, if applicable. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 24: This provides that the criteria for authorization decisions are applied consistently.	
10. The Contractor and its subcontractors have in place mechanisms to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* Contract: Exhibit B-1—11.1.6	*I_UM_2019_Optum_BH_UM_Program Description_Work Plan:* Page 10, Peer Reviewer Determinations and Denials: This describes that Optum will conduct peer review or reconsiderations with the treating physician/practitioner when requested or as applicable for stat-specific or contractual requirements. *I_UM_eviCore_Delegation_Oversight_Summary_2019* Page 2, UM 2: Clinical Criteria for Utilization Management Decisions:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This demonstrates that eviCore's policies include assessment of the individual needs of the Member and consideration of the local delivery system. Input from outside physicians/practitioners with specific expertise is considered. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(d) (ii): This describes that RMHP allows discussion with the attending physician, PCP or requesting physician to collect necessary information to make a preauthorization decision. Page 17, Paragraph 35: This describes that RMHP, allows a rendering provider to request a peer-to-peer review to discuss an adverse determination.	
11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by an individual who has appropriate expertise in treating the member's medical or BH needs. *42 CFR 438.210(b)(3)* Contract: Exhibit B-1—11.1.3	*I_UM_Appropriate Professionals for CM and Pharmacy* Page 3, Section III: This describes the process for practitioner review of non-behavioral healthcare denials. Pages 4-5 Section IV: This describes the process for practitioner review of behavioral healthcare denials. Page 5, Section V: This describes the process for use of board-certified consultants in instances where RMHP Clinical Pharmacists and Associate Medical Directors do not have clinical expertise in the areas for which services or pharmaceuticals are being requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_UM_Preauthorization Policy & Procedure Page 6, Paragraph 23: This describes that UM decisions are made by individuals with the knowledge and skills to evaluate working diagnoses and proposed treatment plans for the member's medical or behavioral health needs.	
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. *Note: Notice to the provider may be oral or in writing.* *42 CFR 438.210(c)* Contract: Exhibit B-1—11.1.8	*I_UM_Preauthorization Policy & Procedure* Pages 15-17, Paragraphs 32-34: This describes the procedures that RMHP has in place to notify Members and requesting providers of decisions to deny or modify service authorization requests, which may be completed orally or in writing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* Contract: Exhibit B-1—11.1.10–11.1.12	**Bullet #1**: *I_UM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Preauth TAT's and Notification Requirements* This document is a grid of regulatory time frames that RMHP follows for notification of preauthorization decisions. The grid indicates that RMHP provides notice of standard authorization decisions within 10 calendar days. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(d)(i):	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This sets forth the timing for issuing a notice for a standard authorization decision. It indicates that RMHP will make a determination and notify the covered person and the covered person's provider of the determination within 10 calendar days after the receipt of the preauthorization request. **Bullet#2:** *I_UM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Preauth TAT's and Notification Requirements* This document is a grid of regulatory timeframes RMHP follows for notification of expedited preauthorization decisions. *I_UM_Preauthorization Policy & Procedure* Page 11, Paragraph 31(b): This sets forth the process for issuing a notice for an authorization decision no later than 72 hours after receipt of the request for those instances when the Member's condition requires an expedited decision.	
Findings: On-site denial record reviews confirmed that RMHP met the required authorization decision time frame for both standard and expedited requests. RMHP's *UM Timeliness of UM Decisions* policy described the process and time frames for making standard and expedited authorization decisions. However, the policy incorrectly identified the time frame for pre-service non-urgent requests as "up to 15 days" from the date of receipt. In addition, the policy did not specify that the time frame is within "calendar days."		
Required Actions: RMHP must correct its *UM Timeliness of UM Decisions* policy to accurately address the 10-calendar day time frame for making standard authorization decisions.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract*:* Exhibit B-1—11.1.10.1–2; 11.1.12.1–2	*I_UM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(d)(iii), Page 14, Paragraph 31 (e)(i)(2): This describes the process for extending the standard or expedited authorization timeframe for up to 14 calendar days when the Member requests an extension or RMHP justifies the need for an extension to the State.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: RMHP's *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies described the process for requesting an extension and specified the time frame for a determination to be reached. However, the *UM Timeliness of UM Decisions* policy inaccurately stated that the Contractor extension time frame is within "15 days" from the end of the initial authorization time frame or at the request of the member or provider. In addition, neither the *UM Preauthorization of Services* policy nor the UM *Timeliness of UM Decisions* policy indicated "calendar days" in the extension time frame.		
Required Actions: RMHP must correct information in its *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies to accurately address the additional "14-calendar day" time frame for extending a standard or expedited authorization decision.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor provides telephonic or telecommunications notice within twenty-four (24) hours of a request for prior authorization of covered outpatient drugs. *42 CFR 438.210(c)(3)* *42 US Code 1396r-8(d)(5)(a)* Contract: Exhibit B-1—8.18.3.1	*I_PH_Preauth and Exception Request_Procedure and TAT's_Notification Requirements* Page 20, Procedure, Paragraph 5.8.7 describes that correspondence (Corro) letters are sent to all Members and Providers who have requested coverage of a drug through RMHP. Pages 20-21, Paragraph 5.8.7.11, describes the procedure to Right-Fax (telecommunications notice) regarding requests for prior authorization of covered outpatient drugs. Page 24, Appendix A, describes the 24-hour turn-around time for Medicaid and CHP+.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* Contract: Exhibit B-1—14.1.3.15.1.1–4	Inform the health plan on-site that proposed federal rule changes include eliminating the 18-point requirement for taglines on denial notices. (Reviewed in Member Information standard.) *I_UM_Preauthorization Policy & Procedure* Page 15, Paragraph 32(a): This describes that notification will be provided to a Member in writing in a manner calculated to be understood by the Member, and that the notice will be available in English and prevalent non-English languages spoken by Members throughout the State and available in alternative formats for persons with special needs. *I_UM_Redacted Denial Letter Child Medicaid-CHP* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_Pharmacy_Sample Denial Letter Medicaid-CHP This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_Pharmacy_Sample QL Denial Letter Medicaid-CHP* This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10.	
Findings: RMHP policies and other submitted evidence demonstrated that template CHP+ NABDs used for UM denials were written in a language easy to understand and informed the member of the availability of the notice in other languages and alternative formats. However, HSAG found two of 10 CHP+ denial record reviews were *Not Met* for "correspondence with the member was easy to understand." RMHP incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the adverse benefit determination. The language content would be difficult for a member with a limited reading ability to understand.		
Required Actions: RMHP must ensure that the NABD in its entirety is written in language that is easy for a CHP+ member to understand.		
17. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes	Inform health plan on-site that federal rule changes for CHIP exclude the requirement that member information include "benefits will continue when the member files an appeal." (However, State contract currently overrides.) *I_UM_Preauthorization Policy & Procedure* Pages 15-16, Paragraph 32(b)(i-x): This describes the content of notices of action or adverse benefit determination and includes the entire list of regulatory requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's (or member's designated representative's) right to request one level of appeal with the Contractor and the procedures for doing so. • The member's right to request a State review after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State review. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances under which the member may be required to pay the cost of these services. • The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable. *42 CFR 438.404(b)* Contract: Exhibit B-1—14.1.3.15.1.5–12	*I_Pharmacy_Sample Denial Letter Medicaid-CHP* This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) *I_UM_Redacted Denial Letter Child Medicaid-CHP* This letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) i **Bullet #1**: Page 1, Paragraph 2 Page 2, Section: "How We Made Our Decision" **Bullet #2:** Page 2, Section: "How We Made Our Decision" Page 2, Section: "Call Us If You Have Questions" Page 3, Section: "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" **Bullet #3**: Page 2, Section-"Call Us If You Have Questions" Page 2, Section-"Know Your Appeal Rights" Page 3, Section-"Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Page 3, Section-"How To Ask for an Appeal?" Pages 4-5, Section-"How to Ask for A Quick Appeal?" **Bullet #4:** Page 2, Section "Before You Begin: Know Your Appeal Rights." Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Pages 5-6, Section "How To Ask for a Formal Hearing"	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet #5: Pages 5-6, Section "How To Ask for a Formal Hearing" **Bullet # 6:** Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Pages 4-5, Section "How To Ask for a Quick Appeal" **Bullet #7:** Page 6, Section "Continuing Your Benefits and Services" Pages 6-7, Section "To Continue Receiving Your Benefits and Services During the Appeal, Quick Appeal or Formal Hearing Process, You Must:" Page 7, Section, "Understanding the Results of Your Appeal, Quick Appeal, or Formal Hearing" **Bullet #8**: Page 6, Section, "How to Ask for An Appeal for a Child Denied Residential Treatment"	
18. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated.	Inform health plan on-site of forthcoming information from the Department regarding implementation by MCO's. (No desk review documentation from health plan needs to be submitted)	*For Information Only*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), and (II), and (III)* Contract: None		
19. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, no later than 10 calendar days after receipt of request for service. • For expedited service authorization decisions, no later than 72 hours after receipt of request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* Contract: Exhibit B-1—14.1.3.15.2.1–7	*I_UM_Preauthorization Policy & Procedure* Page 11, Paragraph 31(c)(i-vi): This incorporates the circumstances and timeframes by reference to Section 8.209 of State Medicaid Rules found in 10 CCR 2505-10. **Bullet #1:** Page 3, Paragraph 5: This indicates that RMHP must notify the member at least 10 days before the date of action for termination, suspension, or reduction of previously authorized Medicaid/CHP+-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214. **Bullet #2:** Page 11, Paragraph 31(c)(ii): This indicates that RMHP provides notice of denial of payment at the time of any denial affecting the claim. **Bullet #3:** Page 12, Paragraph 31(d)(i): This indicates that RMHP will make a determination and notify the covered person and the covered person's provider of the determination within 10 calendar days after the receipt of the preauthorization request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet #4: Page 14, Paragraph 31(e)(i):This indicates for expedited service authorization requests will be responded to within 72 hours of receipt. **Bullet #5** Page 14, Paragraph 31(d)(iv)(2)(a): This indicates that RMHP will respond to extended service authorization decisions no later than the extension expiration date. **Bullet #6:** Page 14, Paragraph 31(d)(iv)(2)(d): This indicates that if RMHP fails to make a determination within the required time frame, RMHP will notify the Member of his/her appeal rights on the date the time frame expires	
20. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services, or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services.	*I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 5: This describes that for reduction, suspension, or termination of previously authorized Health First Colorado (Medicaid)/CHP+-covered services, RMHP notifies the Member at least ten (10) days before the intended effective date of the proposed adverse benefit determination (action). **Bullet #1:** *I_UM_Preauthorization Policy & Procedure* Pages 11-12 Paragraph 31(c)(vi)(1): This describes the scenarios in which RMHP provides notice for reduction, suspension, or termination of a previously authorized Medicaid covered service on or	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* Contract: Exhibit B-1—14.1.3.15.2.1–3	before the intended effective date of the proposed adverse benefit determination. **Bullet #2:** *I_UM_Preauthorization Policy & Procedure* Page 12 Paragraph 31(c)(vi)(2): This describes that if probable Member fraud has been verified, RMHP gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination.	
21. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* Contract: Exhibit B-1—14.1.3.15.2.5.2	*I_UM_Preauthorization Policy & Procedure* Pages 12-13, Paragraph 31(d)(iii): This describes that RMHP may choose to request an extension. If an extension is taken, RMHP sends a written notice of the reason for the extension, which specifically describes the required information necessary to complete the request, gives the Member 14 days from the receipt of the notice to provide the specified information, and gives the Member the right to file a grievance if the Member disagrees with the decision to take the extension.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Exhibit B-1—11.1.1	*I_UM_Program Description_2019-2020* Page 3, Section II: This states that RMHP does not specifically reward practitioners or other individuals for issuing denials of coverage or care and offers no incentives for Pharmacy or UM decision makers to encourage decisions that result in underutilization. *I_UM_Appropriate Professionals for CM and Pharmacy* Page 5, Section VI: This describes RMHP's Affirmative Statement about Incentives.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.31	*I_UM_Emergency Department Services Claim Review Policy* This policy describes that RMHP makes payment for all emergency department services without medical necessity review. *I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: Defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Serious dysfunction of any bodily organ or part. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(a)(i-iii): This describes that RMHP will not deny treatment to a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *2019 Provider Manual* Page 80, Definition of Emergent Care: This provides the regulatory definition of "emergency medical condition." *RMHP CHP+ Benefits Booklet* Page 34, "When to use the Emergency Room:" This informs Members about when to use the emergency room, describing the circumstances contained in the regulatory definition of "emergency medical condition" in plain language.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.32	*I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: This defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *2019 Provider Manual* Page 80-Definition of Emergent Care: Contains the definition of "Emergency/Life and Limb-Threatening Medical Care" including that emergency services means covered inpatient and outpatient services furnished by a provider qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition. *RMHP CHP+ Benefits Booklet* Page 35: This defines emergency services for Members and informs Members that services for evaluation and stabilization are covered.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor defines poststabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-1—1.1.75	*I_CS_Poststabilization Services_Medicaid_CHP+Responsibility* Section 4: This contains the regulatory definition of poststabilization care. *I_UM_Preauthorization Policy & Procedure* Page 2, Definitions:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This defines poststabilization care services as covered services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the Member's condition. *RMHP CHP+ Benefits Booklet* Page 35, What Emergency Care Services are Covered: This explains poststabilization care to Members, including that these are covered services.	
26. The Contractor does not require prior authorization for emergency services or urgently needed services. Contract: Exhibit B-1—8.17.1.3	*I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(a)(i-iii): This describes that preauthorization is not required in medically urgent/emergent situations. *I_UM_ Program Description_2019-2020* Page 20, Section X: UM Case review processes This states that Urgent and emergent services do not require prospective review and all emergency room claims are paid without review through the normal claims payment processes. *2019 Provider Manual* Page 32, Section Access to Care, Paragraph 2: This describes that RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider. *RMHP CHP+ Benefits Booklet* Page 34, Paragraph 1:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This informs Members that they do not need prior authorization from RMHP to go to the emergency room for a true emergency.	
27. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B-1—8.17.1.4	*I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) Page 1, Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services: This claim manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph 3(b): This describes that RMHP covers emergency department services by participating and non-participating practitioners and providers. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(a)(i-iii): This describe that preauthorization is not required in medically urgent/emergent situations. *I_UM_Program Description_ 2019-2020* Page 21, Prospective Review Process Objectives:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This states that urgent and emergent services do not require prospective review and all emergency room claims are paid without review through the normal claims payment processes. 2019 Provider Manual Page 32, Section Access to Care, Paragraph 2: This describes that RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider. *RMHP CHP+ Benefits Booklet* Page 15: This informs Members that the requirement for obtaining care from doctors that work with RMHP does not apply to emergency care.	
28. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers*	*I_UM_Preauthorization Policy & Procedure* Page 4 Paragraph 8(a-b): This describes RMHP will not deny treatment to a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble) • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* Contract: Exhibit B-1—8.17.1.4, 8.17.1.6	RMHP shall not deny treatment if a representative of RMHP instructed the Member to seek emergency services. *I_UM_Emergency Department Services Claim Review Policy* Page 1, Policy (a): This describes that appropriateness of services is assumed based on Prudent Layperson definition. *2019 Provider Manual* Page 80-Definition of Emergent Care: This contains the definition of "Emergency/Life and Limb-Threatening Medical Care" including that emergency services means covered inpatient and outpatient services furnished by a provider qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition. *RMHP CHP+ Benefits Booklet* Page 34: This inform Members that emergency services are covered, explains when to use the emergency room, defines the prudent layperson standard, and provides examples of when a person should go to the emergency room.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* Contract: Exhibit B-1—8.17.3.3, 8.20.1, 8.17.1.7	*I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) Page 1, section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services: This claim Manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. *I_UM_Emergency Department Services Claim Review Policy* Policy (a): This states that RMHP makes payment for all emergency department services at a claim processer level without medical necessity review. Appropriateness of services is assumed based on Prudent Layperson definition. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(c-d): This describes that RMHP does not limit what constitutes an emergency based on a list of diagnoses or symptoms. RMHP does not refuse to cover emergency services based upon the failure of an emergency room provider, hospital, or fiscal agent to notify the member's primary care provider or RMHP of the member's screening and treatment within 10 calendar days of presentation for emergency services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
30. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* Contract: Exhibit B-1—8.17.1.8	*I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(e): This describes that RMHP will not hold a Member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) Page 1, section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services: This claim Manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. *RMHP CHP+ Benefits Booklet* Page 35: This informs Members that emergency care necessary to screen and stabilize is covered.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* Contract: Exhibit B-1—8.17.1.5	*I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(f): This describes that RMHP allows the attending emergency physician, or the provider actually treating the Member, to be responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on RMHP who is responsible for coverage and payment. *2019 Provider Manual* Page 32, Access to Care: This describes that the attending emergency physician or provider actually treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. *RMHP CHP+ Benefits Booklet* Page 35: This informs Members that post-stabilization services are covered and explains that these are services that the provider seeing the Member in the emergency room determines are needed before discharge or transfer.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. The Contractor is financially responsible for poststabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* Contract: Exhibit B-1—8.17.4.1, 8.17.4.3, 8.17.4.5	*I_CS_Poststabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 1: This describes that RMHP is financially responsible for poststabilization services obtained within or outside of the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	network that have been pre-approved by RMHP or its representative. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 10: This describes that RMHP is financially responsible for poststabilization services that are prior authorized by an in-network provider or RMHP representative, regardless of whether they are provided within or outside of RMHP's network of providers.	
33. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further poststabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* Contract: Exhibit B-1—8.17.4.6	*I_CS_Poststabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0-Policy, Paragraph 2: This describes that RMHP is financially responsible for poststabilization services obtained within or outside of the network that have not been pre-approved by RMHP or its representative. *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 13(a): This describes that RMHP is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if: RMHP does not respond to a request for pre-approval within 1 hour.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* Contract: Exhibit B-1—8.17.4.7	*I_CS_Poststabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 3: This describes that RMHP is financially responsible for poststabilization services obtained within or outside of the network that have not been pre-approved by RMHP or its representative under all of the circumstances set forth in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 13(a-c): This describes that RMHP is financially responsible for poststabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if RMHP does not respond to a request for pre-approval within 1 hour, RMHP cannot be contacted, or RMHP's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, RMHP gives the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the member until a plan provider is reached.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
35. The Contractor's financial responsibility for poststabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* Contract: Exhibit B-1—8.17.4.9	*I_CS_Poststabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0 Paragraph 3(c): This describes that RMHP's financial responsibility for poststabilization services it has not pre-approved ends when any one of the four situations occur as stated in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 13(d)(i-iv): This describes that RMHP's financial responsibility for poststabilization care services it has not pre-approved ends when a plan physician with privileges at the treating hospital assumes responsibility for the member's care, a plan physician assumes responsibility for the member's care through transfer, a plan representative and the treating physician reach an agreement concerning the member's care, or the member is discharged.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
36. If the member receives poststabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* Contract: Exhibit B-1—8.17.4.8	*I_CS_Poststabilization Services_Medicaid_CHP+ Responsibility* Page 2, Section 6.0, Paragraph D: This describes that member liability is limited to an amount no greater than what RMHP would charge the member if he or she had obtained the services through RMHP. *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 11: This describes that if a member receives poststabilization services from a provider outside RMHP's network, RMHP does not charge the member more than he or she would be charged if he or she had obtained services through an in-network provider. *RMHP CHP+ Benefits Booklet* Page 35, Paragraph 2, What emergency services are covered: This informs Members that their costs for poststabilization care provided by out-of-network providers will be no more than what the member would pay if services were received from in-network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	29	X	1.00	=	29
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	29
					Total Score ÷ Total Applicable	=	91%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types: • Physicians • Specialists • Hospitals • Pharmacies • BH providers • LTSS providers, as appropriate *42 CFR 438.206(b)(1)* Contract: Exhibit B-1—7.13.1, 14.1.3.6	*II_2019 Provider Network Strategic Plan and Access Plan* Page 1: The "Ancillary Service Provider" definition includes certified nurse midwives, physical therapists, occupational therapists and speech therapists, along with several other provider types. Page 1: Behavioral health, mental health, and substance use disorder care definitions includes health care services for a range of common mental or behavioral health conditions, or substance use disorders that are provided by a physician or non-physician professional. Page 2: Primary Care Physician (PCP) definition includes General Medicine practitioners such as nurse practitioners, physician assistants, Pediatrics, and Internal Medicine. *II_2020 CHP+ Provider Directory* Indicates providers who are able to serve Members with limited English proficiency as well as if they are handicap accessible. *2019 Provider Manual* Page 94, Provider Rights and Responsibilities:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This recommends that providers have a policy and/or procedure that documents how they ensure effective communication with Members with limited English proficiency. It also urges providers to ensure that provider offices and/or facilities are able to accommodate people with special health care needs.	
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated CHP+ enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+ populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted CHP+ services. • The number of network providers accepting/not accepting new CHP+ members. • The geographic location of providers in relationship to where CHP+ members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language. • The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions.	*II_PNM_2017&2018 Availability of Practitioner Analysis* Pages 5-12 reflect CHP+ data and analysis. This document uses data from GeoAccess reports to monitor network adequacy to assure that providers are sufficient in number and accessibility based on current regulatory standards for distance and Member/Provider ratios for all provider networks. In addition this document describes the ability and option to utilize telemedicine. **Bullet#1:** *II_2019 Provider Network Strategic Plan and Access Plan* Page 5: Processing for Monitoring and Assuring Network Sufficiency: This describes that RMHP provides for additional access to physicians, ancillary providers and facilities based upon several factors which include projected enrollment with adequate access to care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.206(a); 438.68(c)(i)–(ix) Contract: Exhibit B-1—7.13.2.2.1	**Bullet #2:** *II_2019 Provider Network Strategic Plan and Access Plan* Page 5, Processing for Monitoring and Assuring Network Sufficiency: This describes the factors that RMHP takes into consideration when establishing and maintaining an adequate network, including the needs identified by RMHP's Utilization and Medical Quality Improvement Team; requests from Members; expansion of the Network service area; and projected enrollment. **Bullet #3:** *II_PNM_2017&2018 Availability of Practitioner Analysis* This analysis uses data from GeoAccess reports to monitor the numbers, types, and specialties required to furnish the contracted CHP+ Services. *II_CHP+_Network Analysis Report* This report describes the numbers, types and specialties of network providers in the RMHP CHP+ network. **Bullet #4:** *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. The tools ask whether the **provider is accepting/not accepting new Medicaid Members.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_PNM_Provider Directory Screenshot Examples* Pages 1-3 show screenshots from the RMHP online provider directory indicate whether a provider is accepting new Members. *II_CDPE_2020 RAE Resource Guide* Pages 44-48, Tier Demonstration Criteria: This details expectation of practices by Tier as it relates to Medicaid access within the PCMP office. Higher Tier practices must be completely open to Medicaid patients. This document is general to RAE PCMPs which includes CHP and Prime Providers. **Bullet#5:** *II_2019 Provider Network Strategic Plan and Access Plan* Pages 3 and 6: This shows that RMHP provides care within a reasonable travel time and distance to Members.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	2019 Provider Manual Page 27, Prime, RAE, CHP+ Network Geographic Access Standards: This demonstrates the provider types and time/distance standards required for the network. *II_PNM_2017&2018 Availability of Practitioner Analysis* Pages 5-12 reflect CHP+ data and analysis. This document uses data from GeoAccess reports to monitor network adequacy to assure that providers are sufficient in number and accessibility based on current regulatory standards for distance and Member/Provider ratios for all provider networks as well as the option to utilize telemedicine *II_CHP+_Network Analysis Report* This report provides the geographic location of providers in relationship to where CHP+ Members live, considering distance, travel time, and means of transportation used by Members **Bullet #6:** *II_PNM_2018 RMHP Provider Language Analysis* Pages 2-3 and 6 reflect CHP+ data and analysis. This document uses data from GeoAccess reports to monitor providers' ability to accommodate linguistic needs and preferences of Members.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. The tool asks about **Language Capabilities for Member communication needs.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. These providers are also in the CHP+ Network. *II_PNM_Provider Directory Screenshot Examples* Pages 7-9: These screenshots from the RMHP online provider directory demonstrate that RMHP informs Members of the types of languages spoken by the provider and/or staff. *II_2019 Provider Network Strategic Plan and Access Plan* Page 10, Members with Limited English Proficiency and Illiteracy: This describes that RMHP has identified providers with the capability to communicate with Members who have limited-English proficiency in their preferred language. Additionally, if direct interaction	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	with a bilingual provider is not possible, RMHP makes interpretation services available. **Bullet #7:** *2019 Provider Manual* Page 94, Provider Rights and Responsibilities: This describes that RMHP urges providers to ensure that their offices and/or facilities are able to accommodate people with disabilities and/or special health care needs. *II_2019 Provider Network Strategic Plan and Access Plan* Page 11, Members with Complex Medical and Social Needs, Paragraph 3: This shows that RMHP monitors physical access for people with disabilities at PCP provider locations through office assessments. *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. The tool asks about the provider’s ability to **ensure physical access, reasonable accommodations,**	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	culturally competent communications, and accessible equipment for Members with physical disabilities. Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. These providers are also in the CHP+ Network. *II_PNM_Provider Directory Screenshot Examples* Pages 4-6: These screenshots from the RMHP online provider directory demonstrate that RMHP informs Members of the handicap accessibility of a provider's office for people with physical disabilities. **Bullet #8:** *II_CDPE_2020 RAE Resource Guide* Page 29, CareNow: Virtual Care Platform: This describes the virtual care program that allows Members to connect to a doctor or therapist through their computer or mobile device. CareNow is available at no cost to RMHP RAE, Prime and CHP+ Members. *II_CI_CareNow Webpage* This document contains a link to and screenshot of the CareNow webpage on RMHP.org. This webpage informs Members about how CareNow can be used as an alternative to health care visits. *II_2019 Provider Network Strategic Plan and Access Plan*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 5, "Access to Care," paragraph 3: This describes RMHP's Access Committee's recommendations for providers to utilize telemedicine when travel is difficult or prohibited for the Member. Note: The Access Committee's name has been changed since the publication of this document, to the Network Advisory Committee.	
3. The Contractor ensures that its primary care and specialty care provider network complies with time and distance standards as follows: • Pediatric primary care providers: − Urban counties—30 miles or 30 minutes − Rural counties—45 miles or 45 minutes − Frontier counties—60 miles or 60 minutes • Pediatric specialty care providers: − Urban counties—30 miles or 30 minutes − Rural counties—45 miles or 45 minutes − Frontier counties—100 miles or 100 minutes • Obstetrics or gynecology: − Urban counties—30 miles or 30 minutes − Rural counties—45 miles or 45 minutes − Frontier counties—60 miles or 60 minutes • Physical therapy/occupational therapy/speech therapy: − Urban counties—30 miles or 30 minutes − Rural counties—45 miles or 45 minutes − Frontier counties—100 miles or 100 minutes	*2019 Provider Manual* Page 28: This informs providers of the CHP+ time and distance standards for the network. *II_CHP+_Network Analysis Report* Page 5: This demonstrates RMHP meets the time/distance standards in regard to PT/OT/ST providers in the CHP+ network. *II_PNM_P&P Practitioner Availability and Accessibility* This P&P describes how RMHP maintains an effective organizational process for monitoring network adequacy, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues. *II_PNM_2017&2018 Availability of Practitioner Analysis* Pages 6-9:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Pharmacy: − Urban counties—10 miles or 10 minutes − Rural counties—30 miles or 30 minutes − Frontier counties—60 miles or 60 minutes • Acute care hospitals: − Urban counties—20 miles or 20 minutes − Rural counties—30 miles or 30 minutes − frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-1—10.2.1.10	This shows the provider to Member ratio and distance/drive time CHP+ requirements for pediatric primary care and OB/GYN. *II_CHP+_Network Analysis Report* The GeoAccess Report for CHP+ was used to populate the Network Adequacy and Services Reporting section of the CHP+ MCO Quarterly report, but was not required as a document for this deliverable. The new Quarterly Network Adequacy report template that was developed for use for Q2 of FY 19-20, includes submission of this report. It provides an analysis of our provider network as it relates to CHP+ Members.	
4. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: − Urban counties—20 miles or 20 minutes − Rural counties—30 miles or 30 minutes − Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for children: − Urban counties—30 miles or 30 minutes − Rural counties—60 miles or 60 minutes − Frontier counties—90 miles or 90 minutes • Mental health providers for children: − Urban counties—30 miles or 30 minutes − Rural counties—60 miles or 60 minutes	*2019 Provider Manual* Pages-27-28: This informs providers of the CHP+ Member/Provider ratios as well as time and distance standards. *II_PNM_P&P Practitioner Availability and Accessibility* This P&P describes how RMHP maintains an effective organizational process for monitoring network adequacy, analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues. *II_PNM_2017&2018 Availability of Practitioner Analysis*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
− Frontier counties—90 miles or 90 minutes • SUD providers for children: − Urban counties—30 miles or 30 minutes − Rural counties—60 miles or 60 minutes − Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B1—10.2.1.11.1)* *42 CFR 438.206(a); 438.68(b)* Contract: Exhibit B-1—10.2.1.12, 10.2.1.13.1	Pages 10-11: This shows the provider to Member ratio and distance/drive time CHP+ requirements for psychiatry and marriage and family therapy. *II_CHP+_Network Analysis Report* The GeoAccess Report for CHP+ was used to populate the Network Adequacy and Services Reporting section of the CHP+ MCO Quarterly report, but was not required as a document for this deliverable. The new Quarterly Network Adequacy report template that was developed for use for Q2 of FY 19-20, includes submission of this report. It provides an analysis of our provider network as it relates to CHP+ Members.	
5. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* Contract: Exhibit B-1—10.2.1.15	*II_CM_P&P_Direct Access for OBGYN Care* This policy describes that RMHP provides for a female Member to have direct access to a contracting obstetrician or gynecologist (OB/GYN) for her reproductive and gynecological care, and that the OB/GYN may serve as the woman's primary care provider. *2019 Provider Manual* Page 66, Paragraph 4: This describes that RMHP provides female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services and is in addition to the Member's designated	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	source of primary care if that source is not a women's health care specialist. *II_2019 Provider Network Strategic Plan and Access Plan* Page 7: This shows that female Members have access, without referral, to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a women's health care specialist. *RMHP CHP+ Benefits Booklet* Page 15: This informs Members that they may directly access women's healthcare specialists within the network.	
6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Exhibit B-1—10.2.1.16	*II_CM_Second Opinions_Out-of-Network Services* Page 1, Policy: This explains that RMHP provides for a second opinion from an in-network provider or arranges for the Member to obtain a second opinion outside the network at no cost to the Member. *2019 Provider Manual* Page 109 in the Access/Availability Criteria – RMHP Prime/CHP+ section:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This shows that RMHP covers one second opinion per medical condition without a referral. *2020 Provider Manual* Pages 108-109, "It is your right" section, Bullet 11: This informs providers that Members can get a second opinion with no referral and at no cost to the Member. *II_2019 Provider Network Strategic Plan and Access Plan* Page 14, Enrollee's Right to a Second Opinion: This shows that RMHP covers a second opinion per medical condition without a referral and at no cost to the Member. *RMHP CHP+ Benefits Booklet* Page 18: This informs Members that they have the right to get a second opinion with no referral.	
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Exhibit B-1—10.2.2.1	*II_CM_Second Opinions_Out-of-Network Services* Page 2,Services Not Available in Network: This explains that if the RMHP network is unable to provide necessary covered services, RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. *2019 Provider Manual* Page 67, Out-of-Network/Out-of-Plan Services:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This informs providers that out-of-network/out-of-plan services are available to Members in a timely manner at the in-network benefit level. *II_2019 Provider Network Strategic Plan and Access Plan* Page 4: This indicates that Members may obtain covered services in a timely manner from out-of-network providers when RMHP has no participating providers who can provide a specific, medically-necessary covered service, or Members do not have reasonable access to a participating provider due to distance or travel time.	
8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Exhibit B-1—10.2.2.2	*II_CM_Second Opinions_Out-of-Network Services* Page 2, Services Not Available in Network: This explains that RMHP will coordinate payment with out-of-network providers to ensure that the cost to the Member is no greater than it would be if the services were furnished in-network. *II_2019 Provider Network Strategic Plan and Access Plan* Page 4, Out-of-Network/Out-of-Plan Services: This shows that Members may obtain covered services from out-of-network providers, subject to preauthorization, at the in-network benefit level. *2019 Provider Manual* Page 67, Out-of-Network/Out-of-Plan Services:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This informs providers that members may obtain covered services from out-of-network/out-of-plan providers at the in-network benefit level in certain circumstances such as for continuity of care.	
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* Contract: None	*II_2019 Provider Network Strategic Plan and Access Plan* Page 3: This demonstrates that RMHP's CHP+ network includes an adequate number of family planning participating providers to ensure timely access to covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care: – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 calendar days after member request. • Non-urgent medical or non-symptomatic well care within 30 calendar days after member request.	*2019 Provider Manual* Page 31, CHP+ Appointment Wait Time Standards: This demonstrates RMHP's guidelines and standards for emergency behavioral care, urgent care, non-urgent symptomatic care, well care visits within 30 days after the request, and outpatient follow up appointments, and states that members will not be placed on waiting lists for initial routine services. *2020 Provider Manual* Page 31, CHP+ Appointment Wait Time Stipulations: This specifies that providers may not place Members on a waiting list for initial routine requests including behavioral health. *II_PNM_Revised Appointment Availability Analysis 2019* This report reviews how Member surveys are sent annually (page 3) to ensure that appointment	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. *42 CFR 438.206(c)(1)(i)* Contract: Exhibit B-1—10.2.1.23.1–7, 10.2.1.23.7.2	availability is sufficient. RMHP is considering conducting these surveys quarterly in 2020. Pages 23-24: The qualitative analysis describes results from the member survey relating to the standards for timely access to care and services.	
11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid members. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Contract: Exhibit B-1—10.2.1.5–7	*2019 Provider Manual* Page 66, RMHP Prime/CHP+ Members, Paragraph 1: This informs providers that they may not limit their hours of operation in a manner which is less than is offered to Members of non-publicly-financed programs. *2020 Provider Manual* Page 66: This demonstrates that RMHP recommends that providers have minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. *II_PNM_Physicians Medical Services Agreement* Pages 5-6, Section A: Medical Services to Covered Persons: This states that providers must arrange for the provision of medical services to covered persons at such time and in such location as required by any health care plan which is offered by RMHP to covered persons in the service area. (Due to the numerous	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	lines of business we offer, we write the agreements in general terms to meet all contractual obligations.) Page 15, Paragraph DD, Non-Discrimination-Publicly Financed Program: This describes that providers may not discriminate against any covered person enrolled in a publicly financed program, including limiting the hours of operation. **Bullet #2:** *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The tools ask providers to report whether they offer extended hours on evenings and/or weekends.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. These providers are also in the CHP+ Network. **Bullet #3:** *II_CPDE_2020 RAE Resource Guide* Page 29, CareNow: Virtual Care Platform: This describes RMHP's virtual care program that allows members to connect to a doctor or therapist through their computer or mobile device. CareNow is available at no cost to RMHP RAE, Prime and CHP+ members.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_CareNow Webpage This document contains a link and screenshot of the CareNow webpage on RMHP.org. CareNow can be used by Members as an alternative to emergency department visits for after-hours urgent care. *II_PNM_Spring_Summer Provider Newsletter 2019* Page 8: This includes news about CareNow, a tool that can be used by RAE, Prime and CHP+ members as an alternative to emergency department visits for after-hours urgent care.	
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Exhibit B-1—10.2.4.1	*II_PNM_Physicians Medical Services Agreement* Page 15, Section AA: 24-Hour Coverage: This describes the requirement for providers to provide or arrange for 24-hour coverage for emergency medical services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* Contract: Exhibit B-1—10.2.1.25.2	*II_PNM_P & P Appointment Availability Surveys* This P & P describes how RMHP maintains an effective organizational process for monitoring appointment scheduling and wait times, through the use of member surveys, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues if applicable. *II_PNM_Patient Appointment Wait Time Surveys* The Appointment Wait Time Surveys are sent annually to Members as a mechanism to ensure compliance with access by network providers, which includes behavioral health providers (prescribing and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	non-prescribing); primary care providers; and specialists (high-volume and high-impact). *2019 Provider Manual* Page 23, Access to Care: This describes how RMHP' maintains quality standards to identify, evaluate, and remedy problems relating to access of care. It also identifies RMHP's targets (goals), for Member/provider ratios, time and distance drive time standards as well as appointment wait time standards. *II_CPDE_2020 RAE Resource Guide* Pages 44-48, Tier Demonstration Criteria, Supporting Documentation/Assessment: This details expectations of practices by Tier as it relates to Medicaid access within the PCMP practice. Higher Tier practices must be completely open to Medicaid patients. Practices must show empanelment and continuity of care for Members within their care teams. Practices must regularly deliver care in alternative formats to meet the needs of the patient population. This also describes assessment criteria related to follow up appointment standards for hospital and emergency room discharges. This document also describes the Value Based Contracting Review Committee (VBCRC) which evaluates providers participating in RMHP's tiering program. This document refers to RAE PCMPs which includes CHP and Prime providers.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CPDE_VBCRC Charter Page 1: The Value Based Contracting Review Committee (VBCRC) Charter details the aim, scope and general structure of the committee that evaluates practices in value based contracts with RMHP for compliance with contractual expectations and requirements. This committee evaluates practices that are participating in Tiers 1, 2, & 3. *II_CPDE_VBCRC Process* This details how the Value Based Contracting Review Committee (VBCRC) evaluates practices in value based contracts with RMHP as it relates to contractual expectations and requirements. Specifically, this document details the frequency of review as well as how practices are notified if there is failure to comply with any requirements and a corrective action plan is implemented. *II_CPDE_RAE PCMP Tiering & Attribution Analysis* This demonstrates that 16/198 (59%) of CHP+ PCPs are evaluated within the VBCRC process for the Value Based Payment Tiering Program. This accounts for 86% of the attributed CHP+ Member population.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_Region 1 BH Focus Group Report This is the final report from the behavioral health focus groups that RMHP conducted throughout RAE Region 1 in spring 2019, in partnership with the Colorado Cross-Disability Coalition. Focus group participants, made up of both providers and clients, reported their experiences with access to care/network gaps. Follow-up community meetings were held to discuss the report findings and next steps in fall 2019.	
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Maintaining policies to provide prevention, health education, and treatment for diseases prevalent in specific cultural or ethnic groups. • Maintaining policies to provide health care services to members that respect individual health care attitudes, beliefs, customs, and practices related to cultural affiliation. • Maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. • Making written materials that are critical to obtaining services available in prevalent non-English languages and alternative formats for the visually and reading-impaired. • Providing cultural competency training programs, as needed, to network providers and health plan staff regarding:	The following documents illustrate that RMHP delivers services to Members in a culturally competent manner: *COMBINED_1557Notice_MLIS_(Medicaid CHP+)* RMHP's notice of nondiscrimination provides for meaningful access and effective communication and includes protections for those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. *II_CM_CM & UM Communication Policy and Procedure* Pages 1 – 2: This describes RMHP's commitment to meaningful and effective communication. *II_CM_Culturally Sensitive Services* This P&P describes RMHP's care management approach to addressing culturally sensitive and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members, including interpreter services and TDD. *42 CFR 438.206(c)(2)* Contract: Exhibit B-1—10.8.2.1-4, 10.8.2.9-10, 10.8.2.12-13	diverse Member populations, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. **Bullet #1:** *II_CM_Culturally Sensitive Services* Page 3, Section 5.0, Paragraph 1: This explains how RMHP facilitates culturally and linguistically appropriate care and outreach to members with diverse cultural and ethnic backgrounds for prevention, health education and treatment for diseases prevalent to those groups. ***Bullet #2:*** *II_CM_Culturally Sensitive Services* This P&P describes RMHP's care management approach to addressing culturally sensitive and diverse Member populations, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. *II_2019 Provider Network Strategic Plan and Access Plan* Pages 10-11: This describes how RMHP addresses the needs of Members with limited English proficiency, illiteracy, diverse cultural and ethnic backgrounds, and physical and mental disabilities**.**	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet#3: *II_CM_Culturally Sensitive Services* Section 3.0: This describes various company policies that address the ADA and Section 504. *II_2019 Provider Network Strategic Plan and Access Plan* Pages 10-11 describe how RMHP addresses the needs of Members with limited English proficiency, illiteracy, diverse cultural and ethnic backgrounds, and physical and mental disabilities. **Bullet#4:** *II_CM_CM & UM Communication Policy and Procedure* Page 2: This explains that RMHP ensures that written materials that are critical to obtaining services are available in prevalent non-English languages and alternative formats for the visually and reading-impaired. **Bullet#5:** *2019 Provider Manual* Page 107: This describes cultural competency and provides direction to providers about where and how to complete cultural competency training.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_Culturally Responsive Care Online Resources for Providers This screenshot lists the links to Culturally Responsive Care resources on the RMHP.org website that providers can access for further training. *II_QI_RMHP 2018 Annual Cultural and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of Members and the actions RMHP takes to meet those needs. Page 8 includes information about staff training that addresses special needs, cultural competency and health disparities as well as diversity and inclusion training. *II_CPDE_Cultural and Generational Communication Presentation* The Practice Transformation team at RMHP hosted an Advanced Practice Learning Collaborative in November 2019 which included a presentation on Cultural and Generational Communication. Over 100 participants from PCMP's across Region 1 attended. **Bullet#6:** *II_CM_Culturally Sensitive Services* Page 3, Section 5.0, Paragraph 4: This demonstrates that Care Management staff will participate in efforts to identify Members whose	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	cultural norms and practices may affect their access to health care. These efforts may include health education or newsletter articles. *II_CM_Cultural and Linguistic Assessment* This document reflects RMHPs approach to identify Members who have cultural norms and practices that may affect their access to healthcare. *II_QI_RMHP 2018 Annual Cultural and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of Members and the actions RMHP takes to meet those needs. Page 11, Analysis: Describes RMHP's response related to cultural norms and practices that were found to impact Members' access to care. **Bullet # 7:** *II_CM_CM & UM Communication Policy and Procedure* Pages 4 and 5: This describes translation, interpreter, and auxiliary services. *II_QI_RMHP 2018 Annual Cultural and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Members and the actions RMHP takes to meet those needs. Pages 11-12, Analysis: This describes RMHP's response related to cultural norms and practices that were found to impact Members access to care. *II_CPDE_2020 RAE Resource Guide* Page 29, Supplemental Resources for Patient Care, Rural Interpreter Services Project (RISP): This describes the availability for providers to use the RISP services when providing care to Members who are deaf, hard of hearing, or deafblind in rural areas at no cost. *II_PNM_Spring_Summer Provider Newsletter 2019* Page 4: The newsletter provides information about the Rural Interpreting Services Project (RISP), a valuable free resource for providers who may need language assistance services for deaf, hard of hearing or deafblind patients. *RMHP CHP+ Benefits Booklet* Page 115: This provides Members with RMHP's Multi-Language notice advising that language assistance services are available free of charge and RMHP's Notice of Nondiscrimination, which explains how to	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	obtain (1) documents in other formats, and (2) free auxiliary aids and services. All significant RMHP Member communications include notices of nondiscrimination and taglines that alert individuals with limited English proficiency and diverse backgrounds to the availability of language assistance services and documents in other languages/formats.	
15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* Contract: Exhibit B-1—10.8.2.10	*II_PNM_QI Standards for Practitioner Office Sites* This P&P describes how RMHP maintains an effective organizational process for monitoring the quality and safety of clinical care and services provided to Members. *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool* The PCMP Demographic Tool is the form that RMHP sends on a quarterly basis to primary care providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. The tool asks providers to report their ability to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical disabilities. Note: There are 3 versions of this tool: PCMP, Prime Specialist, and Behavioral Health Provider. Many of these providers are in the CHP+ network.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_PNM_Provider Directory Screenshot Examples Pages 4-6: These screenshots from the RMHP online provider directory demonstrate that RMHP informs Members about accommodations for people with physical disabilities at provider offices.	
16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Provider Network Strategic Plan is submitted to the State annually. • A Provider Network Capacity and Services Report is submitted to the State quarterly. *42 CFR 438.207(b)* Contract: Exhibit B-1—15.3.1, 15.3.2	*II_2019 Provider Network Strategic Plan and Access Plan* This annual report provides an overview of RMHP's CHP+ Provider Network and Access Plan. It is submitted annually to the Department of Health Care Policy and Finance. *II_CHP+ Network Capacity and Service Report-SFY 18-19* Q4 Pages 1-12: This provides the time and distance standards for the 22 counties within RMHP's CHP+ network. This report has been submitted quarterly to the Department of Health Care Policy and Finance according to the schedule found in the contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
Total Score ÷ Total Applicable						=	100%

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Denials Record Review Tool for Rocky Mountain Health Plans

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 3, 2020–March 4, 2020
Reviewer:	Erika Bowman, BA, CPC
Participating Plan Staff Member(s):	Sandy Dowd, Matthew Cook, Jan Valencia, Tiffany Kikta, Amber Davis, Christy Hunt, Zach Kareus, and Lisa Nelson

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	1/7/19	1/21/19	1/24/19	2/14/19	3/11/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	CL	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	S	S	R	S	E
Date notice of adverse benefit determination (NABD) sent	1/8/19	1/22/19	2/6/19	2/14/19	3/11/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	1	1	NA	0	0
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	M	M	M	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M	NA	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	M	M	M	M	M
Total Applicable Elements	**6**	**6**	**5**	**6**	**6**
Total Met Elements	**6**	**6**	**5**	**6**	**6**
Score (Number Met / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**100%**

* = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)
**** = Redacted Member ID

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	3/12/19	5/3/19	10/4/19	11/25/19	12/2/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	NR	NR	NR	CL
(Standard [S], Expedited [E], or Retrospective [R])	R	S	E	S	R
Date notice of adverse benefit determination (NABD) sent	4/10/19	5/9/19	10/4/19	11/26/19	1/2/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	NA	6	0	1	NA
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	M	M	M	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	NA	M	M	M	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	M	M	M	M	M
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	M	NM	M	NM	M
Total Applicable Elements	**6**	**7**	**7**	**7**	**6**
Total Met Elements	**6**	**6**	**7**	**6**	**6**
Score (Number Met / Number Applicable) = %	**100%**	**86%**	**100%**	**86%**	**100%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)
**** = Redacted Member ID

Comments:

File 7: This was a new service request. RMHP's CHP+ NABD incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the authorization denial. The clinical language content used in the NABD sent to the member would not be easy to understand.

File 9: This was a new service request. RMHP's CHP+ NABD incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the authorization denial. The clinical language content used in the NABD sent to the member would not be easy to understand.

Total Record Review Score*	Total Applicable Elements: 62	Total Met Elements: 60	Total Record Review Score: 97%

* Only requirements with an "*" in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **RMHP**.

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

HSAG Review Team	Title
Erika Bowman	Project Manager
Gina Stepuncik	Associate Director
Kathy Bartilotta	Associate Director
Sarah Lambie (telephonic)	Project Manager II
RMHP Participants	**Title**
Amber Davis	Claims Supervisor
Angela Nottingham	Quality Improvement Intervention Developer
Billie Bemis	Clinical Manager, RMHP Optum
Brandee Hewitt	Quality Improvement Specialist
Carrie Baumann	Projects and Compliance Specialist
Cathy Morehouse	Staff Auditor, Internal Audit
Chelsea Watkins	Clinical Informatics Supervisor, Clinical Program Development
Christy Hunt	Claims Production Manager
Cris Matoush	Regional Crisis System Coordinator
Dale Renzi	Director of Provider Network Management
David Mok-Lamme	Health Information Technology and Data Analytics Director
Eve Presler	Care Management, Manager Special Populations and Training
Greg Coren	Western Slope Provider Relations Manager and Provider Network Manager
James Schneider	Supervisor, Customer Service
Jan Valencia	Registered Nurse (RN), Pre-Authorization
Jeremiah Fluke	Prime Contract Manager and Quality Improvement Analyst
Jerry Spomer	Director of Internal Audit, Member Benefit Administration and Member Enrollment and Billing
Jill Bystol	Quality Assurance Compliance Coordinator
Kathryn Jantz	Accountable Health Communities Model Director
Kendra Peters	CHP+ Contract Manager and RAE Program Operation Support
Kevin Fitzgerald	Chief Medical Officer
Kila Watkins	Manager, RN Care Management

RMHP Participants	Title
Kim Brown	Director of Clinical Program Development and Evaluation (CPDE)
Louisa Wren	RAE Health Neighborhood and Community Program Manager
Marci O'Gara	Senior Director of Business Operations
Marjorie Chamenoy	Community Integration, Quality Analyst
Matthew Cook	Director Claims Operations
Maura Cameron	Director of Quality Improvement
Meg Taylor	RAE Program Officer, Region 1
Nacole Johnson	Customer Service Process Analyst
Nicole Konkoly	RAE Network Relations Manager
Patrick Gordon	Chief Executive Officer of RMHP
Rhonda Michaelson	Supervisor, Customer Service
Sally Henry	AHCM, Project Coordinator
Sandy Dowd	Director of Care Coordination
Sheila Worth	Medical Strategic Initiatives Administrator
Sue Baker	Manager, Customer Service
Tiffany Kikta	Director, Utilization Management
Tim Sherman	Director, Legal and Regulatory Affairs
Violet Willett	Manager, Care Management Northern Colorado Team
Zach Kareus	Clinical Pharmacist, Pharmacy Department
Department Observers	**Title**
Jeff Jaskunas	CHP+ MCO & SMCN Contract and Program Manager—HCPF
Liana Major	Program Specialist—HCPF
Megan Comer	Program Administrator—HCPF
Russ Kennedy	Quality & Compliance Specialist—HCPF

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix D. Corrective Action Plan Template for FY 2019–2020

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 <u>also</u> 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 2019–2020 Corrective Action Plan for RMHP

<table>
<tr><th colspan="3">Standard I—Coverage and Authorization of Services</th></tr>
<tr><th>Requirement</th><th>Findings</th><th>Required Action</th></tr>
<tr><td>13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions:
• For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service.
• If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service.

42 CFR 438.210(d)(1–2)

Contract: Exhibit B-1—11.1.10–11.1.12</td><td>On-site denial record reviews confirmed that RMHP met the required authorization decision time frame for both standard and expedited requests. RMHP's *UM Timeliness of UM Decisions* policy described the process and time frames for making standard and expedited authorization decisions. However, the policy incorrectly identified the time frame for pre-service non-urgent requests as "up to 15 days" from the date of receipt. In addition, the policy did not specify that the time frame is within "calendar days."</td><td>RMHP must correct its *UM Timeliness of UM Decisions* policy to accurately address the 10-calendar-day time frame for making standard authorization decisions.</td></tr>
<tr><td colspan="3">**Planned Interventions**:</td></tr>
<tr><td colspan="3">**Person(s)/Committee(s) Responsible and Anticipated Completion Date**:</td></tr>
</table>

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* Contract: Exhibit B-1—11.1.10.1–2; 11.1.12.1–2	RMHP's *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies described the process for requesting an extension and specified the time frame for a determination to be reached. However, the *UM Timeliness of UM Decisions* policy inaccurately stated that the Contractor extension time frame is within "15 days" from the end of the initial authorization time frame or at the request of the member or provider. In addition, neither the *UM Preauthorization of Services* policy nor the UM *Timeliness of UM Decisions* policy indicated "calendar days" in the extension time frame.	RMHP must correct information in its *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies to accurately address the additional "14-calendar day" time frame for extending a standard or expedited authorization decision.
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 I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10(c)* Contract: Exhibit B-1—14.1.3.15.1.1–4	RMHP policies and other submitted evidence demonstrated that template CHP+ NABDs used for UM denials were written in a language easy to understand and informed the member of the availability of the notice in other languages and alternative formats. However, HSAG found two of 10 CHP+ denial record reviews were *Not Met* for "correspondence with the member was easy to understand." RMHP incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the adverse benefit determination. The language content would be difficult for a member with a limited reading ability to understand.	RMHP must ensure that the NABD in its entirety is written in language that is easy for a CHP+ member to understand.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with 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 two 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 denials of authorization of services (denials) records that occurred between January 1, 2019, and December 31, 2019 (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 denials. • 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 2019–2020 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 Department**
	• 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.