Fiscal Year 2020–2021 Site Review Report

for

Rocky Mountain Health Plans

May 2021

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

HSAG HEALTH SERVICES ADVISORY GROUP

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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 (the 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, Title 42 (42 CFR)—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) 2020–2021 was January 1, 2020, through December 31, 2020. This report documents results of the FY 2020–2021 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 FY 2020–2021 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2019–2020 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for both the grievance and appeal 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 (CAP) process the health plan will be required to complete for FY 2020–2021 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[1-1]

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: July 15, 2020.

Summary of Results

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

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

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	21	20	19	1	0	1	95%
VI. Grievance and Appeal Systems	34	34	33	1	0	0	97%
VII. Provider Participation and Program Integrity	16	16	15	1	0	0	94%
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75%
Totals	**75**	**74**	**70**	**4**	**0**	**1**	**95%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool. Some items were marked as "Not Scored" due to regulation changes which came into effect in December 2020.

Table 1-2 presents the scores for **RMHP** for the grievance and appeal 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)
Grievances	48	39	38	1	9	97%
Appeals	60	52	52	0	8	100%
Totals	**108**	**91**	**90**	**1**	**17**	**99%**

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

Standard V—Member Information Requirements

Summary of Strengths and Findings as Evidence of Compliance

RMHP's policy, *Preparation, Maintenance and Distribution of RAE, Prime, and CHP+ Member Materials*, described the requirements for developing member information documents, which included font size, reading level, translation, and availability of auxiliary aids and services. **RMHP**'s policy required written materials critical to obtaining services to be reviewed by **RMHP**'s member advisory council for feedback. Member information was posted on the **RMHP** website and mailed to newly enrolled members monthly. Paper materials distributed to members included the *CHP+ Benefits Booklet*, the *CHP+ Provider Directory*, and a guide to copay costs. The *CHP+ Benefits Booklet* was written in easy-to-understand language, included the required tagline and font sizes, and described how to access translation and auxiliary services. **RMHP** also reached out to new members through an introductory phone call to provide assistance and answer questions.

RMHP's website was easy to navigate and offered adjustable font size. The **RMHP** *Getting Started Guide*, *CHP+ Benefits Booklet*, and formulary were all available for download in a Portable Document Format (PDF) format. HSAG conducted an accessibility check on a few **RMHP** webpages using the WAVE Web Accessibility Evaluation Tool and found minimal errors. HSAG also ran an accessibility check on several PDF documents available for download from the website, and the test results met Section 508 compliance requirements.

Summary of Findings Resulting in Opportunities for Improvement

RMHP's policy, *Preparation, Maintenance and Distribution of RAE, Prime, and CHP+ Member Materials* noted the availability of paper documents without charge within five business days of request. However, the *CHP+ Benefits Booklet* and *CHP+ Welcome Letter* varied in the information provided in each document. The *CHP+ Benefits Booklet* noted the availability of paper documents but did not explain that materials were available free of charge or specify a time frame for delivery of such materials. The *CHP+ Welcome Letter* stated there was no charge for paper documents but did not include the time frame for the provision of the documents. HSAG recommends **RMHP** align the information across these documents to ensure consistency in the information communicated to members and staff.

Summary of Required Actions

The Continuing Your Benefits section in the *CHP+ Benefits Booklet* did not include the required time frame of 10 days for a member to request that benefits continue after receipt of a notice of adverse benefit determination (NABD) or adverse appeal determination letter. While the member has 60 days from the date of the NABD to request an appeal, the continuation of benefits request must be received within 10 days. After receiving an adverse appeal determination letter, the member must request both the State fair hearing (SFH) and the continuation of benefits within 10 days (if the member does not

wish to continue benefits, they have the full 120 days to request the SFH). Within the same section, the second statement in the continuation of benefits bulleted list, "the original approval must not have expired" did not apply to SFHs. **RMHP** must revise the continuation of benefits description in the *CHP+ Benefits Booklet* to include the 10-day time frame to request continuation of benefits. **RMHP** must also clarify that the bulleted statement, "the original approval must not have expired," applies only to appeals.

Standard VI—Grievance and Appeal Systems

Summary of Strengths and Findings as Evidence of Compliance

RMHP's grievance system included policies and procedures that addressed State and federal requirements regarding member grievance, appeal, and SFH processes and timelines. The appeals and grievance policy and procedure documents reflected processing requirements and time frames for receiving, acknowledging, and resolving grievances and appeals, and adhered to member notice requirements.

RMHP provided training to staff members who manage grievances and appeals that included both regulatory and system documentation information and met weekly with staff members. Monthly documentation audits were conducted by a separate department for a sample of grievances and appeals to verify requirements were met and all documents, records, and other information were taken into account by staff members at the time of processing.

RMHP had provisions in place for members or their authorized representatives to request grievances, appeals, and SFHs. Additionally, **RMHP** demonstrated an effective health information system for documenting and tracking information related to the grievance and appeal system.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

While the written definition of an appeal in the *Member Appeals Process* policy and procedure was accurate, procedural implementation was not consistent with the definition. HSAG determined that three of the appeal cases were provider administrative issues that were misclassified as member appeals. **RMHP** must develop specific criteria for defining provider versus member appeals to assist staff members to accurately identify when an appeal should or should not involve the member.

Standard VII—Provider Participation and Program Integrity

Summary of Strengths and Findings as Evidence of Compliance

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

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

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

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

Summary of Findings Resulting in Opportunities for Improvement

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

Summary of Required Actions

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

Standard IX—Subcontractual Relationships and Delegation

Summary of Strengths and Findings as Evidence of Compliance

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

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

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

2. Overview and Background

Overview of FY 2020–2021 Compliance Monitoring Activities

For the FY 2020–2021 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. HSAG conducted a desk review of materials submitted prior to the site review activities; a review of records, documents, and materials requested during the site review; and interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials.

HSAG also reviewed a sample of the health plan's administrative records related to CHP+ grievances and CHP+ appeals 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) for each of grievances and appeals. Using a random sampling technique, HSAG selected the sample from all CHP+ grievance records that occurred between January 1, 2020, and December 31, 2020, and all CHP+ appeal records that occurred between January 1, 2020, and December 31, 2020. For the record review, the health plan received a score of *Met (M)*, *Not Met (NM)*, or *Not Applicable (NA)* for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance and Appeal Systems. HSAG separately calculated a record review score for each record review requirement and an overall record review score.

The site review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2020–2021 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, 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 four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the health plan into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the health plan, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the health plan's services related to the standard areas reviewed.

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

FY 2019–2020 Corrective Action Methodology

As a follow-up to the FY 2019–2020 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the 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 2019–2020 compliance monitoring site review.

Summary of FY 2019–2020 Required Actions

For FY 2019–2020, HSAG reviewed Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Related to coverage and authorization of services, **RMHP** was required to complete three corrective actions, including:

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

Summary of Corrective Action/Document Review

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

Summary of Continued Required Actions

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

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* CHP Contract: Section 21.A.	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP_Final* This Policy and Procedure is written to assure that all materials intended for distribution to RMHP Medicaid and CHP+ Members are reviewed and edited to promote ease of use for RMHP enrollees, and to assure that they are readily accessible. Page 2, bullet 1, also indicates that RMHP will accommodate Members with vision or other impairments by providing Member materials in alternative formats. Examples of Member materials: *V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* *V_MarComm_CHPBenefitBooklet_Dec2020_Spa_508* *V_CS_CHP+ Welcome Letter EngSp* *V_CI_Combined CHP+_Copay Notices_Eng&Spa* *V_CI_CHP ID Card* *V_PH_Prime-CHP Formulary 7.1.20_508_Eng*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* CHP+ Contract: Exhibit B1—6.3.1.15	*V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* The CHP+ Benefits Booklet includes information to help Members understand the requirements and benefits of the plan. The RMHP Customer service number is listed in the footer of the handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_CI_Combined CHP+_Copay Notices_Eng&Spa CHP+ copay notices are sent with the CHP+ Benefits Booklet, and present copays based on Member income. The following documents are all designed to assist Members to understand the requirements and benefits of the plan. *V_CS_CHP+ Welcome Ltr_Eng_Span* *V_CS_Complete CHP+ Welcome Call Script* *V_CI_CHP ID Card* *V_CI_MD12-Getting Started Guide_Rev123019_Web-508_Eng* *V_CM_CHP Welcome Call Screener*	
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care	*V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* The RMHP CHP Benefit Booklet was modeled after the State Managed Care Network (SMCN) Member Booklet. In the glossary section of the RMHP CHP Benefit Booklet are the definitions as identified in the contract with the Department. *V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP_Final* Page 2, bullet 7, states that RMHP will use the definitions for managed care terminology developed by the Department as soon as they are made available to RMHP. *V_UM_CHP+ NOABD_FinalModel_06192020* This is the model notice of adverse benefit determination that	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* CHP+ Contract: Exhibit B1—2.8.4	was provided by the Department to use when mailing these notices to CHP+ Members. *V_UM_RMHP_CHP+ Residential Denial Sample Notice* *V_UM_RMHP_CHP+ Denial Letter Sample Notice* These are the sample RMHP notices that are modeled after the Department's approved template.	
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.	Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. *V_MarComm_CHPBenefitBooklet_Dec2020_Spa_508* *V_PNM_CHP_Prov_Directory_12.2020_Spa_508* *V_CS_CHP+ Welcome Ltr_EngSp* *V_CS_Sorry We Missed You_EngSp* *V_CI_MD12-Getting Started Guide_Rev123019_Web-508_Spa* *V_COMBINED_1557Notice_01312020 (Medicaid CHP+) (Spanish)* *V_PH_Prime-CHP Formulary 7.1.20_508_SP* *V_PH_CO Rocky Mountain Health Plans 11.1.2020 Member PDL v2_Eng&Spa* *V_UM_CHP+ Residential Denial-Appeal Rights_ Spanish* The documents listed above are examples of documents that are available to Members in Spanish. Spanish is the prevalent non-English language in the RMHP CHP+ service-area.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(d)(3) and (d)(6) CHP+ Contract: Exhibit B1—6.3.1.14, 14.1.3.1, 14.1.3.2, 14.1.3.4, 14.1.3.5	*V_CS_CHP - Grievance and Explanation Resolution* *V_CS_MD.CHP - Overturn Denial Med Review* *V_CS_MD.CHP - Overturn Denial No Med Review* *V_CS_MD.CHP - Uphold Denial Med Review* *V_CS_MD.CHP - Uphold Denial No Med Review* Note: these various documents are sent to translation when we note a Member's preferred language is Spanish. *V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Page 114, in the "Notice of Nondiscrimination" of the CHP+ Benefits Booklet tells Members how to access the information in alternative formats. *V_COMBINED_1557Notice_01312020 (Medicaid CHP+)_Eng* This document indicates in 17 different languages that language assistance services are available to Members free of charge. This notice is inserted in all written materials that are critical to obtaining services. *V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP_Final* Pages 1-2 under Section 4.0 "Procedure," indicate that RMHP will create Member material that is easy to use and understand, and that RMHP will make materials available in non-English languages and alternative formats without charge.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP_Final Page 2, Bullet 2, explains that RMHP will include in large print (18 point font) (1) taglines in non-English languages indicating the availability of language services for individuals who are limited English proficient, and (2) information about how to request auxiliary aids and services. This information will be sent with all Member materials that are considered critical to obtaining services. This document also states that RMHP will use font size no smaller than 12 point. *V_CS_Process for Large Print Document Request* *V_CS_Process for Alternate Language Document Request* These Customer Service processes explain RMHP's process for making written information available in other formats. The following documents are examples of materials critical to obtaining services: *V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* *V_PH_Prime-CHP Formulary 7.1.20_508_Eng* *V_PNM_CHP_Prov_Directory_12.2020_Eng_508* *V_UM_RMHP_CHP+ Denial Letter Sample Notice* *V_COMBINED_1557Notice_01312020 (Medicaid CHP+)_Eng* This document is inserted with all Member materials that are considered to be critical to obtaining services. It includes	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	taglines in large print (18 point font) and how to obtain free auxiliary aids and services in large print (18 point font).	
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days. *42 CFR 438.10(c)(6)* CHP+ Contract: Exhibit B1—14.1.3.13.2	**Bullet 1:** *V_PH_PBM Report Confirming 508 Compliance of Formulary* This accessibility report confirms that the Optum RX Formulary (used for CHP+) is 508 compliant. *V_CI_MD12-Getting Started Guide_Rev123019_Web-508Report_Eng* This report shows the CHP+ Getting Started Guide is 508 compliant. *V_Dig_Message Confirming 508 Compliance of RMHP.org CHP Sections* This message from RMHP IT staff verifies that the CHP+ sections on the rmhp.org website are 508 compliant *V_Dig_Message Confirming 508 Compliance of rmhp.org* This message from RMHP Digital Department confirms that the website at www.rmhp.org is 508 compliant with no errors, according to the WAVE web accessibility evaluation tool recommended by the GSA. *V_IT_Section 508 Compliance Testing Report CUS-100 HealthSparq One* Note: This report will be available for review at the virtual site review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_MarComm_CHPBenefitBooklet_Dec2020_Eng_PAC_Report *V_PNM_CHP_Prov_Directory_12.2020_Eng_PAC_Report* These are the accessibility reports for these Member documents that can be downloaded from the RMHP.org website. **Bullets 2 & 3:** *V_CI_Screenshot of Links to CHP+ Benefits Booklet & Formulary* *V_CI_Screenshot_Customized Website_CHP* These documents demonstrate these Member materials can be electronically printed and retained are readily accessible. **Bullet 4 & 5:** *V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP_Final* Page 1, Section 4.0, "Procedure" of this P&P describes the process that RMHP uses to prepare Member materials that comply with content and language requirements, and on page 2, bullet 5, states that RMHP will make information available to an enrollee in paper form and without charge within 5 days of request. *V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508*Page 4 explains to Members that they can get a new CHP+ Benefits booklet each year or any time they want it – they can ask RMHP to mail it or it is accessible online at rmhp.org.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(i)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1.5	*V_PH_Prime-CHP Formulary 7.1.20_508_Eng* This formulary indicates which medications are covered (both generic and brand) and indicates what tier each medication is on. *V_PH_PBM Report Confirming 508 Compliance of Formulary* This accessibility report confirms that the Optum RX Formulary (used for CHP+) is 508 compliant. *V_CI_Screenshot of Links to CHP+ Benefits Booklet & Formulary* This screenshot demonstrates that Members can electronically obtain these member materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. *42 CFR 438.10(d)(4)* CHP+ Contract: Exhibit B1—7.5, 14.1.3.3, 14.1.7.6	*V_CS_Accommodations for Mem w Disabilities PP* Page 2, 6.0 Procedure, "Members with Communication Barriers," indicates that for non-English speaking Members utilizes Language Line Services (LLS) to interpret for the Member. *V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Page 4 indicates that for callers who do not speak English or Spanish, RMHP uses Language Line Services. RMHP provides interpretation services at no cost to Members. Members are advised to tell RMHP if they need interpreter services or help in other languages. *V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP_Final*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 1, bullet 4, indicate that RMHP will translate documents into prevalent non-English languages. *V_COMBINED_1557Notice_01312020 (Medicaid CHP+)_Eng* This document indicates in 17 different languages that language assistance services are available to Members free of charge. This notice is inserted in all written materials that are critical to obtaining services. **Bullet 1:** *V_COMBINED_1557Notice_01312020 (Medicaid CHP+)_Eng* The Notice of Nondiscrimination indicates that RMHP provides: ◆ Free auxiliary aids and services to people with disabilities such as qualified sign language interpreters (remote interpreting service or on-site appearance), and written information in other formats (large print, audio, accessible electronic formats, other formats) ◆ Free language assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages. This document is inserted in all member material that is considered critical to the Member receiving services. It is found in the CHP+ Benefits Booklet on page 114. Members are told that they may access these services by calling RMHP.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)* CHP+ Contract: Exhibit B1—14.1.3.5, 14.1.3.10.1.3	*V_COMBINED_1557Notice_01312020 (Medicaid CHP+)_Eng* The Notice of Nondiscrimination indicates that RMHP provides: ◆ Free auxiliary aids and services to people with disabilities such as qualified sign language interpreters (remote interpreting service or on-site appearance), and written information in other formats (large print, audio, accessible electronic formats, other formats) This document is inserted in all member material that is considered critical to the Member receiving services. It is found in the CHP+ Benefits Booklet on page 114. Members are told that they may access these services by calling RMHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* CHP+ Contract Amendment 3: Exhibit B1—6.7.1	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP_Final* Page 3, Section "RMHP CHP+," of the P&P explains how the new member packet is mailed within a reasonable timeframe after notification of the Member's enrollment. RMHP strives to send these materials within the first two weeks of a Member's initial enrollment. Information is included in the Getting Started Guide on how Members can obtain a Member Benefit Booklet online as well as a print copy upon request at no charge.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* CHP+ Contract: Exhibit B1—6.7.2, 14.1.3.13.3	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP_Final* Page 2, Bullet #6, indicates that RMHP will provide enrollees at least a 30-day notice of any change in the information that the State defines as significant. Note: No significant changes were necessary to communicate to Members in 2020.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* CHP+ Contract: Exhibit B1—7.12.2, 14.1.8.1	*V_CM-CS-PNM 01 Notification of Provider Termination* It is the policy of RMHP to ensure that all Members assigned to a Primary Care Physician (PCP) with at least one visit with a PCP within the previous twelve months, are notified when the PCP is no longer contracted with RMHP. This document outlines, at a high level, the cross departmental workflow of the PCP termination process. *V_CS_Prov Term Notif_PP* Details the process for letting Members know that their provider is no longer contracted with RMHP. *V_CS_PCP Term Ltr MD_CHP* *V_CS_ Facility Term* *V_CS_Spec Term MD_CHP* These provider termination notice templates are used when RMHP provides written notice of the termination of a participating PCP or specialist.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_PH_Pharmacy Term These provider termination notice templates are used when RMHP provides written notice of the termination of a participating PCP, specialist or pharmacy.	
12. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.*	*V_PNM_CHP_Prov_Directory_12.2020_Eng_508* The CHP+ Provider Directory is available on the RMHP website in both electronic and paper form. The paper directory includes the provider's name, group affiliation, street address, and specialty. In addition, the paper provider directory indicates: ◆ Languages offered ◆ If the provider accepts established patients only through use of an icon showing a circle with strike mark ◆ PCPs through use of an icon showing the letter "P" within a circle ◆ Handicap accessibility through use of a wheelchair icon. ◆ Accommodations for people with physical disabilities in the office and exam rooms. Page 14, Chad Derosa, is an example of a provider who has completed RMHP's Disability Competent Care Training Program and Cultural Competency Training. Information about the electronic provider directory can be found at www.rmhp.org. It indicates that practitioners and hospitals may self-report, or update upon RMHP's request, the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(h)(1-3) CHP+ Contract: Exhibit B1—14.1.3.6-7	demographic information displayed in the directory, including name, address, phone number, gender, languages spoken, medical group affiliation, hospital affiliation, an accepting current patients. This data is updated weekly to maintain accuracy. The Directory is current as of Wednesday of each week. (Provider website URLs are not available at this time)	
13. Provider directories are made available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)* CHP+ Contract: Exhibit B1—14 1.3.8	*V_PNM_CHP_Prov_Directory_12.2020_Eng_508* Provider directory is available for download and is in a machine readable file and format. *V_CI_Screenshot of Links to CHP+ Directory* Shows where Members can download a copy of the Provider Directory from the website.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider.	*V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* **Bullet 1:** Pages 30-72, Section 5, Covered Services describe the amount, duration and scope of benefits available as well as on pages 11-12, "Summary of Covered Benefits." **Bullet 2:** Procedures for obtaining benefits are explained as follows: ◆ Page 16, Section 1, Getting Care,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider. • The process of selecting and changing the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered benefit that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services. *42 CFR 438.10(g)(2)(iii, iv, vi, vii, x) and (g)(ii)(A-B)* CHP+ Contract: Exhibit B1—14.1.3.10 14.1.3.13.3.7 Exhibit K—1.1.4.1–3, 1.1.14, 1.1.30 Amendment 3: Exhibit K—1.1.7	"Pre-authorization" explains pre-authorization ◆ Page 14, "Specialty Care" explains that referrals are not needed to see a specialist that works with RMHP. ◆ Page 15 explains how to get hospital care, pregnancy care, prescription drugs. **Bullet 3:** Page 18, Section 2, Member's Rights & Responsibilities, bullet 10, indicates the right to get family planning services from any Health First Colorado provider in or out of RMHP's network, with no referral. Pages 36-37, Section 5, Covered Services, "Family Planning/Reproductive Health", indicates that family planning/reproductive health services do not require pre-authorization or referral for any provider regardless of whether they are in-network or not. This could be a PCP or an OB/GYN. Page 15, "Doctors that do not work with RMHP", explains that in general Members must obtain services from network providers, but that this requirement does not apply to emergency or urgent care. The section goes on to instruct the Member to call RMHP if they need care from a doctor that does not work with RMHP. In this case, RMHP may give permission to see the OON doctor and the Member will not have to pay for the care.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet 4: Page 7, Information for New Members, "I am a New Member. What do I do Now," explains to Members how to pick a primary care provider. Page 9, Information for New Members, "How to Change your PCP," explains how a Member may change their primary care provider. **Bullet 5:** Note: Restriction of choice among network providers: RMHP does not restrict choice among network providers. **Bullet 6:** Note: RMHP does not exclude any counseling or referral services due to moral or religious objections.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member.	*V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Pages 18-19, Section 2-Member Rights & Responsibilities, enumerate the member rights and protections set forth in 42 CFR 438.100. This information is set forth in the member handbook in accordance with the information requirements set forth in 42 CFR 438.10 (e.g., in a manner and format that is easily understood and readily accessible).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(g)(2)(ix) CHP+ Contract: Exhibit B1—14.1.3.10, 14.1.1.2.1-6, 14.1.1.3 Exhibit K—1.1.2		
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair	V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508 Pages 89-93, Section 9, "Complaints, Appeals & Grievances, explains the process for filing grievances and appeals, including timeframes for filing, the right to request a State fair hearing, assistance that is available and the rules around continuing benefits during while the appeal/hearing is pending.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.18, 1.1.18.1, 1.1.18.1.1, 1.1.18.1.3, 1.1.18.2.1		
Findings: The Continuing Your Benefits section in the *CHP+ Benefit Booklet* did not include the required time frame of 10 days for a member to request that benefits continue after receipt of an NABD or adverse appeal determination letter. While the member has 60 days from the date of the NABD to request an appeal and 120 days to request an SFH from the date of the adverse appeal determination letter, benefit continuation must be requested within 10 days of the date of the NABD and adverse appeal determination letter. Within the same section, the second statement in the continuation of benefits bulleted list, "the appeal must involve termination, suspension or reduction of a previously approved course of treatment," did not apply to SFHs.		
Required Actions: RMHP must revise the continuation of benefits description in the *CHP+ Benefits Booklet* to include the 10-day time frame to request continuation of benefits. RMHP must also clarify that the bulleted statement, "the original approval must not have expired" applies only to appeals.		
17. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care.	*V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Pages 33-36, Section 5, Covered Services, "Emergency and Urgent/After-Hours Care," explains how after-hours and emergency coverage are provided. Pages 34-35 describe Emergency medical condition (including examples) Pages 35-36 discuss Emergency services that are covered. Page 34 explains the fact that prior authorization is not required	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(g)(2)(v) CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.10.1, 1.1.10.1.1, 1.1.10.2, 1.1.10.5	for emergency services. Page 34 explains that a Member can get emergency care anywhere in the United States and that permission from RMHP is not required.	
18. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse. • How to access auxiliary aids and services, including information in alternative formats or languages. *42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.3, 1.1.19	*V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* **Bullet 1:** Pages 22-24, Section 3, "What you Pay for Enrollment & Service," explains all cost sharing (enrollment fees and co-payments) imposed at all income levels on services under the CHP+ State plan. **Bullet 2:** Note: RMHP covers all benefits that are covered under the CHP+ State Plan **Bullet 3:** Pages 70-71, Section 5, Covered Services, provides an explanation of emergency ambulance services that are covered. No other transportation (including non-emergency medical transportation) is a covered benefit under the CHP+ State plan or RMHP's contract. **Bullet 4:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The toll-free telephone number for member services is found on the cover of the benefits booklet, at the bottom of every page and on page 4 "How to Contact Rocky Mountain Health Plans." On page 18, under "How to Contact RMHP Care Coordination," a telephone number for customer service is provided that a Member may use to ask from help with care coordination. **Bullet 5:** Pages 80-81, Section 7, Administrative Information and Additional Information, "Fraud Activity," provides information to Members about how to report suspected fraud or abuse. **Bullet 6:** Page 114, Notice of Non-Discrimination, provides information about how to access auxiliary aids and services, including alternative formats and languages. **Bullet 1:** *V_CI_Combined CHP+Copay Notices_Eng&Spa* A CHP+ copay notice is included in the Getting Started Guide. The Co-pay notice illustrates the amount of Member copays (varies based on member income).	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The member handbook provided to members following enrollment includes how to exercise an advance directive as required in 438.3 (j): • The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. • The Contractor's policies and procedures respecting implementation of advance directives, with a clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • Informing members that grievances concerning noncompliance with the advance directive requirements may be filed with the State Department of Public Health and Environment. *42 CFR 438.10(g)(2)(xii)* CHP+ Contract: Exhibit B1—14.1.1.2.7, 14.1.1.2.7.1, 14.1.9 Exhibit K—1.1.24	*V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Pages 19-20, Section 2-Member Rights & Responsibilities- "Your Right to Make Health Care Decisions-Advance Directives. What is an Advance Directive," describes the three kinds of Advance Directives. *V_PNM_PNM-007 Advance Directives 12.30.*2020 Page 2 of this P & P indicates that RMHP does not have any limitations regarding implementation of Advance Directives as a matter of conscience; therefore, a statement of limitation is not made. *V_PNM_2020RMHPProviderNL_Webv2* This newsletter informs providers that RMHP does not have any limitations regarding implementation of Advance Directives as a matter of conscience; therefore, a statement of limitation is not made. *V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Page 21, "How do I complain if my Advance Directive isn't followed," Informs Members where they can complain if a provider isn't following their advance directive requirements. Members are directed to send their complaint to the CDPHE (Colorado Department of Public Health and Environment).	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Scored

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The Contractor provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* CHP+ Contract: Exhibit B1—14.1.3.10.1	**Bullets 1 & 2:** *V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP_Final* Page 2, Bullet 5, states that RMHP will make materials available to a Member in paper form via U.S. mail and without charge within 5 days of request. Page 4, Section-"Sending Member Materials upon Request," describes the process for sending member materials upon request by mail or by e-mail, including the timeframe for response to the request. Customer Service Reps will document if the Member agrees to receive the information by e-mail. **Bullet 3:** *V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Page 4, informs Members that they can get a CHP+ Benefits Booklet at any time, and that they can ask RMHP to mail a copy or they can access it online. Page 6, lists the RMHP website URL under Important Websites, and informs Members that they can go to the website for information about providers, for a copy of the Benefits Booklet and more. Page 7, tells Members that the Benefits Booklet and Provider Directory are at rmhp.org where they can view or print these documents. They can also ask Rocky Mountain Health Plans Customer Service to mail a copy at any time at no cost. Page 61, tells Members that the most up-to-date list of prescription medications covered under the CHP+ plan is on	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP's website at www.rmhp.org. A paper copy is available by calling RMHP Customer Service. **Bullet 4:** *V_CI_MD12-Getting Started Guide_Rev123019_Web-508_Eng* Informs Members that they can request a copy of the CHP Benefit Booklet is available online at RMHP.org and they can additionally get a printed copy, free of charge. *V_CI_Screenshot of Member Portal for Benefit Booklet* This screenshot shows a view from the RMHP Member portal which guides Members to where they can obtain the CHP Benefit Booklet.	
21. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* CHP+ Contract: None	*V_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Page 81-82, "No Withholding of Coverage of Necessary Care" states that Members can ask Customer Service to receive information on RMHP's physician incentive plans.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	19	X	1.00	=	19
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Scored	=	1	X	NS	=	NS
Total Applicable		=	20	**Total Score**		=	19
			Total Score ÷ Total Applicable			=	95%

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeal system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* CHP+ Contract: Exhibit B1—7.9.1 10 CCR 2505-10—8.209.1	*VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *VI_CS_MD.CHP - Uphold Denial Med Review* *VI_CS_MD.CHP - Uphold Denial No Med Review* *VI_CS_MD.CHP - Overturn Denial Med Review* *VI_CS_MD.CHP - Overturn Denial No Med Review* *VI_CS_Process for Accepting Appeal or Grievance* The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). • For a resident of a rural area with only one managed care plan, the denial of a CHP+ member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the	*VI_CS_Appeals Policy and Procedure* Page 16, Subsection VII, Paragraph A-G: This defines "Adverse Benefit Determination." Page 19, Section F addresses the circumstances of a resident of a rural area to exercise their right to obtain services outside the network due to various reasons. *VI_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Page 89, Describes the example of the kinds of decisions a Member may appeal which includes when RMHP denies certain services if a Member lives in a rural area. The Member has the right to use a provider, even if they are not in the RMHP network.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
main source of a service to the member—provided that: – The provider is given the opportunity to become a participating provider. – If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: Exhibit B1—1.1.3 10 CCR 2505-10—8.209.2.A		
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.4 10 CCR 2505-10—8.209.2.A.7	*VI_CS_Appeals Policy and Procedure* Page 16, Subsection VI: This defines "appeal" as a review by RMHP of an adverse benefit determination.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: While the written definition of an appeal in the *Member Appeals Process* policy and procedure was accurate, procedural implementation was not consistent with the definition. HSAG determined that three of the appeal cases were provider administrative issues that were misclassified as member appeals.		

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: RMHP must develop specific criteria for defining provider versus member appeals to assist staff members to accurately identify when an appeal should or should not involve the member.		
4. The Contractor defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.44 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	*VI_CS_Appeals Policy and Procedure* Page 15-16, Subsection V: Grievance *VI_CS_Grievance Policy and Procedure* Page 6, Section 5.0 - Definitions: In both documents, grievance is defined as a verbal or written expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to quality of care or services provided, aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by RMHP to make an authorization decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has provisions for who may file: • A member may file a grievance, a Contractor-level appeal, and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance, a Contractor-level appeal, and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* CHP+ Contract: Exhibit B1—14.1.4.1.1, 14.1.5.1	*VI_CS_Grievance Policy and Procedure* Page 2, Section 3.0, Paragraph III: This indicates that a Member or their designated representative may file grievances. Page 2, Section 4.0, Paragraph IV: This states that RMHP must obtain authorization in writing from the Member or his/her designated client representative, including a treating health care professional, to represent his or her interests related to grievances. *VI_CS_Appeals Policy and Procedure* Page 2, Section I, Paragraph C: This indicates that procedures for authorized representatives to appeal on a Member's behalf are outlined in the "Designation of Representatives" Process. Page 11-12, Section XI: Paragraph A-D: This states that the Member or their DCR may request a State Fair Hearing. *VI_CS_Process Designation of Representatives* Page 1, Section 3.0, Paragraph 2: This states that a Member, or a designated client representative acting on behalf of a Member with the Member's written consent, or the legal representative of a deceased Member's estate, may file a grievance, a health plan-level appeal, and may request a State Fair Hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* CHP+ Contract: Exhibit B1—None 10 CCR 2505-10—8.209.4.C	*VI_CS_Appeals Policy and Procedure* Page 1-2, Section 4.0, Subsection I, Paragraph B: This explains how RMHP assists Members in completing any forms required, putting verbal requests, including requests for a State fair hearing, into writing and taking other procedural steps. *VI_CS_Grievance Policy and Procedure* Page 2, Section 4.0, General Information: This explains how RMHP assists Members with completing any forms or completing other procedural steps. *VI_CS_COMBINED_1557Notice_MLIS_01312020 (Medicaid CHP+)* *Tagline and Notice of Nondiscrimination* This document is sent with all significant Member communications, including with all appeals and grievances Member mailings. Page 1: The Notice of Nondiscrimination states that RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge, including auxiliary aids and services.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B1—14.1.4.1.6, 14.1.5.8 10 CCR 2505-10 8.209.5.C, 8.209.4.E	*VI_CS_Appeals Policy and Procedure* Page 4, Section IV, Paragraph C: This describes the requirements for the grievances and appeals reviewers/decision-makers. The Medical Director and the clinical consultant must not have been involved in the initial decision or be the subordinate of the medical director involved in the initial review. The reviewer or consultant must have the appropriate clinical expertise in treating the Member's condition or disease. *VI_CS_Grievance Policy and Procedure* Pages 4-5, Section Process Paragraph I, Bullet 3: This indicates that RMHP ensures that individuals who make decisions on grievances are individuals who were not involved in any aspect of the circumstances or decision-making that led to the grievance nor a subordinate of any individual who was involved, and have the appropriate clinical expertise in treating the Member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* CHP+ Contract: None 10 CCR 2505-10—8.209.5.C, 8.209.4.E	*VI_CS_Appeals Policy and Procedure* Page 4, Section IV, Paragraph C(4): This states that the individuals who make decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B1—14.1.5.6 10 CCR 2505-10—8.209.5.D	*VI_CS_Grievance Policy and Procedure* Page 2, Section 4.0-General Information: This lists the ways that RMHP accepts grievances, both orally and in writing. *VI_CS_Process for Accepting Appeal or Grievance* This document describes the process that Customer Service Representatives follow to accept Member grievances orally by phone. *VI_CS_Complaints and Appeals Routing* Page 2, Section 6.0: This explains how Customer Service Representatives receive grievances by phone or email.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* CHP+ Contract: Exhibit B1—14.1.5.4 10 CCR 2505-10—8.209.5.A	*VI_CS_Grievance Policy and Procedure* Page 2, Section 4.0-General Information: States that Members or their designated representative can file grievances at any time.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor sends the member a written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.5.5 10 CCR 2505-10 8.209.5.B	*VI_CS_Grievance Policy and Procedure* Page 3, Section General Information Paragraph V: This states that acknowledgment letters are sent to Members within two working days.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor must resolve each grievance and provide notice as expeditiously as the enrollee's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1)and (d)(1)* Contract: Exhibit B1—14.1.5.7, 14.1.5.9, 14.1.3.1 10 CCR 2505-10 8.209.5.D	*VI_CS_Grievance Policy and Procedure* Page 5, Section Process Paragraph I, Bullet 3: This states that RMHP must respond to a grievance within 15 working days from the date of receipt, or as expeditiously as the Member's health condition requires. Page 3, Section General Information paragraph VI: This describes that the reviewer's resolution must be in language that is easily understandable. It must provide a rationale in sufficient detail that may be easily understood by the Member.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VI_CS_CHP - Grievance and Explanation Resolution This template is used to provide notice to the Member of the disposition/resolution of their grievance. It is in a format and include standard language that can be easily understood by Members.	
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. CHP+ Contract: Exhibit B1—14.1.5.11 10 CCR 2505-10 8.209.5.G	*VI_CS_CHP - Grievance and Explanation Resolution* This template includes the disposition /resolution process and the date it was completed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* CHP+ Contract: None	*VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *IV_CS_MD.CHP - Uphold Denial Med Review* *IV_CS_MD.CHP - Uphold Denial No Med Review*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VI_CS_Process for Accepting Appeal or Grievance The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. The documents indicate that there is only one level of appeal with the health plan for RAE and Prime Members. Members are provided clear instructions about how to request a State Fair Hearing after exhausting RMHP's appeal process, or if RMHP fails to adhere to the required timeframes for processing appeals.	
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.1 10 CCR 2505 10 8.209.4.B	*VI_CS_MD.CHP Timelines* Page 1, Member Appeal Submission: This indicates the 60 calendar day time frame Members have to submit an appeal.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)*	*VI_CS_Appeals Policy and Procedure* Page 1, Section 4.0 Subsection I, Paragraph A 1-4: This indicates that appeals will be accepted by fax, e-mail, standard mail or verbally. Page 3, Subsection II, Paragraph A(1): This explains how verbal appeals are acknowledged and	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.406 (b)(3) CHP+ Contract: Exhibit B1—14.1.4.1.2, 14.1.4.1.8.2 10 CCR 2505 10 8.209.4.B	describes the process for obtaining a written, signed appeal of an oral request. *VI_ CS_Verbal Appeal Acknowledgment Template* This template explains to the Members what RMHP believes to be the reason for the appeal, and indicates that the Member can sign and return the letter if they agree that RMHP understands what they are appealing. This notice also explains that the Member must sign and return the letter.	
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B1—14.1.4.1.3 10 CCR 2505-10 8.209. 4.D	*VI_CS_MD.CHP Timelines* This document indicates the time frame to acknowledge receipt of a standard appeal. *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* These letter templates are used to provide written acknowledgement of verbal and written appeals and are sent within two working days of receipt of standard appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.1, 14.1.4.1.8.2, 14.1.4.1.5.4 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	*VI_CS_Appeals Policy and Procedure* Page 3, Section II, Paragraph A (1-2): This explains that verbal inquiries are treated as appeals. Page 3, Subsection II, Paragraph A(1): This describes the procedure for confirming a standard appeal in writing and that written confirmation is not required for an expedited appeal. *VI_CS_Process Designation of Representatives* Page 1, Section 3.0 Paragraph 2: This explains that the Member, the Member's designated representative or the legal representative of a deceased Member's estate are the parties to the appeal.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and	*VI_CS_Appeals Policy and Procedure* Page 3, Subsection II Paragraph A(2): This explains how RMHP gives Members an opportunity to submit further evidence, including in cases of expedited resolution where time is limited. Page 3, Subsection II Paragraph A(2 c): This explains how RMHP gives Members an opportunity to receive a copy of the Member's case file free of charge and in advance of the appeal resolution time frame.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(3-5)* CHP+ Contract: Exhibit B1—14.1.4.1.5.2-3 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	*VI_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Page 89, "Standard Review," paragraph 2, describes that Members they will receive information in their acknowledgement letter about how to access their appeal file and that they may provide more information about their appeal to RMHP either in person, or in writing.	
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* CHP+ Contract: Exhibit B1—14.1.4.1.8.1, 14.1.4.1.8.5 10 CCR 2505-10 8.209.4.Q-R	*VI_CS_Appeals Policy and Procedure* Pages 5-6, Subsection V: This describes the expedited review process. Page 6, Subsection V, Paragraph B(3): This states that punitive action will not be taken against a provider for requesting an expedited appeal or supporting a Member's appeal. *VI_PNM_Physicians Medical Services Agreement* Page 22, Section 7, Paragraph G, Limitations on Adverse Actions: This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. *VI_PNM_Professional Services Agreement* Pages 23-24 Paragraph G, Limitations on Adverse	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Actions: This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. *VI_PNM_Hospital Services Agreement* Page 26-27 Paragraph G, Limitations on Adverse Actions: This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision.	
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.1 10 CCR 2505-10 8.209.4.S	**Bullet 1:** *VI_CS_Appeals Policy and Procedure* Page 6, Subsection V, Paragraph B (1): This describes that if RMHP denies a request for expedited resolution, it will transfer the appeal decision to the standard time frame and will make reasonable efforts to give the Member verbal notice followed by written notice of the denial within two calendar days. **Bullet 2**: *VI_CS_Appeals Policy and Procedure* Page 6, Subsection V, Paragraph B (4): This describes that the Member has the right to file a grievance if he or she disagrees with the decision not to expedite the appeal. *VI_CS_MD.CHP - No Expedited Appeal*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This template provides the standard text contained in a notice that an appeal will not be expedited and demonstrates that the content is in a format and language that may be easily understood by the Member.	
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* CHP+ Contract: Exhibit B1—14.1.4.1.4, 14.1.3.1 10 CCR 2505-10 8.209.4.J.1	**Bullet 1 –** *VI_CS_MD.CHP Timelines* This document provides timeframes for appeals process and decisions. **Bullet 2 –** *VI_CS_Appeals Policy and Procedure* Page 5, Subsection IV, Paragraph D: This describes the content of appeal resolution letters, including that they must be in a format and language that is easily understood by the Member. *VI_CS_MD.CHP - Uphold Denial Med Review* *VI_CS_MD.CHP - Uphold Denial No Med Review* *VI_CS_MD.CHP - Overturn Denial Med Review* *VI_CS_MD.CHP - Overturn Denial No Med Review* These templates provides the standard text contained in	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	a notice of appeal resolution and demonstrates that the content is in a format and language that may be easily understood by the Member.	
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: Exhibit B1—14.1.4.1.8.4.2, 14.1.4.1.8.4.5 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	*VI_CS_MD.CHP Timelines* This document describes that the timeframe for resolving an expedited appeal is within 72 hours of receipt. *VI_CS_Appeals Policy and Procedure* Page 6, Subsection V, Paragraph B (2): This describes that RMHP will make reasonable efforts to provide oral notice to the Member of the expedited resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest.	*VI_CS_Appeals Policy and Procedure* Page 7-8, Subsection VI, Paragraph H (1): This explains the circumstances under which RMHP will extend the time frames for resolution of both expedited and standard appeals. *VI_CS_Grievance Policy and Procedure* Page 4-5, Section Process Paragraph I: This explains the circumstances under which RMHP will extend the time frame for resolution of a grievance.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(c)(1) CHP+ Contract: Exhibit B1—14.1.4.1.4.1, 14.1.4.1.8.4.3 10 CCR 2505-10 8.209.4.K, 8.209.5.E		
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* CHP+ Contract: Exhibit B1—14.1.4.1.4.2, 14.1.4.1.8.4.4–5	*VI_CS_Appeals Policy and Procedure* Pages 7-8, Section VI, Paragraph H (1): This explains that if RMHP extends the time frame, reasonable efforts will be made to give the Member prompt oral notice of the delay and the Member will be given written notice of the reason for the delay within two calendar days, informing the Member that they may file a grievance if they disagree with the decision. Further, this P&P explains that the appeal will be resolved as expeditiously as the Member's health condition requires and no later than the date the extension expires. *VI_CS_Grievance Policy and Procedure* Page 4-5, Section Process Paragraph I: This explains the circumstances under which RMHP will extend the time frame for resolution of a grievance. *VI_CS_MD.CHP - Plan Needs Additional Time* This template illustrates the notices that the plan needs additional time to complete appeal and the Member's rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provided 10-day advance notice to terminate, suspend, or reduce. In addition, to be eligible for continued benefits during a State fair hearing, the member must have received continued benefits during the Contractor appeal process.* *42 CFR 438.408(e)* CHP+ Contract: Exhibit B1—14.1.4.1.7 10 CCR 2505-10 8.209.4.M	*VI_CS_Appeals Policy and Procedure* Page 5, Subsection IV, Paragraph M: This describes the information that must be included in the notice of appeal resolution. *VI_CS_MD.CHP - Uphold Denial Med Review* *VI_CS_MD.CHP - Uphold Denial No Med Review* These templates illustrates that the notices of appeal resolution contains the required language.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: Exhibit B1—14.1.4.1.10.1-2 10 CCR 2505-10 8.209.4.N and O	*VI_CS_Appeals Policy and Procedure* Pages 11-12, Subsection XI, Paragraph A.: This explains that the Member or their DCR may request a State fair hearing within 120 days from the date of the notice of resolution. The P&P also explains that a Member is deemed to have exhausted the appeal process and may request a State fair hearing if RMHP does not adhere to the notice and timing requirements. *VI_MarComm_CHPBenefitBooklet_Dec2020_Eng_508* Page 90, "Standard Review" paragraph 5, informs Members they may request a State fair hearing within 120 calendar days from the date of the notice of resolution and that if RMHP does not adhere to the notice and timing requirements, the Member may request a State fair hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B1—14.1.4.1.10.3	*VI_CS_Appeals Policy and Procedure* Page 12, Section XI, Paragraph D: This explains that RMHP, as well as the Member and his or her representative, participate in the State Fair Hearing. *VI_CS_Process Designation of Representatives* Page 1, Section 3, Paragraph 2: This explains that a representative of a deceased Member's estate is considered a party to a State Fair Hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal is pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal within 60 days of the notice of adverse benefit determination. **This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)*	*VI_CS_Appeals Policy and Procedure* Page 12-13, Subsection XII: This describes the policy for continuation of benefits during the appeal process. *VI_CS_MD.CHP - Uphold Denial Med Review* *VI_CS_MD.CHP - Uphold Denial No Med Review* Page 2, How to Ask for your Services to Continue During a State Fair Hearing: These Member notices describes the continuation of benefits policy while RMHP appeal and State fair hearing are pending.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor provides for continuation of benefits/services (when requested by the member) while the State fair hearing is pending if: • The member requests a State fair hearing with a request for continuation of benefits in a timely manner—defined as on or before the following: – Within 10 days of the Contractor mailing the notice of appeal resolution not in favor of the member. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment (and the member requested and received continued benefits during the Contractor appeal). • The services were ordered by an authorized provider. *42 CFR 438.420(a) and (b)* CHP+ Contract: Exhibit B1—14.1.4.1.9.1 10 CCR 2505-10 8.209.4.T		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal. • The member does not request continued benefits during a State fair hearing within 10 calendar days after the Contractor sends the notice of an appeal resolution not in the member's favor.	*VI_CS_Appeals Policy and Procedure* Page 12, Section XII, Paragraph F (1-3): This describes how long benefits are continued while an appeal or State Fair Hearing is pending and the events that must occur before benefits can be discontinued.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
If, at the member's request, the Contractor continues or reinstates the benefits while the State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the request for a State fair hearing. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* CHP+ Contract: Exhibit B1—14.1.4.1.9.2 10 CCR 2505-10 8.209.4.U		
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* CHP+ Contract: Exhibit B1—14.1.4.1.9.3 10 CCR 2505-10 8.209.4.V	*VI_CS_Appeals Policy and Procedure* Page 12, Subsection XII, Paragraph G (1): This describes the Member's responsibility for the cost of continued services if the appeal decision is adverse to the Member.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. Effectuation of reversed appeal resolutions: • If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. • If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424* CHP+ Contract: Exhibit B1—14.1.4.1.9.4–5 10 CCR 2505-10 8.209.4.W-X	*VI_CS_Appeals Policy and Procedure* Page 12-13, Subsection XII, Paragraph G (3): This describes RMHP's responsibility for effectuating the State hearing decision if it reverses RMHP's decision to deny, limit or delay services that were not furnished while the appeal was pending. *VI_CS_Appeals Policy and Procedure* Page 12, Subsection XII, Paragraph G (2): This describes that RMHP must pay for services when the State fair hearing officer reverses a decision to deny authorization of services and the Member received the disputed services while the appeal was pending.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
33. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the	*VI_CS_Appeals Policy and Procedure* Page 2, Subsection I, Paragraph G.: This describes the records of appeals that RMHP maintains. *VI_CS_Grievance Policy and Procedure* Page 4, Section General Information Paragraph XII: This describes the records of grievances that RMHP maintains.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* CHP+ Contract: Exhibit B1—14.1.4.1.12, 15.5.1 10 CCR 2505-10 8.209.3.C	*VI_CI_CHP_GrieveAppealRpt_Q1FY20-21* This report, provides identified trends regarding timely response and completion of grievances and appeals, and any actions taken. Note: Grievance and Appeal approved template with Q1FY20-21 data will be available on site.	
34. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member.	*VI_PNM._Physicians Medical Services Agreement* Page 12-13, Paragraph U. Expressing Disagreement: Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or requested in written form. Page 12, Paragraph T. Compliance, Cooperation and Participation in RME's Policies and Procedures: Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing.* – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. * *Time frames specified for filing:* *During an appeal: Request continued benefits within 10 days of the notice of adverse benefit determination.* *During a State fair hearing: Request continued benefits within 10 days of the notice of adverse appeal resolution.* *42 CFR 438.414* *42 CFR 438.10(g)(xi)* CHP+ Contract Amendment 3: Exhibit B1—14.1.4.1.1.1, 14.1.5.1.1 10 CCR 2505-10 8.209.3.B	*VI_PNM_Professional Services Agreement* Pages 12-13 Paragraph Q. Expressing Disagreement: Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 12 Paragraph P. Compliance, Cooperation and Participation in RME's Policies and Procedures: Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *VI_PNM_Hospital Services Agreement* Page 16 Paragraph W. Expressing Disagreement: Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 16 Paragraph V. Compliance, Cooperation and Participation in RME's Policies and Procedures: Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request.	

Results for Standard VI—Grievance and Appeal Systems							
Total	Met	=	33	X	1.00	=	33
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	34	**Total Score**		=	33
				Total Score ÷ Total Applicable		=	97%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* CHP+ Contract: Exhibit B1—14.2.1.1	*VII_PNM_CR.01.20 Credentialing Criteria and Process* This P&P defines a consistent credentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for credentialing of its providers. *VII_PNM_RC.01.20 Recredentialing Process* This policy defines a consistent recredentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for recredentialing of its providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b) and (e)* CHP+ Contract: Exhibit B1—14.2.1.3, 14.2.1.5	*VII_PNM_CR.01.20 Credentialing Criteria and Process* The Contractor complies with NCQA standards and guidelines for credentialing and recredentialing its providers. *VII_PNM_HDO.01.20 Health Delivery Organizations* Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* CHP+ Contract: Exhibit B1—14.2.1.1.2.1—2	*VII_PNM_CR.14.20 Non Discriminatory Credentialing* This policy describes the process used to monitor for and prevent against discriminatory credentialing practices.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and	*VII_PNM_CR.01.20 Credentialing Criteria and Process* Pg. 11 Section D Final Decision and Notifications: This section explains the notification procedure for practitioners applying to the RMHP panel and being denied. *VII_PNM_RC.01.20 Recredentialing Process* Pg. 11, Section E. Final Decision and Notification: This section sets forth the notification procedure for practitioners applying to the RMHP panel. *VII_PNM_RC.04.20 MPRC - Reduction, Suspension or Termination*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
are consistent with its responsibilities to members. *42 CFR 438.12(a-b)* CHP+ Contract: Exhibit B1—14.2.1.1.2.4, 14.2.1.1.5	Pages 2-5, Section 1. This policy outlines the process for notifying a provider of the reduction, suspension or termination of a health care provider's contracting status.	
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* CHP+ Contract: Exhibit B1—10.1	*VII_PNM_Professional Services Agreement* Page, 6 Paragraph HH, "Professional Health Care Services" provides the term "Health Care Professional" who is legally authorized to provide services under Colorado law and under their licensure and or certification. This agreement is used for all behavioral health providers. *VII_PNM._Physicians Medical Services Agreement* Page 4, Paragraph GG, "Participating Physician" Provides that the term "participating physician" means a person who holds a degree of Doctor of Medicine or Doctor of Osteopathy, is licensed by the State of Colorado to practice medicine, has a written agreement directly with RMHP. *VII_PNM_Hospital Services Agreement* Page 4, Paragraph V, "Hospital Services" defines those services which are provided at a Hospital Facility.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* CHP+ Contract: Exhibit B1—14.2.1.6, 19.1.1	*VII_PNM_CR.01.20 Credentialing Criteria and Process* This policy defines the credentialing process for Practitioners applying to the RMHP panel. Pg. 7: If a provider is on the OIG's list of debarred providers, credentialing/contracting will not be initiated. Pg. 8: RMHP's credentialing verification sources include License Sanction Status (#8), and Medicare/Medicaid Sanction Status (#9). *VII_PNM_ PNM-016 Initial Credentialing and Provider Notification of Request Process* Pages 2-3, Section C, Provides that before credentialing can begin, SAM, OFAC and OIG websites must be checked to ensure provider is not excluded from participation in federal healthcare programs. *VII_PNM_CR.05.20 National Practitioner Databank* Page 1, under "Policy," Describes RMHP's process for accessing the NPDB for all new practitioners and all currently contracted practitioners. This serves as primary source verification of sanctions against or limitations on licensure, sanction activity by Medicare and Medicaid, and malpractice history. *VII_Compliance_New Hire and Periodic Employee Sanction Review Policy* This policy describes the process for ensuring that	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP does not hire, continue to employ or contract with ineligible persons. *VII_Compliance_Prohibition Against Contracting With Any Person Policy* This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons.	
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* CHP+ Contract: Exhibit B1—19.1.1 and 19.1.2	*VII_Compliance_New Hire and Periodic Employee Sanction Review Policy* This policy describes the process for ensuring that RMHP does not hire, continue to employ or contract with ineligible persons. *VII_ Compliance_Economic Sanctions and Sanctions Monitoring Policy* Page 2, Section "General," demonstrates that RMHP is prohibited from engaging in activities with, provide goods, insurance or services or employ or contract with individuals or entities prohibited by law. *VII_Compliance_Prohibition Against Contracting With Any Person Policy* This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* CHP+ Contract: Exhibit B1—10.4.3	*VII_PNM._Physicians Medical Services Agreement* Page, 13, Paragraph U, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation, and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with Ms and will not penalize providers for such discussions. Page, 13, Paragraph V, "Medicaid Recipients Right to Participation" RMHP recognizes the Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. Page 23, Paragraph G, " Limitations on Adverse Actions" RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with the Member whether covered by the health plan or not.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_PNM_Professional Services Agreement Pages 12-13 Paragraph Q, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with Members and will not penalize providers for such discussions. Page 16, Paragraph X, "Medicaid Recipients Right to Participation" RMHP recognizes the Member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. Page, 26, Paragraph G, "Limitations on Adverse Actions" RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with Member whether covered by the health plan or not.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	2020 Provider Manual Pg. 13 Affirmative Statement RMHP encourages open communication between providers and Members in discussing appropriate care services, including medication treatment options, regardless of benefit coverage limitations. Contracted providers are not prohibited or discouraged from protesting or expressing disagreement with a medical decision, medical policy, or medical practice, including, without limitation, medication treatment options, made by RMHP or an entity representing or working for RMHP (e.g., a utilization review company).	
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* CHP+ Contract: Exhibit B1—14.1.3.13.3.7 Amendment 3: Exhibit K—1.1.7	NOTE: RMHP does not have objections to providing services on moral or religious grounds; therefore this requirement is not applicable.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract: Exhibit B1—14.2.5.2–3, 14.2.5.4.1–2, 14.2.5.4.9, 14.2.7.2–5	**Bullet 3 –** *VII_Compliance_Compliance Program Document* Page 4: Compliance Committee Structure Describes the Compliance Committee structure. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 1: Key Preventive Structures and Processes/bullet 1 Provides information regarding program governance, including a regulatory compliance oversight committee. **Bullet 4 –** *VII_Compliance_Compliance Program Document* Page 4: Effective Training and Education Describes the annual company training and education requirements for all employees, which includes the Compliance Officer, management, and staff as well as vendors. *VII_Compliance_RMHP Compliance Plan Addendum September 2020* Page 1: Key Prevention Structures and Processes/bullet 3 Discusses training and education topics, training processes and record retention.	

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

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

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2: Key Correction Structures and Processes Describes the program's commitment to prompt response to identified issues and credible allegations and effective corrective action plans. *VII PM&A-203_Medicaid FWA Deterrence & Reporting* Pages 3-4, Section 6, describes the procedure for prompt response to compliance issues as they are raised, including identification of referral, preliminary review, conducting the review, reporting internally and reporting to Regulatory Agencies.	
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12.)	**Bullet 1** *VII_Compliance_Control FWA Policy* Provides high-level depiction of how RMHP/UHC follow identified guidelines. *VII_Compliance_False Claims Act Compliance Policy RMHP 2020* Provides information regarding fraud, waste and abuse as it relates to the False Claims Act. Page 3, Whistleblower and Whistleblower Protections, describes the prohibition of retaliation when an employee provides any truthful information to a law enforcement officer that is related to any possible federal offense.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.608 (a)(6-8) CHP+ Contract: Exhibit B1—14.2.6.1, 14.2.7.1, 14.2.7.6	**For Bullet 2** *VII_PM&A-210_ Process for Monitoring, Investigating and Reporting Fraud, Waste and Abuse* Page 2, Section 2 – Reporting, A. and B. describes the process for prompt referral of any potential fraud to State Regulatory Agencies. **For Bullet 3** *VII PM&A-203_Medicaid FWA Deterrence & Reporting* Page 3, Section 6 Paragraph B, describes the process for suspension of payments for which the State determines any credible allegation of potential fraud.	
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by	**For Bullet 1** *VII_PM&A-210_ Process for Monitoring, Investigating and Reporting Fraud, Waste and Abuse* Page 2, Section 2 – Reporting, A. and B. describes the process for prompt referral of any potential fraud to State Regulatory Agencies. **Bullet 2:** *VII_MEB-PP Notice to State_Enrollee Circumstance Change* This policy and procedure outlines the steps RMHP takes to notify the State when there is a change in a Member's circumstance which may affect the Member's eligibility.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract: Exhibit B1—14.2.5.4.3–7	**Bullet 3:** *VII_CI_Monthly FWA_Provider Term Notification Template* This document is produced monthly and sent to the Department to report FWA activity as well as overpayment recoveries and Provider Termination from the RMHP network. (This is an example of the template used monthly) *Note: Actual monthly report will be available on site as it contains PHI.* *VII_CI_Monthly FWA_Provider Term Notification Dec 2020* Email example of notification to the Department of FWA, overpayment recoveries, and provider term notification. **For Bullet 4** *VII_PM&A-215_Member Verification of Services Process* This document describes the process of verifying services delivered by network providers were received by Members.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected enrollees. *42 CFR 438.608 (b)* CHP+ Contract: None	*VII_PNM_LAW EXHIBIT-Provider* Page 11, Paragraph 8 states that Contractor shall be enrolled with the State of Colorado in accordance with the disclosure, screening, and enrollment requirements of the State of Colorado for Medicaid and CHP+ providers. *VII_PNM_PNM-016 Initial Credentialing and Provider Notification of Request Process* Page 3, Section D (last bullet): RMHP credentialing department validates the providers State Medicaid ID number. If the provider has a valid Medicaid number a CP (Common Practitioner) will be created. If not, the request is returned to the PR Rep who notifies the applicant that a valid Medicaid ID number is required prior to the initiation of credentialing. *VII_PNM_Physicians Medical Services Agreement* Page 8, Paragraph F, "Enrollment Requirements" If the contractor serves Health First Colorado (Colorado Medicaid) or CHP+ Members, then the provider must be enrolled with Health First Colorado consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR Part 455, Subparts B and E and requirements of the State of Colorado. The provider must include in its RMHP enrollment application its Medicaid Identification number and the date of Health First Colorado enrollment or most recent validation.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has procedures to provide to the State: • Written discosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104) • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* CHP+ Contract: Exhibit B1—19.4.1, 19.4.4	*VII_Compliance_Prohibited Affiliations PP* This policy states that RMHP will disclose to Colorado's Department of Health Care Policy and Finance ("HCPF") any relationship RMHMO has with an individual who is debarred, suspended or otherwise excluded from participating in a federal or state health care program. *VII_Compliance_Prohibition Against Contracting With Any Person Policy* This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons. *VII_Compliance_Ownership & Control PP* This policy indicates that RMHP will disclose to HCPF information on ownership and control in a form acceptable to HCPF, and delineates what the disclosures will include. *VII_PRGREC_Reporting Overpayments to State* This describes the procedure to identify and report within 60 calendar days any capitation or other payments in excess of the amounts specified in the contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)* CHP+ Contract: Exhibit B1—16.3.4.1.6	*VII_PM&A-210_ Process for Monitoring, Investigating and Reporting Fraud, Waste and Abuse* Page 2, Section 2- Reporting, Paragraph C describes the process to report semi-annually to the State on recoveries of overpayments. *2020 Provider Manual* Page 49, Refunding Rocky Mountain Health Plans: Instructions are given to providers for reporting overpayments no later than 60 days after the overpayment is identified. Providers are instructed to include a written statement of the reason for the overpayment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.	*VII_PNM_Physicians Medical Services Agreement* Page 12, Paragraph S, No Recourse Against Medicaid Recipients, sections (1), (2), (3): Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. *VII_PNM_Professional Services Agreement* Page 12, Paragraph O, No Recourse Against Medicaid Recipients, sections (1), (2), and (3):	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.106 CHP+ Contract Amendment 3: Exhibit B1—16.4.1	Provider contracts state that Members are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. *VII_PNM_Hospital Services Agreement* Page, 15 Paragraph U No Recourse Against Medicaid Recipients, sections (1), (2), and (3): Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly.	
Findings: The *Professional Services Agreement*, *Physicians Medical Services Agreement*, and the *BH Provider Manual* all provided accurate information regarding member liability for covered services. However, in the provider manual, the information regarding member liability was included under a heading titled "Cost Sharing" with the subheading "RMHP Prime Members" that included a citation (C.R.S. 25.5-4-301[1]), which was not entirely accurate for CHP+ members. The paragraph did not include additional context regarding some instances where CHP+ members may have a copay or out-of-network liabilities.		
Required Actions: RMHP must update the member liability language in the provider manual to accurately address the various lines of business that may have variations in copay and liabilities. HSAG recommends using 42 CFR 438.106 language as a basis, with additional consideration to the individual contract language.		

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

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

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

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

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	delegated with timeframes required. Page 43, Exhibit F, Delegated Activities Grid, displays the delegation functions that shall be in accordance with the provisions of the Agreement. *IX_UM_UBH dba Optum Pre-Delegation Review* This document provides the results of RMHP's pre-delegation audit of and is an example of the type of pre-delegation RMHP undertakes before entering into a contract that involves a delegation of duties. **Note:** The following documents are for CY2019 as the CY2020 reports were not complete at the time of submission. *IX_UM_eviCore Annual Delegation Oversight ReportCY2019* *IX_UM_eviCore Annual Delegation Oversight ReportCY2019_XLS* *IX_UM_Optum Annual Delegation Oversight ReportCY 2019* *IX_UM_Optum Annual Delegation Oversight ReportCY 2019_XLS* These report provide a summary of the oversight activities of these delegated entities.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_PH_UHC Pharmacy Delegated Entity Oversight Policy RMHP is a party to the Inter-segment agreement between UnitedHealthcare and OptumRx. United performs the function of oversight of the PBM, per the UHC Pharmacy Delegated Entity Oversight Policy. *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 4-6, Paragraph 2.4, "Oversight" specifies that the delegated entity agrees to allow RMHP to maintain reasonable oversight and what that includes. Page 45, Exhibit 3, in its entirety sets forth the Table of performance standards and monitoring that will occur under the agreement.	
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities. • Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the	*IX_ PNM_ Delegated Credentialing Agmt* Page 2, Paragraph 2.A., and Exhibit A describe the delegated credentialing activities. Page 2, Paragraph 2.D., describes the reporting responsibilities of the delegate. Page 1 sets forth the delegate's agreement to perform the delegated credentialing activities and reporting responsibilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract: Exhibit B1—2.3	Pages 5-6, Paragraph 4, Revocation/termination of delegated activities is addressed *IX_UM_Delegated Utilization Management* Page 1, Section 3.1, provides that a written agreement between the parties will describe the delegated activities. Page 2, Section 3.1.6, provides that the written agreement will describe the remedies available if the delegate does not fulfill its oblations, including the circumstances that would cause revocation. **Obligations and reporting responsibilities in written delegation agreements** *IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 18, Section 3.1 Utilization Management and/or Complex Case Management, explains that the Vendor is delegated for Utilization Management and/or complex case management and maintain a utilization management and/or complex case management program and that the Vendor's process shall comply with the applicable requirements of the NCQA or Accrediting Agency and for Medicare, Medicaid and any other government business and any additional requirements under federal and state law.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 18, Exhibit B, describes that to the extent required by a regulatory or accrediting agency, the parties have documented in Exhibit F, the level of specificity required by applicable government authorities and/or RMHO's accreditation agencies the activities related to the services that have been delegated with timeframes required. Page 43, Exhibit F, Delegated Activities Grid, displays the delegation functions that shall be in accordance with the provisions of the Agreement. Pages 19-20, Section 6, Other Services, 6.1 General Services (a) (i)-(ii), describes the Vendor's reporting responsibilities. **Provisions for revoking or other remedies in delegated agreements** *IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 9, Section 6.4 Delegation of Activities; Oversight, explains that to the extent applicable to any Covered Services, in compliance with the delegation and oversite obligations imposed on RMHP, including the applicable state or under its contracts with any state and/or federal regulatory agencies, RMHP (a) shall conduct at least an annual audit of Vendor's performance or such delegated activities.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 5-6, Section 5.4 Corrective Action Plans, describes the corrective action plan process. Page 9, Section 6.4 Delegation of Activities; Oversight, item(b) states that RMHO has the right to revoke any functions or activities delegated to the Vendor under the Agreement, if in RMHO's reasonable judgement, Vendor's performance under the agreement does not comply with RMHO's obligations. Pages 9-10. Section 7.1 Term and Termination, items (d)(e), describe specified circumstances for immediate termination of delegated functions. *IX_PH_OptumRX_ISA12012020-Full Contract_redacted* Page 25, Section 15, G,(5) Delegation and Oversight. RMHMO reserves the right to revoke functions or activities delegated to the PBM in the event of non-compliance. **Obligations and reporting responsibilities in written delegation agreements** *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Pages 26-30, Exhibit 1, describes the delegated activities.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 27-28, Section 1.E, Reporting Requirements, describe the delegated entity's reporting responsibilities. **Provisions for revoking or other remedies in delegated agreements** *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 9, Paragraph 3.6.1 Evaluation of Delegated Entity Services, provides that in the event of a deficiency, the delegated entity shall implement and submit a corrective action plan within 15 business days of notification of the deficiency. Page 21, Paragraph 10.3, "Termination or Suspension Upon Notice," provides for termination or suspension upon notice if the delegated entity is not performing UM activities in compliance with NCQA requirements or applicable law.	
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable Medicaid/CHP+ laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract: Exhibit B1—20.B	*IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 123, Section 11.2 Amendment, explains that the Agreement may be amended in compliance with any and all notice and/or approval requirements of the insurance laws in the state in which RMHO is domiciled.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 18, Section 3.1 Utilization Management and/or Complex Case Management, explains that the Vendor is delegated for Utilization Management and/or complex case management and maintain a utilization management and/or complex case management program and that the Vendor's process shall comply with the applicable requirements of the NCQA or Accrediting Agency and for Medicare, Medicaid and any other government business and any additional requirements under federal and state law. *IX_PNM_Law Exhibit Template_Provider* Page 11, Section III, Paragraph 8, demonstrates the credentialing delegation agreement contains the required language regarding compliance with all applicable Medicaid Laws and regulations as stated in this element. *IX_LRA_Law Exhibit_Non-Provider 12-19* Page 9, Paragraph 23, demonstrates the credentialing delegation agreement contains the required language regarding compliance with all applicable Medicaid Laws and regulations as stated in this element. *IX_PH_OptumRX_ISA12012020-Full Contract_redacted* Page 27, Paragraph 23, "State Contracts."	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Contractor agrees to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and the requirements of Rocky's CHP+ and Medicaid contract. *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 7, Paragraph 3.1.4, specifies that the delegated entity agrees to meet or exceed RMHP standards, policies and procedures, NCQA standards and federal and state statutory or regulatory provisions. Further, if any accrediting organization standards, federal or state regulatory provisions are changed or revised, the delegated entity agrees to comply with or implement any such change as may be required by applicable law. This provision incorporates the applicable regulatory language in this requirement that is contained in RMHP's contracts with HCPF.	
4. The written agreement with the subcontractor includes: • The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.	*IX_UM_UBH_RMHMO_BHSA_Redacted20180201* (Optum Behavioral Health) Page 25, Section 4.7 Records, (b) Government access to Records, (i)-(ii) describes that the Vendor acknowledges and agrees that Secretary of HHS, the Comptroller General or their designee shall have the right to audit, evaluation and inspect any pertinent books, contracts, computer or other electronic system (including medical records),	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems related to CHP+ enrollees. – The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later. – If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. *42 CFR 438.230(c)(3)* CHP+ Contract: Exhibit B1—2.3	patient care documentation and other records and information belonging to the Vendor that involve transactions related to the CMS contract. Page 25, Section 4.7 Records, (b), Paragraph 2, describes that the Vendor shall make available its premises, physical facilities and equipment, records related to the services performed pursuant to the Agreement. Page 5, Section 5.1 Maintaining Records, describes provisions for recording keeping and access to records for the purposes of inspection Pages 34-36, Section II, related to Federal Health Care Programs, Sections 1-7 describe that CMS may inspect, evaluate and audit a Contractor at any time id determined there is a possibility of fraud or similar fault. *IX_PNM_Law Exhibit Template_Provider* Page 7, Section III, Paragraph 2, "Records and Audits" is part of the credentialing delegation agreement and contains the required language as stated in this element. *IX_LRA_Law Exhibit_Non-Provider 12-19* Page 4, Paragraph 11, "Medicaid and CHP+ Records and Audits" is part of the credentialing delegation agreement and contains the required language as stated in this element.	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_PH_OptumRX_ISA12012020-Full Contract_redacted Page 22, Section 1, "Medicaid and CHP+ Records and Audits," provides that OptumRx shall maintain records and permit inspection, evaluation and audit as described in this requirement. *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 5, Paragraph 2.4.5, grants permission for federal, state and local governmental authorities to audit any and all documents and materials related to services under the agreement at the delegated entity's place of business Page 6, Paragraph 2.4.10, provides that the period for retaining all data, information, records and documentation related to is performance of delegated entity services for the period required by law.	
Findings: While many of the RMHP subcontracts included language to grant the HHS-OIG, Comptroller General, or other designees the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor for up to 10 years, some of the delegated credentialing agreements did not include this information and the other specific language required.		
Required Actions: RMHP must update the delegated credentialing agreements that do not include the detailed language specified in 42 CFR 438.230(c)(3) to meet this requirement.		

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Rocky Mountain Health Plans CHP+

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	March 16, 2021
Reviewer:	Erica Arnold-Miller
Participating Health Plan Staff Member(s):	Rhonda Michaelson

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	01/03/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	01/15/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
2	****	01/22/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	01/31/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This case was incorrectly included as a member appeal. The case was removed from the sample and replaced with a case from the oversample appeals.											
4	****	02/07/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	02/18/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
5	****	02/13/20	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	02/14/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
6	****	04/20/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	04/30/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
7			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This case was incorrectly included as a member appeal. The case was removed from the sample and replaced with a case from the oversample appeals.											
8	****	04/30/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	05/12/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
9			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This case was incorrectly included as a member appeal. The case was removed from the sample and replaced with a case from the oversample appeals.											
10	****	08/27/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/11/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Appeals Record Review Tool
for Rocky Mountain Health Plans CHP+

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
OS1	****	02/25/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	03/09/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
OS2	****	03/20/20	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	03/24/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
OS3	****	04/06/20	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	04/13/20	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			8	10	4				10	10	10
Column Subtotal of Compliant (Met) Elements			8	10	4				10	10	10
Percent Compliant (Divide Met by Applicable)			100%	100%	100%				100%	100%	100%

Key: M = Met; N = Not Met
N/A = Not Applicable
Yes; No = Not scored—information only

Total Applicable Elements	**52**
Total Compliant (Met) Elements	**52**
Total Percent Compliant	**100%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—+14 calendar days).

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

**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Grievance Record Review Tool
for Rocky Mountain Health Plans CHP+

Review Period:	January 1, 2020–December 31, 2020
Date of Review:	March 16, 2021
Reviewer:	Erica Arnold-Miller
Participating Health Plan Staff Member(s):	Rhonda Michaelson

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	01/03/20	M ☒ N ☐ N/A ☐	01/07/20	2	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
2	****	04/14/20	M ☒ N ☐ N/A ☐	04/27/20	9	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: .										
3	****	05/01/20	M ☒ N ☐ N/A ☐	05/04/20	1	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
4	****	06/26/20	M ☒ N ☐ N/A ☐	07/15/20	13	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Resolution letter did not include the results of follow-up with the provider.										
5	****	07/10/20	M ☐ N ☐ N/A ☒	07/13/20	1	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
6	****	08/13/20	M ☒ N ☐ N/A ☐	09/03/20	15	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
7	****	10/01/20	M ☐ N ☐ N/A ☒	10/02/20	1	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
8	****	11/02/20	M ☐ N ☐ N/A ☒	11/03/20	1	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments:										
9			M ☐ N ☐ N/A ☐			M ☐ N ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐
Comments:										
10			M ☐ N ☐ N/A ☐			M ☐ N ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2020–2021 Grievance Record Review Tool
for Rocky Mountain Health Plans CHP+

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			5			8	8	2	8	8
Column Subtotal of Compliant (Met) Elements			5			8	8	2	7	8
Percent Compliant (Divide Met by Applicable)			100%			100%	100%	100%	88%	100%

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**39**
Total Compliant (Met) Elements	**38**
Total Percent Compliant	**97%**

* Grievance timeline for resolution and notice sent is 15 working days (unless extended).
**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.
**** = Redacted Member ID

Appendix C. Site Review Participants

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

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

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

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

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

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 SAFE site, with an email notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the health plan to proceed with implementation, or • Instruct the health plan to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The health plan will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the health plan will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.) If the health plan is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

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

The CAP template follows.

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

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
16. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State	The Continuing Your Benefits section in the *CHP+ Benefit Booklet* did not include the required time frame of 10 days for a member to request that benefits continue after receipt of an NABD or adverse appeal determination letter. While the member has 60 days from the date of the NABD to request an appeal and 120 days to request an SFH from the date of the adverse appeal determination letter, benefit continuation must be requested within 10 days of the date of the NABD and adverse appeal determination letter. Within the same section, the second statement in the continuation of benefits bulleted list, "the appeal must involve termination, suspension or reduction of a previously approved course of treatment," did not apply to SFHs.	RMHP must revise the continuation of benefits description in the *CHP+ Benefits Booklet* to include the 10-day time frame to request continuation of benefits. RMHP must also clarify that the bulleted statement, "the original approval must not have expired" applies only to appeals.

Standard V—Member Information Requirements		
Requirement	**Findings**	**Required Action**
fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract: Exhibit B1—14.1.3.10 Exhibit K—1.1.18, 1.1.18.1, 1.1.18.1.1, 1.1.18.1.3, 1.1.18.2.1		
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 VI—Grievance and Appeal Systems		
Requirement	**Findings**	**Required Action**
3. The Contractor defines "appeal" as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* CHP+ Contract: Exhibit B1—1.1.4 10 CCR 2505-10—8.209.2.A.7	While the written definition of an appeal in the *Member Appeals Process* policy and procedure was accurate, procedural implementation was not consistent with the definition. HSAG determined that three of the appeal cases were provider administrative issues that were misclassified as member appeals.	RMHP must develop specific criteria for defining provider versus member appeals to assist staff members to accurately identify when an appeal should or should not involve the member.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* CHP+ Contract Amendment 3: Exhibit B1—16.4.1	The *Professional Services Agreement*, *Physicians Medical Services Agreement*, and the *BH Provider Manual* all provided accurate information regarding member liability for covered services. However, in the provider manual, the information regarding member liability was included under a heading titled "Prime Members" and included a citation (C.R.S. 25.5-4-301[1]), which was not entirely accurate for CHP+ members. The paragraph did not include additional context regarding some instances where CHP+ members may have a copy or out-of-network liabilities.	RMHP must update the member liability language in the provider manual to accurately address the various lines of business that may have variations in copay and liabilities. HSAG recommends using 42 CFR 438.106 language as a basis, with additional consideration to the individual contract language.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

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

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

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed site review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the site review and assigned HSAG reviewers to participate in the site review. • Sixty days prior to the scheduled date of the site review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and site review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the site review 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 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 member grievance and all member appeal records that occurred between January 1, 2020, and December 31, 2020 (to the extent available at the time of the site review). Health plans submitted the lists to HSAG 10 days following receipt of the desk review request. HSAG used a random sampling technique to select records for desk review and the site review. HSAG notified the

For this step,	HSAG completed the following activities:
	health plan five days following receipt of the lists of records regarding the sample records selected. • The HSAG review team reviewed all documentation submitted prior to the site review and prepared a request for further documentation and an interview guide to use during the site review.
Activity 3:	**Conduct Health Plan Site Review**
	• During the site review, HSAG met with groups of the health plan's key staff members to obtain a complete picture of the health plan's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the site review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2020–2021 Department-approved Site Review Report Template to compile the findings and incorporate information from the pre-site review and site review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Site Review Report to the health plan and the Department for review and comment. • HSAG incorporated the health plan and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the health plan and the Department.