Fiscal Year 2021–2022 Site Review Report

for

Rocky Mountain Health Plans

May 2022

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. The updated Medicaid and Child Health Plan *Plus* (CHP+) managed care regulations published May 6, 2016, became applicable to CHIP effective July 1, 2018. Additional revisions were released in November 2020, with an effective date of December 2020. 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 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) 2021–2022 was January 1, 2021, through December 31, 2021. This report documents results of the FY 2021–2022 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 2021–2022 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2020–2021 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 credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan (CAP) process the health plan will be required to complete for FY 2021–2022 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: Sep 27, 2021.

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)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%
IV. Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%
VIII. Credentialing and Recredentialing	32	32	32	0	0	0	100%
X. Quality Assessment and Performance Improvement	18	18	18	0	0	0	100%
Totals	**65**	**65**	**65**	**0**	**0**	**0**	**100%**

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	100	86	86	0	14	100%
Recredentialing	90	76	76	0	14	100%
Totals	**190**	**162**	**162**	**0**	**28**	**100%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

RMHP's *Care Coordination* policy and procedure demonstrated a comprehensive care management program that outlined timely coordination of care and promoted continuity of care for CHP+ members, including those with special health care needs (SHCN). **RMHP** staff members stated that care coordination policies and procedures, processes, and workflows are applied to all lines of business with little variation for CHP+.

CHP+ members had various ways of joining the care management program, such as **RMHP** being notified of admission, discharge, transfer (ADT) alerts for transition of care; community outreach; new member initial screenings; and referrals. Additionally, **RMHP** conducted targeted outreach toward specific populations that included complex and high-risk health members. The care management department is made up of registered nurses, behavioral health specialists, social workers, and care coordinators. Care coordinators often accessed the language line when trying to communicate in a non-English language. **RMHP** provided care coordination services for general and complex CHP+ members across the region. All care coordination documentation and tracking of case management (CM) tasks occurred through Essette, **RMHP**'s care coordination system platform. Essette provided secure access to member assessments, care plans, CM activities, and other information needed to care for the member. Community Mental Health Centers (CMHCs) also accessed and utilized Essette for referrals and care coordination. By sharing member information through one platform, this allowed coordination with multiple entities providing care to the member and reduced duplication of efforts.

In an effort to target members with identified health risks who were not previously targeted, **RMHP** began a new way to stratify members. Beginning on March 1, 2022, **RMHP** implemented Impact Pro (IPro), a predictive risk modeling program that is used to stratify members based on over 1,000 data markers that classify complex members from non-complex members. Previously, **RMHP** utilized the National Committee for Quality Assurance (NCQA) stratification model. The new IPro model supported **RMHP**'s ability to target high-risk members and on a larger scale, including 300 newly identified complex CHP+ members.

RMHP outlined a procedure for timely efforts to conduct new CHP+ member welcome calls within 90 days. The welcome calls introduced the member to **RMHP**, included an initial health screening, and identified continuity of care needs for members with SHCN. **RMHP** reported a success rate of 25 to 30 percent in completing the initial screening during the welcome call. If customer service staff members were not able to get a hold of the member within two telephonic outreach attempts, a "Sorry We Missed You" letter was sent to the member explaining services provided through CHP+, how to select a primary care provider (PCP), and contact information for **RMHP**'s one-call center number. The one-call center number can provide assistance to the member regarding any matter. In addition, when a member is onboarded to care coordination, a care coordinator contacts the member to conduct additional screenings, assessments, and give the member their care coordinator's name and phone number. The care coordinator utilizes evidence-based screenings and assessments to identify physical health,

behavioral health, social determinants of health, and psychosocial needs. For members with SHCN, additional screenings are utilized to determine ongoing treatment and monitoring. Once needs are identified, the coordinator will develop an appropriate care plan that is unique to the CHP+ member with consideration and feedback from the member's family/caregiver and other providers who are involved in the member's care. Policies and procedures outlined that care plans are monitored regularly and reevaluated at least biannually to establish the most appropriate care.

Member care plans also addressed continuity of care and transitions of care. **RMHP**'s policies and procedures described mechanisms for providing assistance during short- and long-term care transitions, including transitions from other MCOs, fee-for-service providers, and community entities. Additionally, to prevent disruption of care, **RMHP** members did not need a referral to see an in-network provider, including specialists.

RMHP utilized the local health information exchange (HIE), Quality Health Network (QHN), to support coordination and continuity of care, increase collaboration with multiple entities involved in the member's care, and reduce duplication of services. When working with outside entities involved in the member's care, **RMHP** required the entity to sign a release of information and only share information through secured and encrypted platforms. The Physician Medical Services Agreement required providers to maintain and share medical records with other providers and the provider manual outlined the requirements for maintaining, sharing, and transferring medical records in a confidential and secure manner in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Summary of Findings Resulting in Opportunities for Improvement

RMHP described the process for informing members of their assigned care coordinator and providing contact information through telephonic outreach calls. Though the outreach calls convey all the general required information, HSAG recommends a follow-up letter detailing the information provided over the phone should the member want to reach out to their care coordinator.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard IV—Member Rights, Protections, and Confidentiality

Summary of Strengths and Findings as Evidence of Compliance

RMHP provided the *Member Rights and Responsibilities* policy that outlined the rights of members as stated in 42 CFR §438.100. In addition to the policy, **RMHP** delineated the rights of members through various channels such as the *CHP+ Benefit Booklet*, *Getting Started Guide*, provider manual, provider agreements and contracts, regular trainings, email reminders, provider and member newsletters, and **RMHP** website. *The CHP+ Benefit Booklet* contained information about enrollment, benefits, member rights, and grievance and appeal processes. **RMHP**'s staff members described that when there are changes to laws pertaining to member rights, **RMHP** disseminates this information to its workforce through policy updates and trainings and to its provider network through newsletters.

Staff members described that depending on the medical record requested by the member, **RMHP** will work collaboratively to connect the member with providers, which may involve a three-way telephone call. **RMHP**'s policies and procedures and staff member interviews outlined a comprehensive approach to ensure compliance with applicable federal, State, and local laws and regulations. **RMHP** supports member feedback and complaints through the customer service phone line and emails. Staff members discussed that the Member Experience Advisory Council (MEAC) reviews grievance reports monthly, and **RMHP**'s leadership receives and review these reports daily and is able to promptly address issues relating to a member's right. **RMHP** submitted supporting documents to demonstrate that information about federal and State laws that pertain to member rights is posted on the RMHP.org website and in prominent locations in **RMHP** physical office locations.

RMHP provided an array of documents that showed how the organization protects protected health information (PHI). The *Confidentiality and Retention of Member Records* policy stated that "employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our employees, members, physicians and other providers. All information obtained in an official capacity is confidential and will comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Regulations." In addition, staff members stated that **RMHP** reinforces confidentiality to its workforce, including subcontractors, through annual privacy trainings, and additional or specific privacy trainings are offered if a supervisor notices a violation.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

RMHP submitted extensive credentialing policies, procedures, and well-organized records that aligned with NCQA requirements**. RMHP** performed its own credentialing for all but one sample record review file, but also delegated credentialing and recredentialing to 18 contracted organizations. HSAG reviewed delegation agreements, which described the activities, responsibilities, and reporting requirements. One of **RMHP**'s credentialing files was delegated to University Physicians, Inc. (UPI)/Colorado University Medicine (CU Medicine). **RMHP** staff members submitted the UPI contract and amendment, and both met NCQA requirements. Credentialing files processed by **RMHP** contained primary source details and detailed verification of work history. The National Practitioner Data Bank was used to search State and federal listings to ensure that the practitioner was in good standing.

Staff members described the Medical Practice Review Committee (MPRC), which included an array of practitioners that consist of a range of specialties to conduct a peer review of provider applications. **RMHP** described a process to outreach to the community if an additional specialist review is necessary. **RMHP** described the process of credentialing with three categories. For category one, the file meets all of **RMHP**'s and NCQA's guidelines, has all requested information present, and is absent of discrepancies and negative reports from verification sources. In this case, the medical director reviews, signs, and approves the applicant. For category two, the medical director may either approve the applicant, defer the file for MPRC's review and recommendation, request additional information, or deny the applicant depending on the criteria not met by the applicant. For category three, the MPRC may approve the applicant, request additional information, or deny the applicant based on circumstances outlined in the policy. Deferred applicants are listed on a memo for the MPRC to review, which could result in requesting additional documentation and possible reconsideration. Upon approval, applicants are notified through a letter from an **RMHP** professional relations representative within 60 days from submitting an application. Denied practitioners are notified in writing within 20 days by the **RMHP** chief medical officer and informed of the appeal process in the letter.

RMHP reported that the vendor, Novilis, conducts quarterly outreach to providers to validate that the credentialing and provider directory data are accurate. Submitted documentation further outlined that the provider relations staff members are responsible for additional validation steps.

Health Deliver Organizations (HDOs) were described to have a different credentialing process that does not flow through the credentialing committee, but still meets NCQA verification requirements. **RMHP** utilized the NCQA coronavirus disease 2019 (COVID-19) extension for two organizational providers but were able to stay within the 38-month time frame. The Facets system captured credentialing information and allowed the credentialing coordinator to monitor timelines.

RMHP described how quality of care (QOC) concerns are integrated into the MPRC review and decision process. Although, **RMHP** had very few QOCs, staff members were able to detail how the QOC database was queried for potential issues prior to the credentialing determinations.

Summary of Findings Resulting in Opportunities for Improvement

RMHP described annual monitoring and internal audits, if needed, to review approved and denied provider trends. HSAG requested the most recent annual report as supporting evidence. **RMHP** submitted a report from calendar year (CY) 2019 that reviewed for many aspects of the credentialing process, including non-discrimination. HSAG recommends that **RMHP** conduct monitoring annually, as outlined by NCQA guidelines.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

RMHP maintained an ongoing, comprehensive quality assessment and performance improvement (QAPI) program for services it provides to members. HSAG reviewed **RMHP**'s annual QAPI documents, which included the *CY 2020 Corporate Quality Program Impact Analysis Annual Report*, *2021 Quality Improvement (QI) Program Description*, and *2021 QI Corporate Work Plan*. These documents, referred to by **RMHP** as the "Corporate Trilogy" documents, established the QAPI program's purpose, goals, objectives, structure, governance, and committees, and discussed **RMHP**'s additional quality activities.

Annually, **RMHP** evaluated all QI activities and initiatives and documented the findings and assessment in the *Impact Analysis Annual Report*. During the interview session, staff members described how this annual evaluation is used to inform the next year's QI program description and activities. **RMHP** additionally shared the *RMHP 2021 Quality Work Plan*, which clearly identified goals and objectives as well as the activities required to meet goals, owners, the applicable committee, time frames, performance monitoring, and completion. This demonstrated that **RMHP** maintained a thorough mechanism to track QI activities across departments such as utilization management (UM) and CM.

Staff members described several of the various committees within the quality department: the QI Committee maintained oversight and implemented functions of the QI program; the MEAC monitored and assessed member experience through review of Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] and other member satisfaction surveys, as well as member complaints and appeals; the Medical Advisory Council monitored all QI activities impacting clinical operational requirements; the Intervention Committee oversaw activities related to improving key performance measures prioritized by the QI Committee; and the UM Committee maintained responsibility for the review of data and activities related to the utilization of healthcare services, such as monitoring for

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

overutilization and underutilization. **RMHP** utilized concurrent and prior-authorization reviews along with emergency room, pharmacy utilization, and gaps in care reports to address instances of overutilization and underutilization and develop interventions to ensure that members receive necessary and appropriate services. Committee meeting minutes provided evidence that **RMHP** regularly monitors and tracks QI initiatives through each of these committees.

RMHP's policies and interview discussion provided detailed information about how **RMHP** identifies, investigates, tracks, and resolves QOC concerns. While **RMHP** only had two QOC concerns for CHP+ in 2021, **RMHP** had comprehensive processes in place to handle the concerns and a tracking and trending system to assist in identifying any patterns.

The QAPI program established extensive mechanisms to assess the quality and appropriateness of care furnished to members with SHCN. **RMHP** implemented an SHCN internal audit utilizing guidelines and medical record review to assess four established domains of care related to quality and summarized findings, barriers, and recommendations for improvement in the *SHCN CY 2021 Analysis Report*.

RMHP adopted and disseminated clinical practice guidelines (CPGs) based on relevant and reliable evidence; input was solicited through contracted providers and were approved by the appropriate medical director. **RMHP** additionally described its process for identifying the need for and developing new CPGs and the annual review of guidelines to ensure the CPGs are up to date on current clinical practices. While CPGs were available on the website, **RMHP** ensured providers were notified of CPG updates through notices in the provider newsletter and confirmed CPGs are available to members upon request. Additionally, **RMHP** had policies and an established a process in place that assure decisions in operational areas, such as UM, that may be impacted by the CPGs are consistent with updated CPGs.

Submitted documents and the interview discussion provided a thorough overview of **RMHP**'s HIPAA-compliant health information system (HIS) through which inputs and outputs, Facets, **RMHP**'s data hub, care coordination tool, member services platform, and various systems for utilization, claims, and grievances and appeals were described. Additionally, **RMHP** described how the HIS enabled disenrollment reporting and allowed **RMHP** to track disenrollment for a reason other than loss of CHP+ eligibility; staff members reported that disenrollment reporting trends were discussed at the MEAC quarterly. **RMHP**'s policies also defined steps to evaluate that data received from providers are accurate and complete and to process both electronic and paper claims. Finally, **RMHP** described the process to ensure the 837 files are completed and submitted to the State timely, as well as the reconciliation process for reviewing and editing the file, if needed.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2021–2022 Compliance Monitoring Activities

For the FY 2021–2022 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights, Protections, and Confidentiality, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of 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+ credentialing and recredentialing to evaluate implementation of federal healthcare regulations. Reviewers used standardized monitoring tools based on NCQA credentialing standards and guidelines 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 credentialing and recredentialing, and three records with an oversample of an additional three records for organizational providers. Using a random sampling technique, HSAG selected the sample from all CHP+ credentialing and recredentialing records that occurred between January 1, 2021, and December 31, 2021. 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 VIII—Credentialing and Recredentialing. 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 2021–2022 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information Requirements, Standard VI—Grievance and Appeal Systems, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontractual Relationships and Delegation.

Objective of the Site Review

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

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

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

FY 2020–2021 Corrective Action Methodology

As a follow-up to the FY 2020–2021 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 2020–2021 compliance monitoring site review.

Summary of FY 2020–2021 Required Actions

For FY 2020–2021, HSAG reviewed 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.

Related to Standard V—Member Information Requirements, **RMHP** was required to complete the following actions:

- Revise the continuation of benefits description in the *CHP+ Benefit Booklet* to include the 10-day time frame to request continuation of benefits. (After the time of the original report, continuation of benefits was removed from the CHP+ FY 2021–2022 contract; therefore, during the CAP process, **RMHP** did not need to complete this required action. However, **RMHP** was required to remove references to CHP+ continuation of benefits).
- Clarify that the statement "the original approval must not have expired" applies only to appeals.

Related to Standard VI—Grievance and Appeal Systems, **RMHP** was required to develop specific criteria for defining provider appeals and member appeals.

Related to Standard VII—Provider Participation and Program Integrity, **RMHP** was required to 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.

Related to Standard IX—Subcontractual Relationships and Delegation, **RMHP** was required to update the delegated credentialing agreements that did not include the detailed language specified in 42 CFR §438.230(c)(3) to meet this requirement.

Summary of Corrective Action/Document Review

RMHP submitted a proposed CAP in July 2021. HSAG and the Department reviewed and approved the proposed plan. Initial documents as evidence of completion were submitted in October 2021 and additional documents in December 2021. **RMHP** resubmitted final CAP documents in January 2022.

Summary of Continued Required Actions

RMHP successfully completed the FY 2020–2021 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers, including mental health providers, for the provision of covered services. • Addressing those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any medical treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208(b)* Contract: Exhibit B-2—10.5.1, 10.5.2, 10.5.3.3	**Bullet 1:** *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 2, the 1st bullet states that RMHP receives referrals and prioritizes follow-up in a timely manner. Pages 15 & 16, Referrals indicates that all referrals are sent to the respective RMHP team and responded to within 7 days or as urgently as the situation requires. Page 22, Care Plan Development, indicates that care planning identifies services that a member receives from another MCO, FFS CHP+, Community or support providers and any other entity that is involved in the member's plan8 **Bullet 2:** *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 4 describe RMHP Stratification. Pages 6-8 describe Clinical Event Management. Pages 8-15 describe RMHP response to members with specific needs. These provisions demonstrate that RMHP provides care coordination to Members who require services from multiple providers, facilities, and agencies;	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and who require complex coordination of benefits and services. **Bullet 3:** *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 21 & 22, Care Plan Development, indicates that RMHP ensures that the Members authorized family Members or guardians are involved in treatment planning and consent to the medical treatment when appropriate. *III_1,3,8,10_CM_People w SHCN Policy 2021* Page 4, Section 3 b. states that RMHP will ensure involvement of all Members and or family Members or guardians as applicable in the care planning, establishment of goals and consent for care. **Bullet 4:** *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 2, 1st bullet, establishes RMHP's commitment to receive referrals and prioritize follow-up in a timely manner as well as to coordinate with outside partners as needed. Pages 21-23, "Care Plan Development," demonstrate that care plan interventions include	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	coordination of appropriate resources for care by specialist, subspecialist and community-based organizations, including a follow-up process to determine whether the members act on referrals. **Bullet 5:** *III_1,3_CM_Continuity and Coordination of Care in Transitions* Page 4, Medicaid and CHP+ Members, documents the policy and process to ensure continuity of care when new members are enrolled to prevent disruption in the provision of medically necessary services. *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Pages 23-24, "Continuity of Care and Transitions of Care," describes the process for providing continuity of care and transitions of care to avoid barriers to care to assure continuity of services when a member is transitioning from one system to another. *III_1_CM_ Referral Campaign Workflow* This document shows RMHP's referral workflow process. The documents listed below demonstrate procedures to deliver care to and coordinate services for all members.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_1_CM_Care Plan Workflow v6 *III_1_CM_Essette Documentation Screenshot*	
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B-2—10.5.3.1	*III_CI-RMHP CHP Benefits Booklet_English* Pages 16–17 describe the care coordination program and pages 17-18 tells Members how to contact a care coordinator. *III_2,4_CS_Complete CHP+ welcome call script* Page -4 Medical Conditions, sets forth the script informing members with medical conditions how to access a care coordinator. *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 19, "Screening," indicates that for Members identified as Persons with Special Health Care Needs, an assessment will be initiated within 30 days to identify any ongoing special conditions that require a course of treatment or regular monitoring. Pages 27 & 28, "Active Care Plan Maintenance and Follow-up," shows that RMHP ensures that each member has an ongoing source of care appropriate to his or her needs by providing the Member with ongoing information about choices of settings, providers, treatment option and resources as needed and appropriate.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 16, "Integrated Community Care Coordination Teams," states that RMHP is exclusively responsible for ensuring that appropriate care coordination is provided for all Medicaid and CHP+ members. Page 24, "Care Coordinator," indicates the care plan identifies a lead care coordinator who is formally designated as primarily responsible for coordinating covered services furnished to the member. Page 19, "Next Steps," states that once a member is engaged with their local Care Coordinator the member is provided with the direct contact information for the Care Coordinator.	
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract: Exhibit B-2—10.5.3.2.1, 10.5.3.2.1.1-2, 10.5.3.2.1.4	*III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Pages 7 first paragraph, states that RMHP care coordinators will provide assistance during care transitions from hospitals or other care institutions to home or community-based settings or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 23-24, "Continuity of Care and Transitions of Care," describe the procedures for coordinating services to Members under the circumstances listed. *III_1,3,8,10_CM_People w SHCN Policy 2021* This document describes RMHP's comprehensive policy for serving People and Children with Special Health Care Needs (P/CSHCN), which includes ensuring that members are referred to community based resources and that care coordinators support communication across all members of the health care team. Page 5, Section 4.a., describes RMHP's process for coordinating services for children with special healthcare needs with other agencies, and for linking these members with community based services. *III_1,3_CM_Continuity and Coordination of Care in Transitions* Page 6 demonstrate that RMHP will coordinate services when a member is transitioning from one managed care plan to another managed care plan or from FFS CHP to the MCO.	
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful.	*III_4_CS_Medicaid Prime and CHP+ Member Rights and Responsibilities* This policy indicates that the CHP+ Welcome Calls (screens) are attempted within 90 days if enrollment.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• An assessment for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities. *42 CFR 438.208(b)(3)* Contract: Exhibit B-2—10.4.1, 10.4.1.1, 10.4.1.2, 10.4.1.4	**Bullet 1:** *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Pages 18-19, "Screening, Assessment, Care Planning," describe RMHP's procedures for conducting initial screenings. *III_4_CS_RAE _CHP+_ sorry we missed you letter Eng_Spa* This letter is a subsequent attempt to reach CHP+ Members when the initial attempt is unsuccessful. This letter is sent to all new CHP+ enrollees, even those who are reached through the Welcome call screens. **Bullet 2:** *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 18, Multiple outreach attempts are made to encourage each Member to participate in the screening process. Outreach attempts include at least three non-automated phone calls and one mailed letter ("Unable to Reach You" letter) to the Member's last known address. *III_2,4_CS_Complete CHP+ welcome call script*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These documents provide the text for welcome call screens for pregnancy, mental health, Special Health Care Needs, and Social determinations of health. *III_CM_4_CHP High Risk, Prenatal & Postpartum Workflow* This workflow demonstrates the process for assessing for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems that prenatal or postpartum members may experience. *III_4_CM_CHP_OB Prenatal Screening Tool* The Screening Tool used by care coordinators to assess for needs. **Bullet 3:** *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Pages 20, RMHP deploys a care management comprehensive assessment which assesses the Member's health and behavioral health risks, medical and nonmedical needs, social determinants of health needs including determining if a care plan exists and creating a care plan if one does not exist and is needed.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B-2—10.4.1.3	*III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 2 explains that RMHP utilizes a care management system platform named Essette to achieve distribution of all of the members identified by stratification, ADT alerts, Special Populations and Referrals to RMHP. Screening, assessment, care planning, and follow up are all managed through Essette. The sharing and integration of Essette allows coordination of the many entities that may be providing care/services to a members resulting in better member outcomes and less duplication of care and services. Page 25, Second paragraph, describes the activities that ensure, to the extent possible, that all communications and interventions have been established. The third bullet, describes activities of sharing assessments and identified needs of the Member with other providers serving the member in order to prevent duplication of activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B-2—10.5.6	*III_6_PNM_2021 Provider Manual* Page 112 describes all aspects of Medical Records and Release of Information and Transfer of Records including how each provider needs to make health service records available to the Member and to other participating providers and authorized individuals in accordance with HIPAA and the terms of the RMHP Provider Agreement. Member confidentiality is described in the 4th paragraph on page 113. Page 113-115 includes detailed information to PCP's and Specialists about what office records should include. Providers are responsible for the maintenance of adequate medical records, which are to be secure, complete, legible, accurate, accessible, organized, and maintained in a format that facilitates retrieval of information. *III_6_PNM_Physician Medical Services Agreement_CHP+* Page 11-12, Section N. Records: This section specifies medical records requirements in accordance with professional, state and law requirements, including paragraph 7 which requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B-2—10.5.5.9, 13.1.2	*III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 26, first paragraph, provides that any communication with a non-Member representative will require the appropriate Appointment of Representative/HIPAA paperwork to be filled out. *III_7,9_CM_HIPAA Authorization to Release Information_English* *III_7,9_CM_HIPAA Authorization to Release Information_Spanish* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR requirements to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *III_7,9_CM 14 Confidentiality and Retention of Member Records* Page 1, section I, states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our members. All information obtained in an official capacity is confidential and staff will comply with HIPAA Privacy Regulations.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. • The assessment must be completed within 30 calendar days from the completion of the initial screening, if the initial screening identified special health care needs. *42 CFR 438.208(c)(2)* Contract: Exhibit B-2—10.5.9.1.1	*III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* RMHP conducts comprehensive assessments of Members identified as having special health care needs whether they are identified through screeners or referrals. Page 16 lists Examples of referral sources, which includes FFS CHP+. *III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 19, indicates that for Members identified as Persons with Special Health Care Needs, an assessment will be initiated within 30 days to identify any ongoing special conditions that require a course of treatment or regular monitoring. Page 20-21, lists the elements of the comprehensive assessment. *III_8_CM12 Complex Case Management Process* This document describes the process for complex care management when a member has been identified as having any ongoing special conditions of the member that requires a course of treatment or regular care monitoring. Page 6 indicates an assessment of the Member's specific needs is initiated.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 7, indicates that assessments will be completed within 30 days when a member is determined eligible for Complex Case Management. *III_8_CM_NewComplex Assessment* This assessment is used with persons identified as having special health care needs. *III_1,3,8,10_CM_People w SHCN Policy 2021* Pages 2-3 of Assessment and Needs Identification describe how RMHP Care Managers proactively assess individuals with special healthcare needs for conditions that require ongoing treatment and monitoring. RMHP will assess the member with special healthcare needs within 30 days of the referral to the Care Management team.	
9. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards. • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's	*III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* 1st Bullet Approval by RMHP is not required. 2nd Bullet: Page 23, "Goals," second paragraph, indicates that RMHP care plans use the SMART goal method for creating care plan goals, which means each goal should be: Specific, Measurable, Attainable, Realistic and Timely. Any services specified in the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B-2—10.5.9.1.2-3	care plan would comport with any applicable limits or standards established by the State, if any. 3rd Bullet: Page 27-28, "Active Care Plan Maintenance and Follow-up" states that Care Coordinators must assign a reasonable timeframe for re-evaluation to facilitate a progressive plan of care. The Care Coordinator will document a schedule for follow-up and communication with the member. Appropriateness of goals and interventions are re-evaluated bi-annually at a minimum according to acuity level and/or when changes in member's health or care are identified.	
10. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B-2—10.5.9.1.4	*III_1-2_3_4_5_7_8_9_10_CM 28 Care Coordination Policy and Procedure* Page 19, "Screening," provides that if the member has been identified as a Person with Special Health Care Needs, an assessment will be initiated within thirty (30) days to identify any ongoing special conditions that require a course of treatment or regular monitoring. NOTE: RMHP does not require referrals to any contracted provider. Members have direct access to specialists. *III_1,3,8,10_CM_People w SHCN Policy 2021*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 3-5, Continuation of Care, explain the process for providing continuity of care and minimizing disruptions for newly enrolled members with special health care needs	

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10
Total Score ÷ Total Applicable						=	100%

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B-2—7.3.6.1	*IV_1,3,4_CS_Medicaid Prime and CHP+ Member Rights and Responsibilities* This Policy and Procedure documents RMHP"S written policy regarding a Prime, RAE, or CHP+ Member's Right ad Responsibilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract: Exhibit B-2—15.10.9.2	*IV_2,4_PNM_ 2021 Provider Manual* Page 117-119 of the Provider Manual describes Prime, RAE and CHP+ Member rights to network providers. Page 106-107 informs providers of the values and tenents of the RMHP Compliance Plan/Code of conduct which demonstrate compliance with Federal and State laws that pertain to Member rights. *IV_2,4_PNM_LawExhibit to Provider Agreements* See Page 8-9, Section 5: Medicaid Recipient Rights and Section 6: Medicaid and CHP+ Contracts Statutes and Regulations lists the federal and State laws with which RMHP, providers and subcontractors shall comply with. *IV_2_CI_Screen Shot_Federal and State Laws* Information about federal and State laws that pertain to Member rights is posted on the RMHP.org website. It is also posted in prominent locations in RMHP physical office locations. *IV_2_Law Exhibit_Non-Prov_Ind Contractor*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This Law Exhibit is attached to all non-provider contracts that are executed with RMHP. It includes requirements for compliance with all applicable federal and state law that pertain to member rights. *IV_2,5_CM_Confidentiality and Retention of Member Records* Page 1, Purpose statement identifies that RMHP complies will all federal and state regulations that pertain to member activity and confidentiality. *IV_2_PM&A_COMBINED_1557Notice_MLIS_01312020 (Medicaid CHP+)_Eng* This document demonstrates that RMHP complies with applicable federal and state laws that pertain to member rights. *IV_2,5_CM_HIPAA Authorization to Release Information English* *IV_2,5_CM_HIPAA Authorization to Release Information Spanish* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's 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 their 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 their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B-2—7.3.6.2-6	*IV_1,3,4_CS_Medicaid Prime and CHP+ Member Rights and Responsibilities* Page 2, Section 6 Member rights as specified in state and federal regulation *IV_3_CM89-Member Annual Notice-CHP-2021* These Member Annual Notices advise Members how to find information online to learn more about their Member rights and responsibilities. *IV_Getting Started Guide-CHP+* *IV_Getting Started Guide-CHP+ Prenatal* Members are directed how to find information online to learn more about their Member rights and responsibilities in these Getting Started Guides that are sent to all new members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B-2—7.3.6.3.7	*IV_CI-CHP Benefit Booklet_English* Page 18, bullet #8 indicates to Members that they are able to exercise their rights without being treated differently. *IV_2,4_PNM_ 2021 Provider Manual* Page 118 includes the Members right to freely exercise their rights without being treated differently *IV_2,4_PNM_LawExhibit to Provider Agreements* Page 8, Section 5: Medicaid Recipient Rights, paragraph C states that "Contractor shall ensure that Medicaid Recipients have the rights set forth in 42 C.F.R. section 438.100(b)(2), including but not limited to the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, consistent with 42 C.F.R., section 438.100.(b)(2)(v)." *IV_1,3,4_CS_Medicaid Prime and CHP+ Member Rights and Responsibilities* Page 2, bullet #8 indicates that the member is able to exercise their rights without being treated differently.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.	*IV_2,5_CM_HIPAA Authorization to Release Information English* *IV_2,5_CM_HIPAA Authorization to Release Information Spanish* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this Authorization to Use or	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.224 Contract: Exhibit B-2—10.5.5.9, 13.1.2	Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *IV_2,5_CM_Confidentiality and Retention of Member Records* Page 1, Section I states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our Members. All information obtained in an official capacity is confidential and will comply with HIPAA Privacy Regulations. Section II describes how RMHP protects the confidentiality of all Member records.	

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5
Total Score ÷ Total Applicable						=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract: Exhibit B-2—9.2.3.1	Note: These are NCQA health plan (HP) requirements available at the time of drafting this tool (07/2021). *VIII_PNM_CRED_Credentialing Criteria and Process* *VIII_PNM_CRED_Recredentialing Process* These two documents define RMHP's credentialing and recredentialing processes for evaluating and selecting licensed independent practitioners to provide care to our Members.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *Examples of BH practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's-level psychologists, master's-level clinical social workers, master's-level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.*	*VIII_PNM_CRED_Credentialing Criteria and Process* Section B, table on pages 4-6 outlines the types of practitioners *VIII_PNM_CRED_Recredentialing Process* Section C, table on pages 3-5, outlines the types of practitioners	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Examples of HP practitioners include medical doctors, chiropractors, osteopaths, podiatrists, NPs, etc. *42 CFR 438.214(a)* NCQA CR1—Element A1		
2.B. The verification sources it uses. NCQA CR1—Element A2	*VIII_PNM_CRED_Credentialing Criteria and Process* Section B, pages 7-9 *VIII_PNM_CRED_Recredentialing Process* Section C, pages 8-9 These sections (Source Verification) outline the sources used to verify practitioner credentials (approved credentialing verification sources).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	*VIII_PNM_CRED_Credentialing Criteria and Process* Sections A-B, pages 2-6 *VIII_PNM_CRED_Recredentialing Process* Sections A-C, pages 2-6 These sections outline the criteria used for credentialing and recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	*VIII_PNM_CRED_Recredentialing Process* Sections D-E., pages 9-11 *VIII_PNM_CRED_Initial Credentialing Workflow 2021* *VIII_PNM_CRED_Recredentialing Workflow 2021* These sections "Review and Determination", "Final Decision" and "Notifications", and the Workflow diagrams describe RMHP's process for making credentialing and recredentialing decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	*VIII_PNM_CRED_Credentialing Criteria and Process* Section C, pages 9-10 *VIII_PNM_CRED_Recredentialing Process* Section D., pages 9-11 These sections describe the process for managing credentialing and recredentialing files according to RMHP's criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include: non-discrimination of applicant, process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* NCQA CR1—Element A6	*VIII_PNM_CRED_Nondiscriminatory Credentialing* This policy establishes the steps that RMHP takes during credentialing processes to monitor and prevent discriminatory practices.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	*VIII_PNM_CRED_Credentialing Criteria and Process* Section B., page 7, paragraph 3 *VIII_PNM_CRED_Recredentialing Process* Section C., page 8, paragraph 4 These sections provide the process that RMHP follows for notifying practitioners if information obtained from sources varies substantially from that provided on the application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	*VIII_PNM_CRED_Credentialing Criteria and Process* Section D., page 11 *VIII_PNM_CRED_Recredentialing Process* Section E, page 11 These sections indicate when a determination has been made by Medical Direction or the Medical Practice Review Committee (MPRC), the practitioners are notified of accepted status via letter from the Professional Relations Representative within 60 days. Practitioners are notified of denial via letter from Chief Medical Officer within 20 days. *VIII_PNM-016 Initial Credentialing and Provider Notification of Request P&P* Page 1, "3.0 Policy" section and the "II.A Approved Credentialing" section on page 3 indicate that approval notification is sent to providers and groups within 30 days.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	*VIII_PNM_CRED _Credentialing Criteria and Process* See Policy on Page 1 *VIII_PNM_CRED_Recredentialing Process* See Policy on Page 1 This paragraph in both documents indicates that the RMHMO Board of Directors (BOD) has delegated the responsibility for the credentialing function, review and approval authority for the credentialing policies and procedures and determination as to panel acceptance to the RMHP Chief Medical Officer, and that any	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Associate Medical Directors may cover for the RMHP Chief Medical Officer for credentialing purposes.	
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	*VIII_PNM_CRED_Credentialing Criteria and Process* Section F, page 11-12 *VIII_PNM_CRED_Recredentialing Process* Section G, pages 11-12 These sections delineate the RMHP process for ensuring the confidentiality of information obtained in the credentialing and recredentialing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	*VIII_2K_PNM-002 Physician and Hospital Directory Updates P&P* This policy outlines how RMHP validates physician and hospital information for updates to the printed and web-based directories. *VIII_2K_PNM-003 Provider Relations Validation Letters & Demographic Tool P&P* This policy describes the quarterly process for evaluating provider directory information by contacting providers and asking them to validate their information. *VIII_PNM_CRED_Practitioner Specialties* This document delineates the process for ensuring that listings in practitioner directories are accurate.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The contractor is not required to make references, recommendations, and peer-review protected information available.* NCQA CR1—Element B1	*VIII_PNM_CRED_Credentialing Criteria and Process* *VIII_PNM_CRED_Recredentialing Process* Procedure sections, which both start on page 6 of these policies, explain that RMHP utilizes the Colorado Health Care Professional Credentials Application (CHCPCA). Through use of this state mandated application, the applicant is informed of their rights: -To review information submitted to support their credentialing or re-credentialing application. -To correct erroneous information that varies substantially from information provided. -To receive the status of their credentialing or re-credentialing application, upon request. *VIII_PNM_CRED_CHCP_Credentials_Application* Page 23, item 12 also explains these rights *VIII_PNM_CRED_Screen Shot_Join RMHP Providers* This screen shot of RMHP.org website shows the explanation of practitioners' rights related to the provider application process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.B. To correct erroneous information. NCQA CR1—Element B2	*VIII_PNM_CRED_Credentialing Criteria and Process* *VIII_PNM_CRED_Recredentialing Process* Procedure sections, which both start on page 6 of these policies, explain that RMHP utilizes the Colorado Health Care Professional Credentials Application (CHCPCA). Through use of this state mandated application, the applicant is informed of their rights:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_PNM_CRED_CHCP_Credentials_Application Page 23, item 12 also explains these rights *VIII_PNM_CRED_Screen Shot_Join RMHP Providers* This screen shot of RMHP.org website shows the explanation of practitioners' rights related to the provider application process.	
4. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2—Element A1	*VIII_PNM_CRED_Credentialing Committee* This policy describes the Credentialing committee structure and function.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A	*VIII_5_QI_MPRC_Member List* This Medical Practice Review Committee (MPRC) listing shows the range of specialties participating in each regional credentialing committee. *VIII_5,10_QI_MPRC_Minutes 02.17.21* This is a sample of the credentialing committee meeting minutes where practitioners who do not meet established thresholds were reviewed. *VIII_PNM_CRED_Credentialing Criteria and Process* Section C, pages 9-10 *VIII_PNM_CRED_Recredentialing Process* Section D, pages 9-11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These sections, Review and Determination, describe the various levels of review/response by the Medical Director or credentialing committee based on the status of the applicant's file. *VIII_PNM_CRED_Medical Director Review of Clean Files* This documents how a Medical Director reviews and approves a weekly list of files that meet established criteria.	
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits: • A current, valid license to practice (verification time limit = 180 calendar days). • A valid, current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit = prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school graduate; completion of residency; or board certification (verification time limit = prior to the credentialing decision; if board certification, time limit = 180 calendar days). • Work history—most recent five years—if less, from time of initial licensure—from practitioner's application or CV (verification time limit = 365 calendar days).	*VIII_PNM_CRED_Credentialing Criteria and Process* Section B, pages 7-9 *VIII_PNM_CRED_Recredentialing Process* Section C, pages 8-9 The Section "Source Verification" indicates that RMHP verifies all required elements for credentialing and recredentialling within 180 days prior to Medical Direction or credentialing committee review. *VIII_PNM_CRED_State Licensing Verification Letters* These are primary source verification letters for training that are collected annually from the State for specific specialties.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit = 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to member.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit = 180 days): • State sanctions, restrictions on licensure or limitations on scope of practice. • Medicare and Medicaid sanctions.	*VIII_PNM-016 Initial Credentialing and Provider Notification of Request P&P* This policy describes the process that Provider Relations (PR) Representatives follow to initiate credentialing for prospective practitioners. If a practitioner is found in any of the databases, credentialing is not initiated	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR3—Element B	*VIII_PNM_CRED_Credentialing Criteria and Process* Section B., pages 7-9 *VIII_PNM_CRED_Recredentialing Process* Section C, pages 8-9 The section "Source Verification" outlines the process for initial credentialing and recredentialing, including license sanction status (State Board of Medical Examiners, NPDB, HIPDB) and Medicare/Medicaid sanction status (Office of Inspector General Debarment Report). *VIII_PNM_CRED_National Practitioner Databank* This policy establishes the written guidelines for accessing the NPDB to verify sanctions, license limitations, and malpractice history for all new applicants and all currently contracted practitioners as part of the recredentialing process.	
8. Applications for credentialing include the following (attestation verification time limit = 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions.	*VIII_PNM_CRED_Credentialing Criteria and Process* *VIII_PNM_CRED_Recredentialing Process* Pages 3, 6-7 These pages/sections indicate that RMHP utilizes the Department of Public Health & Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentialing Application. *VIII_PNM_CRED_CHCP_Credentials_Application*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	RMHP utilizes the Department of Public Health and Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentials Application (CHCPCA), or Council for Affordable Quality Healthcare's (CAQH) Universal Provider Database (which also utilizes Colorado's state mandated CHCPCA) -Page 26 ability to perform essential functions of the position -Page 25: attestation regarding illegal drug use -Page 19-20: attestations regarding loss of license and felony convictions -Page 19-20: attestation regarding loss or limitation of privileges or disciplinary actions -Page 16: attestation of current malpractice or professional liability insurance coverage -Page 21: attestation confirming correctness and completeness of the application	
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	*VIII_PNM_CRED_Recredentialing Process* Last sentence page 1 states that recredentialing will occur at least every three years.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. NCQA CR5—Element A	*VIII_10_QI_QOC Workflow Chart* This flowchart illustrates the RMHP Quality of Care case review process. *VIII_5,10_QI_MPRC_Minutes 02.17.21* These Medical Practice Review Committee (MPRC) minutes illustrate examples of interventions when instances of poor quality are identified. *VIII_PNM_CRED_Midcycle Credentialing* Sections A-D, pages 2-3 Explains the RMHP process for reviewing provider status updates related to sanctions or limitations on licensure, adverse events and instances of poor quality. *VIII_PNM_CRED_Ongoing Monitoring Sample Reports 2021* A sample of a monthly report collected and reviewed for sanctions will be available onsite. *VIII_PNM_CRED_Complaints Log* The log of complaints that were collected and reviewed will be available at site review. There were no office site complaints during this review period.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	**Bullet 1:** *VIII_11_QI_ MPRC_Reduction Suspension or Termination Policy and Procedure* This policy describes the procedures for taking action against a practitioner for quality reasons. Pages 2-4, Section 1.a and Section 1.c. on page 5 describes the formal appeal process offered to the practitioner. Page 2, Section 1, describes the range of actions available to RMHP, including mentoring, increased oversight or other proposed professional review action. Pages 6-7, Section 4, indicates that the RMHP Chief Medical Officer shall report any sanction, suspension or termination of a health care provider due to quality of care issues to the state licensing agency, Colorado Board of Medical Examiners (CBME) and NPDB/HIPDB, as applicable. **Bullet 2:** *VIII_11_QI_ MPRC_Reduction Suspension or Termination Policy and Procedure* This policy describes the procedures for taking action against a practitioner for quality reasons. Pages 2-4, Section 1.a and Section 1.c. on page 5 describes the formal appeal process offered to the practitioner including the right to request a hearing within 30 days and the right to have an attorney or other person of their choice represent them.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 5, Section 1.e. describes the process for notifying the practitioner of the decision, including the reasons supporting it. *VIII_11_QI_Hearing Panel Notice Template* This notice of MPRC Hearing provides details of the Hearing and lists the Hearing panel members. *VIII_11_QI_Initial Denial Letter template* *VIII_11_QI_Recredential Denial Letter template* These denial letters provide written notification that a professional review action has been brought against a practitioner, provides reason for the action, and includes the appeal process, including the right to be represented by an attorney or another person of their choice, and the timeframe for requesting a hearing. Letters include the specific reason(s) for each case decision as appropriate.	
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm--which may only include applicable state or federal agency, agent of the applicable state or federal agency, or copies of credentials*	*VIII_PNM_CRED_Health Delivery Organizations* -This policy describes the initial credentialing and recredentialing criteria for organizational providers. Section C, page 6 states that each organizational provider with which RMHP contracts will be assessed by the credentialing staff for continued compliance with the Standards for Participation every two (2) years for the duration of the contract. -Section B, pages 2-3 lists the documentation that must be submitted by all organizational providers to demonstrate that they are in good standing with regulatory or accrediting bodies.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
(e.g., state licensure) from the provider. Attestations are not acceptable. NCQA CR7—Element A1	-The accrediting bodies recognized by RMHP are listed in Section C, pages 3-4. -Section D., page 5 indicates that a non-accredited organization must provide a copy of the State/CMS Survey report, including the cover letter and correction of deficiencies statement or a letter from CMS or the applicable state agency which shows the organization was reviewed and indicates that it passed inspection.	
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm—which may only include applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	*VIII_PNM_CRED_Health Delivery Organizations* -This policy describes the initial credentialing and recredentialing criteria for organizational providers. Section B, pages 2-3 lists the documentation that must be submitted by all organizational providers to demonstrate that they are in good standing with regulatory or accrediting bodies. -The accrediting bodies recognized by RMHP are listed in Section C, page 3-4. -Section D, page 5 indicates that a non-accredited organization must provide a copy of the State/CMS Survey report, including the cover letter and correction of deficiencies statement or a letter from CMS or the applicable state agency which shows the organization was reviewed and indicates that it passed inspection.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include: on-site quality assessment criteria for each type of unaccredited organizational provider; a process for ensuring that the provider credentials its practitioners.*	*VIII_PNM_CRED_Health Delivery Organizations* Section D, page 5 Section F, pages 7-8 This document describes how RMHP will accept the standards set forth in the State Operations Manual for RMHP credentialed Health Delivery Organizations	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.) NCQA CR7—Element A3	(HDO) facilities in lieu of performing site visits internally. Indicates that the RMHP Credentialing Lead and Manager verify that the survey process evaluates the facilities procedures for the credentialing of medical staff providing services to members. Indicates that CMS or state quality reviews substituted for a site visit are no more than three years old. *VIII_12C_PNM_CRED_Mechanism for Evaluation per State Operations Manual* This document describes how RMHP will accept the standards set forth in the State Operations Manual for RMHP credentialed Health Delivery Organizations (HDO) facilities in lieu of performing site visits internally. Page 2 indicates that the RMHP Credentialing Lead and Manager verify that the survey process evaluates the facilities procedures for the credentialing of medical staff providing services to Members.	
13. The Contractor's organizational provider assessment policies and process includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers:	*VIII_PNM_CRED_Health Delivery Organizations* See Policy on Page 1, first paragraph lists the organizational providers defined for the purposes of this policy, including hospitals, home health agencies, skilled nursing facilities, and free-standing surgical centers; and behavioral health facilities providing mental health or substance abuse services in inpatient, residential, or ambulatory settings.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7-Elements B&C		
14. The Contractor has documentation that it assesses behavioral health and/or physical health providers every 36 months. NCQA HP CR7-Elements D&E	*VIII_PNM_CRED_Health Delivery Organizations* Page 6, Section C: "Recredentialling" This document states that RMHP recredentials all organizational providers every two years. *VIII_PNM_SAMPLE_Accredited HDO* This is a sample credentialing record of an accredited organizational provider (Health Delivery Organization) credentialed by RMHP. *VIII_PNM_SAMPLE_Non-Accredited HDO* This is a sample credentialing record of a non-accredited organizational provider (Health Delivery Organization) credentialed by RMHP. *VIII_PNM_CRED_SAMPLE_Accredited HDO - BH* This is a sample credentialing record of an accredited organizational provider (Health Delivery Organization) credentialed by RMHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_PNM_CRED_SAMPLE_Non-Accredited HDO - BH This is a sample credentialing record of a non-accredited organizational provider (Health Delivery Organization) credentialed by RMHP. *VIII_PNM_CRED_CHP Organizational Providers CY2021* This file represents RMHP contracted organizational providers (Health Delivery Organizations) that have been reviewed since January 1, 2021.	
15. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of	*VIII_PNM_CRED_Delegated Credentialing Audit Activities* Section B, page 2 of this policy describes RMHP's oversight of delegated activities. Each delegated credentialing entity is audited on at least an annual basis by RMHP for compliance with RMHP standards. *VIII_PNM_CRED_2021 Montrose Memorial Delegated Audit* *VIII_PNM_CRED_2021 Vail Valley Delegated Audit* *VIII_PNM_CRED_2021 Pueblo Healthcare Delegated Audit* These completed audit tools provide evidence of RMHP oversight of delegated credentialing activities. *VIII_PNM_CRED_Delegated Credentialing & Recredentialing*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	*NOTE: There were no Pre-Delegation activities during calendar year 2021 period, and therefore are no samples to include.	
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. NCQA CR8—Element C	*VIII_PNM_CRED_Delegated Credentialing Audit Activities* Page 1, under "Policy," it is noted that RMHP annually audits credentialing delegates for compliance with RMHP and NCQA standards. *VIII_PNM_CRED_Delegate Annual Oversight Tracking Tool* This tracking tool illustrates current RMHP activity to audit delegated credentialing files. *VIII_PNM_CRED_2021 Montrose Memorial Delegated Audit* *VIII_PNM_CRED_2021 Vail Valley Delegated Audit* *VIII_PNM_CRED_2021 Pueblo Healthcare Delegated Audit* These delegated credentialing audits illustrate how RMHP annually audits each delegate against RMHP and NCQA Credentialing Standards. Included are review of policies, procedures and files. *VIII_PNM_CRED_Delegate Semi-Annual Report Tracking Tool* Demonstrates RMHP activity to evaluate credentialing reports from Delegates semiannually.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_PNM_CRED_Samples of Semiannual Reports Examples of self-identifying and reporting improvement activities on the Semi-Annual Credentialing Submission Form.	
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	N/A - There were no opportunities for improvement identified during calendar year 2021 period.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* Contract: Exhibit B-2—14.1.1	The following documents describe the ongoing comprehensive Quality Assessment and Performance Improvement Program for services provided to our Members. *X_1,4,6_QI_RMHP 2021 QI Program Description* *X_1,2,3,4,6_QI_RMHP 2021 QI Corporate Work Plan* *X_1,2,3,4,18_QI_RMHP Corporate Quality Program_Impact Analysis_Annual Report CY 2020* *X_1_CI_R1_QualityRpt_FY20-21* *X_1_CI_R1_QualityImprovePln_FY20-21*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* Contract: Exhibit B-2—14.2.1.1, 14.3	*X_1,2,3,4,6_QI_RMHP 2021 QI Corporate Work Plan* Page 15, row 131: PIP reporting to RMHP's Quality Improvement Committee *X_1,2,3,4,18_QI_RMHP Corporate Quality Program_Impact Analysis_Annual Report CY 2020* Pages 147-148 discuss the close-out of the previous PIPs and start of new PIPs. *X_2,18_CI_CO2020-21_CHP+_TechRpt_F1* Pages 3-58 through 3-60, and page 4-1 through 4-2 describes the PIPs conducted during this review period. Activities include: measurement, implementation, and evaluation of the focused areas.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* Contract: Exhibit B-2—14.4	*X_1,2,3,4,6_QI_RMHP 2021 QI Corporate Work Plan* Pages 4, rows 26-27, describe RMHP activity in HEDIS data collection and reporting. *X_1,2,3,4,18_QI_RMHP Corporate Quality Program_Impact Analysis_Annual Report CY 2020* Pages 23-24: HEDIS data is collected, validated, and submitted as required.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* Contract: Exhibit B-2—14.6	*X_1,4,6_QI_RMHP 2021 QI Program Description* Pages 27-28 describe the overutilization and underutilization monitoring activities included in the QI program. *X_1,2,3,4,6_QI_RMHP 2021 QI Corporate Work Plan* The overutilization and underutilization reports reviewed by the Utilization Management Committee are listed on pages 10-11 (rows 76-83) and page 12 (row 88). *X_1,2,3,4,18_QI_RMHP Corporate Quality Program_Impact Analysis_Annual Report CY 2020*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Beginning on page 91, the Utilization Management Program section describes activities to detect and impact overutilization and underutilization. Pages 94-96, section E: monitoring over and underutilization for behavioral health Pages 97-99, section F: monitoring over and underutilization for physical health Pages 100-102, section G: monitoring of overutilization, hospital readmissions within 30 days of discharge Pages 102-104, section H: monitoring over and underutilization, provider attribution reports Pages 108-112, section K: Member and provider outreach for gaps in care *X_4_QI_Pfizer_CO_Postcard_MissedDose* *X_4_QI_CO_UHC_Postcard_16_17YO* These materials were used in an outreach campaign in 2021 to address underutilization of immunizations. The campaign included monthly postcard mailings to the target population of children who missed an immunization between six months and 18 months of age and adolescents who missed an immunization between 16-18 years of age. *X_4_QI_QI108A_CHP+_16MonthImms_2021* *X_4_QI_QI151A_PreTeen IMA_2021* *X_4_QI_QI149A_CHP+_3-6 Wellness_2021*	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_4_QI_QI150A_CHP+_7-9 Wellness_2021 *X_4_QI_QI126A_CHP+_TeenWellness_2021* *X_4_QI_QI133A_CHP+_PreteenWellness_2021* *X_4_QI_QI83A_CHP+_Diabetes_2021* *X_4_QI_QI128A_CHP+_Postpartum_2021* These are examples of Member mailings for gaps in care in 2021. The incentive programs were developed to address underutilization of wellness visits, underutilization of immunizations, underutilization of postpartum visits, and underutilization of chronic care management. The brochures are mailed to Members identified as having a gap in care. *X_4_UM_Program Description* Pages 18-19, Over & Underutilization Monitoring, describes how RMHP monitors over and underutilization of service to ensure Members receive the necessary and appropriate care. *X_4_CM_PH15_Drug Safety and Medication Adherence* The Drug Safety and Medication Adherence Program Description defines RMHP's strategy for managing appropriate and effective utilization of drug and medication therapies. Page 1 gives an overview of the program.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 4 and following describes how RMHP identifies the population who may be at risk for negative outcomes due to under and overutilization and the programs used to address and manage associated risks.	
5. The Contractor's QAPI Program includes mechanisms for identifying, investigating, analyzing, tracking, trending, and resolving any alleged quality of care concerns. Contract: Exhibit B-2—14.7.1-2	*X_5_QI_Retrospective Quality Case Review Process* This Policy and Procedure describes the process undertaken to investigate any potential quality of care issues identified by Members, providers and others. Page 3 indicates that upon request, a letter will be submitted to HCPF (within 10 business days) that includes a brief description of the quality of care issue, the efforts taken to investigate the issue, the outcome of the review, and any action RMHP intends to take with the providers involved.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications,*	*X_1,4,6_QI_ RMHP 2021 QI Program Description* Pages 24-25, section titled Continuity and Coordination of Care, describes how RMHP works to facilitate and promote continuity and coordination of care between medical practitioners and between medical and behavioral health practitioners. Pages 26-27, section titled Complex Case Management Program, describes that Members with complex health needs are referred to the Complex Care Management Program. Eligible Members are offered comprehensive and enhanced coordination of care to assist with their needs across a continuum of settings.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
special diets, interventions or accommodations at home or at school. *42 CFR 438.330(b)(4)* Contract: Exhibit B-2—14.6.1	Page 28, section titled Special Health Care Needs, discusses the SHCN medical record audit to assess the quality of care for people with special health care needs. *X_6,9_QI_Psychosocial Factors in CYSHN and their Families* *X_6,9_QI_Bright Futures Guidelines_Promoting Health for CYSHN* *X_6,9_QI_Adults with SHCN Guidelines* These are the clinical practice guidelines RMHP has adopted relating to children and adults with special health care needs. The guidelines are available on the website and upon request. *X_6_QI_SHCN 2021 Analysis Report* This is a summary of the 2021 assessment of the quality of care for people with special health care needs. *X_6_QI_Assessing Quality of Care for People with SHCN Process* This describes the process for assessing the quality of care for people with special health care needs. *X_6_CM_NewComplex Assessment* This assessment document demonstrates the questions that are asked of a member who has been identified	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	members who are identified as Complex or have Special Health Care Needs. Care plans are then developed to help Members overcome barriers and achieve specific treatment goals.	
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* Contract: Exhibit B-2—14.2.5	*X_1,2,3,4,18_QI_RMHP Corporate Quality Program_Impact Analysis_Annual Report CY 2020* Pages 1-4 describe that program activities are structured around an ongoing process of quality monitoring, reporting, and assessment. A detailed evaluation of the Quality Improvement Program and its activities is conducted annually. This report is a formal summary of the annual evaluation of quality improvement activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated periodically, as appropriate. *42 CFR 438.236(b)* Contract: Exhibit B-2—10.5.8.2-4	*X_UM_ Clinical Criteria for UM Decisions* Page 1-2, Sections I and II, describes the process used to apply written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services. Pages 3-4, Section III, indicates that throughout the process of making a determination, RMHP considers many sources of clinical information, individual Member needs and characteristics of the local delivery system Page 3, Section II, Paragraph E indicates that practitioners with professional knowledge or clinical expertise in the relevant area have an opportunity to give advice or comment on development, review and adoption of UM criteria and on instructions for applying criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 5, Section V, describes that clinical criteria and procedures for applying clinical criteria are reviewed at least annually. *X_UM_Specialist Review Letter and Feedback* The Specialist Review Letter and Feedback Form is sent to participating providers for feedback on new guidelines prior to implementation of the guidelines. *X_8,10,11_QI_Clinical Practice Guidelines Process* Page 2, Section 1.b: Guidelines address physical and behavioral health care. Page 2, Section 1.b: Guidelines will be reviewed and adopted directly from a recognized source (a national organization that develops evidence based clinical practice guidelines). Page 3, Section 1.c: When evidence based guidelines are not available, guidelines may be developed from a consensus of Health Care Professionals in a particular field. Page 4, Section 4.a: Includes an analysis of the relevancy of the guideline to the RMHP population. Page 2, Section 1.a: Annually and when new scientific evidence and/or national standards warrant, guidelines are reviewed for updates or changes to current clinical practice by the Quality Improvement Department with subsequent consultation by other internal clinical staff as necessary (e.g. Medical Directors and pharmacists).	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor adopts or develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. Contract: Exhibit B-2—10.5.8.1	**First bullet:** *X_9_QI_Perinatal Care Guidelines* Document demonstrates the Perinatal Care guidelines that RMPH has established. *X_9,10_CI_Screen Shot of Clinical Practice Guidelines-Website* This document provides the location on the RMHP.org website of the clinical practice guidelines related to perinatal, prenatal, and postpartum care. **Second bullet:** *X_6,9_QI_Psychosocial Factors in CYSHN and their Families* *X_6,9_QI_Bright Futures Guidelines - Promoting Health for CYSHN* *X_6,9_QI_Adults with SHCN Guidelines* These are the clinical practice guidelines RMHP has adopted relating to children and adults with special health care needs. The guidelines are available on the website and upon request. *X_9,10_CI_Screen Shot of Clinical Practice Guidelines-Website* This document demonstrate where the Clinical Practice guidelines can be found on the RMHP.org website related to conditions related to special health care needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Third bullet: *X_9_QI_Recommendations for Preventive Pediatric Health Care* *X_9_QI_Recommended Child and Adolescent Immunizations Schedule* These are the clinical practice guidelines RMHP has adopted relating to child wellness care. The guidelines are available on the website and upon request. *X_9,10_CI_Screen Shot of Clinical Practice Guidelines-Website* This document provides the location on the RMHP.org website of the clinical practice guidelines related well-child care.	
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members and potential members. *42 CFR 438.236(c)* Contract: Exhibit B-2—10.5.8	*X_10_PNM_Provider Insider Plus_August 2021* Newsletter Article: Clinical Practice Guidelines Update: Page 3 This article provides an update to clinical practice guidelines. Guidelines listed include Pediatric Preventive care, Perinatal Care and Special Healthcare Needs. The RMHP Clinical Practice Guidelines are available on the RMHP website or by contacting the Quality Improvement Department to request a copy. *X_10,11_PNM_2021 Provider Manual* Review Criteria: Page 90 This section includes how criteria is used in decision-making and is available, free of charge, to Physicians,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Practitioners, facilities and Members upon request to RMHP. *X_UM_ Clinical Criteria for UM Decisions* Pages 6, Section VI indicates that guidelines used in UM decision-making are available at no cost upon request. Practitioners and Members are notified in writing that they are available. *X_UM_CHP+ Denial Letter 9.28.2021* *X_UM_CHP+ Residential Denial 9.28.2021* Both letters contain language that a copy of the criteria used for the decision can be obtained at no cost. *X_8,10,11_QI_Clinical Practice Guidelines Process* Page 3, Section 2.a-e: Providers are notified that approved clinical practice guidelines are on the RMHP website. Guidelines are provided to Members, non-Members, and the public upon request. *X_9,10_CI_Screen Shot of Clinical Practice Guidelines-Website* RMHP disseminates information on its public website regarding current clinical practice guidelines.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* Contract: Exhibit B-2—10.5.8.5	*X_10,11_PNM_2021 Provider Manual* Utilization and Care Management: Page 83 Addresses the many aspects of the Utilization and Care Management program by describing the organizational structure in place to support correct and consistent development and application of guidelines. Page 92: The first two paragraphs describe how consistency is maintained including inter-rater reliability testing, audits and utilization clinical rounds. *X_UM_ Clinical Criteria for UM Decisions* Page 6, Section VII, describes how RMHP assesses at least annually the consistency with which physician and non-physician reviewers apply UM criteria in decision-making. *X_8,10,11_QI_Clinical Practice Guidelines Process* Page 3, Section 1.e: RMHP assesses whether Member materials, benefit configuration, UM decisions, prior authorization list, or other operational functions are consistent with adopted clinical guidelines and/or need to be updated as a result of any changes to the clinical guidelines.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1	*X_PT_Referrals_Med Nghbrhd_ Peds* *X_PT_Engaging in the Med Nghbrhd* These two documents are provided as examples of how RMHP helps its provider network use data and health information exchange for purposes of improving the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	care provided to patients. This includes an example of a workflow using health information exchange when a visit to the emergency room triggers a notification to the patient's PCP, e.g., pages 6-7 of Engaging in the Medical Neighborhood. *X_CL_Steps to Process a Medical Claim* Describes the steps the RMHP takes to process electronic and paper claims from providers—includes the processing steps, role of examiners, systems utilized, workflows and queues. *X_CI_RMHP_CHP_GrieveAppealRpt_Q1-FY 21_22* This report, provides identified trends regarding timely response and completion of grievances and appeals, and any actions taken. The Appeals and Grievance team shares Members perception on access and availability of services with appropriate departments for follow up. Note: Grievance and Appeal approved template with Q1FY21-22 data will be available on site. *X_12,13_CI_RMHP Health Information Systems_CHP+* This flowchart illustrates the various health information systems used by RMHP to collect, analyze, integrate and report data.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)* Contract: Exhibit B-2—13.1.1, 8.1	*X_12,13_CI_RMHP Health Information Systems_CHP+* This flowchart indicates the various reporting and analytics that are done in the areas of utilization, claims, grievances and appeals, etc. *X_13_PRGREC_MedicaidandCHP+_DisenrollmentReporting* RMHP has several processes and controls in place to ensure that each and every one of our eligible members are able to obtain services. We track the incoming data from the Department and look for any anomalies. RMHP created disenrollment reports for our CHP+, RAE and PRIME populations in order to track the number of disenrollments we receive on a monthly basis and to look for any irregularities. On a quarterly basis, our MEAC committee meets to discuss these results. The intent is to look for reasons of disenrollment other than loss of eligibility and subsequently take action for future prevention if necessary.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter	*X_14,17_PRGREC 1017 Medicaid CHP+ Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Medicaid and CHP+ Claim Encounter Data to the Colorado Department of Health Care Policy and Finance (HCPF).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
claims (reflecting claims paid, adjusted, and/or denied by the Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* Contract: Exhibit B-2—13.1.6.2	*Claims note regarding Mechanism for verifying accuracy of claims/encounter data: All Health Care Professionals must comply with adopted HIPAA standards and all ANSI claims submission requirements for acceptance of their claims. In addition, RMHP utilizes a series of national published correct coding guidelines to ensure Providers are submitting accurate claims. *X_14,17_PRGREC_Medicaid_CHP+ Pharmacy Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Pharmacy Claim Encounter Data to HCPF.	
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* Contract: Exhibit B-2—13.1.5.1, 13.1.6.2	*X_15_PT_PCP Practice Monthly Report_PHI Removed* This PCP Practice monthly report demonstrates how RMHP collects and uses data on Member and provider characteristics regarding services furnished to Members. The various worksheets provide practice summaries, patient summary, patient detail, Members who are assigned but unattributed, and enrollment and claims data. *X_12,15_PT_Engaging in the Med Nghbrhd* Pages 4-5 provides information for providers on tracking utilization in the emergency department and hospital, and on the attribution report (the practice monthly report noted above) and how practices can use it.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* Contract: Exhibit B-2—13.6.1, 13.1.6.5.1	*X_16_PM&A Annual Audit & Monitoring Plan JAN-DEC 2021* This annual audit plan describes RMHP audit activities to verify accuracy and timeliness of reported data; screening data for completeness, logic and consistency; and collecting information in standardized formats. See Page 4 lists the summary of audits for 2021. *X_16_PM&A-003 Procedure for Medical Claims Accuracy Reporting* *X_16_PM&A-007 Medical Claims Auditing Manual* RMHP conducts a monthly retrospective payment review of a sample of medical and hospital claims processed in the prior month to identify claims that may be paid incorrectly, applied incorrect Member responsibility, or are possibly fraudulent claims. *X_16_PM&A-004 CAS Policy and Procedure* RMHP conducts a post-payment claims review utilizing specialized software (CAS) with algorithms to identify claims and claim combinations that may be paid incorrectly or should not have been paid depending on set criteria. *X_16_PM&A-009 HRI (Optum Equian) Monthly Data Extraction*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP conducts post-payment PBA and DRG audits that identify, validate, and recover overpayments at four of RMHP's high-volume network hospitals. *X_16_PM&A-216 Durable Medical Equipment Review* *X_16_PM&A-216.1 DME Type of Service* *X_16_PM&A-216.2 Finance Crosswalk Instructions* *X_16_PM&A-216.3 Finance GL Matrix* These documents are used by RMHP to conduct ongoing monitoring of DME vendors to verify DME claims have been billed, processed, and paid accurately based on regulatory, coding, and contractual requirements. *X_16_PM&A-207 Correct Coding Process for E&M services* RMHP conducts post-payment reviews of E&M coding practices to monitor potential upcoding of claims and to improve the accuracy of and consistency of codes submitted by participating providers. *X_CL_Steps to Process a Medical Claim* Describes the steps the RMHP takes to process electronic and paper claims from providers—includes the processing steps, role of examiners, systems utilized, workflows and queues. • Verify accuracy and timeliness examples Page 3: checking of line items	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 4: claims sorted and worked by age Page 4: errors researched and cleared Page 4: duplicates are checked by the system automatically • Completeness, logic and consistency examples Page 2: claim with lack of information or eligibility is rejected Page 3: checking of line items Page 4: claims that do not meet criteria are pended • Service information in standardized formats examples Page 1: claims can be received electronically *X_16,17_Leif_Appendix I_CHP+ Flat File Specification* *X_16,17_Leif_CHP+ Flat File* A general description of what happens between RMHP giving data to Leif (RMHP's data actuary) and Leif providing HCPF (The Department) monthly Flat Files. This would be for both FFS and encounter claims.	
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate.	*X_14,17_PRGREC 1017 Medicaid CHP+ Claim Encounter Data Submission PP* Describes the process and procedure for the submission of Medicaid and CHP+ Claim Encounter Data to the Colorado Department of Health Care Policy and Finance (HCPF). *X_14,17_PRGREC_Medicaid_CHP+ Pharmacy Claim Encounter Data Submission PP*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Submits member encounter data to the State at the level of detail and frequency specified by the State. *42 CFR 438.242(c)* Contract: Exhibit B-2—13.1.6.2, 13.1.6.3.1, 13.1.6.4-5	Describes the process and procedure for the submission of Pharmacy Claim Encounter Data to HCPF. *X_16,17_Leif_Appendix I_CHP+ Flat File Specification* *X_16,17_Leif_CHP+ Flat File* A general description of what happens between RMHP giving data to Leif (RMHP's data actuary) and Leif providing HCPF (The Department) monthly Flat Files. This would be for both FFS and encounter claims.	
18. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Call center data. • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] surveys. Contract: Exhibit B-2—14.5.1-2	*X_1,2,3,4,18_QI_RMHP Corporate Quality Program_Impact Analysis_Annual Report CY 2020* Pages 112-141 describe various Member satisfaction survey tools, results, and analyses. Pages 112-113: Customer Service Email and Telephone Internal Audit Page 113: Post Call Survey Page 113: Net Promoter Score Pages 113-114: Cultural and Linguistic Needs Assessment Pages 114-118: Member Appeals and Grievance Analysis Pages 118-119: Statewide survey to evaluate Member experience with PCP and specialist visits Page 137-141: CHP CAHPS survey	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_CI_RMHP_CHP_GrieveAppealRpt_Q1-FY 21_22 This narrative report, provides identified trends regarding timely response and completion of grievances and appeals, and any actions taken. The Appeals and Grievance team shares Members perception on access and availability of services with appropriate departments for follow up. Note: Grievance and Appeal approved excel template with Q1FY21-22 data will be available on site. *X_CS_MEAC Quarterly Report* This report is presented quarterly to the Member Experience Advisory Committee (MEAC) to report the number of appeals and grievances received as well as the categories which include member perception to access, attitude/service, billing/financial, and quality of practitioner office site. *X_2,18_CI_CO2020-21_CHP+_TechRpt_F1* Pages 3-69 and 5-22 reflect the CAHPS Survey results from FY2018-19 through FY20-21. This information is used to assist in the creation of the RMHP Corporate Quality Program Annual report in order to identify perceptions of accessibility and adequacy of services provided to members.	

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	18
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Rocky Mountain Health Plans

Review Period:	January 1, 2021—December 31, 2021
Date of Review:	March 1, 2022
Reviewer:	Crystal Brown
Health Plan Participant:	Erin Nipper

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #1 Provider ID: **** Credentialing Date: 01/01/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: This provider's file was terminated from UPI/CU Medicine but remained practicing under RMHP. UPI/CU Medicine conducted initial credentialing and the file was placed into the RMHP recredentialing cycle.										
File #2 Provider ID: **** Credentialing Date: 01/08/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #3 Provider ID: **** Credentialing Date: 01/29/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #4 Provider ID: **** Credentialing Date: 02/11/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #5 Provider ID: **** Credentialing Date: 03/19/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Credentialing Record Review Tool
for Rocky Mountain Health Plans

Sample #	1	2	3	4	5	6	7	8	9	10
	Valid License/No Sanctions	DEA/CDS Certificate	Education/ Training	Board Certified	Work History	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits
File #6 Provider ID: **** Credentialing Date: 04/16/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #7 Provider ID: **** Credentialing Date: 04/23/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #8 Provider ID: **** Credentialing Date: 05/21/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #9 Provider ID: **** Credentialing Date: 07/19/21	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
File #10 Provider ID: **** Credentialing Date: 11/11/21	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:										
Number of Applicable Elements	**10**	**3**	**10**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**3**	**10**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**86**
Total Number of Compliant Elements	**86**
Overall Percentage Compliant	**100%**

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

Instructions:

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

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

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2021–2022 Recredentialing Record Review Tool
for Rocky Mountain Health Plans

Review Period:	January 1, 2021—December 31, 2021
Date of Review:	March 1, 2022
Reviewer:	Crystal Brown
Health Plan Participant:	Erin Nipper

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #1 Provider ID: **** Current Recredentialing Date: 02/05/21 Prior Credentialing or Recredentialing Date: 03/08/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #2 Provider ID: **** Current Recredentialing Date: 02/05/21 Prior Credentialing or Recredentialing Date: 03/29/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #3 Provider ID: **** Current Recredentialing Date: 03/29/21 Prior Credentialing or Recredentialing Date: 04/26/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #4 Provider ID: **** Current Recredentialing Date: 04/30/21 Prior Credentialing or Recredentialing Date: 05/17/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
Comments:									
File #5 Provider ID: **** Current Recredentialing Date: 05/07/21 Prior Credentialing or Recredentialing Date: 05/11/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #6 Provider ID: 117813 Current Recredentialing Date: 06/17/21 Prior Credentialing or Recredentialing Date: 05/31/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: This practitioner was recredentialed over the 36-month time frame. Due to COVID 19, NCQA issued an extension beginning March 1, 2020, through June 30, 2022, that extended the practitioner and provider recredentialing cycle by two months, to 38 months. RMHP used the extension and met the recredentialing time frame of 38 months.									
File #7 Provider ID: **** Current Recredentialing Date: 07/19/21 Prior Credentialing or Recredentialing Date: 07/12/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #8 Provider ID: **** Current Recredentialing Date: 08/20/21 Prior Credentialing or Recredentialing Date: 08/16/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									

Sample #	1	2	3	4	5	6	7	8	9
	Valid License/ No Sanctions	DEA/CDS Certificate	Board Certified	Malpractice History	Malpractice Insurance/ Required Amount	Not Excluded From Federal Programs	Signed Application/ Attestation	Verified Within Time Limits	Recredentialed Within 36 Months
File #9 Provider ID: **** Current Recredentialing Date: 10/22/21 Prior Credentialing or Recredentialing Date: 10/04/18	Y ☒ N ☐	Y ☐ N ☐ NA ☒	Y ☐ N ☐ NA ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments:									
File #10 Provider ID: **** Current Recredentialing Date: 12/03/21 Prior Credentialing or Recredentialing Date: 11/14/18	Y ☒ N ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐ NA ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐
Comments: This practitioner was recredentialed over the 36-month time frame. Due to COVID 19, NCQA issued an extension beginning March 1, 2020, through June 30, 2022, that extended the practitioner and provider recredentialing cycle by two months, to 38 months. RMHP used the extension and met the recredentialing time frame of 38 months.									
Number of Applicable Elements	**10**	**3**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Number of Compliant Elements	**10**	**3**	**3**	**10**	**10**	**10**	**10**	**10**	**10**
Percentage Compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Number of Applicable Elements	**76**
Total Number of Compliant Elements	**76**
Overall Percentage Compliant	**100%**

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

Instructions:

1. Current, valid license with verification that no State sanctions exist
2. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate (applicable to practitioners qualified to write prescriptions—e.g., psychiatrists, MD, DO)
3. Applicable if the practitioner states on the application that he or she is board certified
4. Malpractice settlements in most recent five years
5. Current malpractice insurance (physicians: $500,000/$1.5 million) verified through certificate of insurance
6. Verified that provider is not excluded from participation in federal programs
7. Application must be complete (see compliance tool for elements of complete application)
8. Verification time limits:

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

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

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2021–2022 site review of **RMHP**.

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

HSAG Review Team	Title
Sarah Lambie	Project Manager III
Sara Dixon	Project Manager II
Evarista Ogbon	Project Manager I
Lauren Gomez	Project Manager I
Crystal Brown	Project Coordinator III
RMHP Participants	**Title**
Alyssa Rose	Chief Compliance Officer
Billie Bemis	Director of Utilization Management
Braden Neptune	Director of Member Enrollment and Billing (MEB) & Program Reconciliation
Carlee Lindell	Care Management Operations Manager
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 Mok-Lamme	Vice President of Data Analytics and Strategy, Health Information Technology and Data Director
Erin Nipper	Lead Credentialing Coordinator
Greg Coren	Senior Manager, Provider Networks
Jeremiah Fluke	Prime Contract Manager & Quality Analyst
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 Quality Improvement
Krista Cavataio	Contract Manager, Behavioral Health Administrative Services Organization
Krystal Ewing	Senior Compliance Analyst, UnitedHealthcare Audit Management

RMHP Participants	Title
Liz Mullin	Network Program Manager
Lisa Latts	Chief Medical Officer, Chief Clinical Officer
Marci O'Gara	Senior Director of Business Operations
Matt Swanson	Senior Compliance Analyst, UnitedHealthcare Audit Management
Maura Cameron	Director of Clinical Quality and Accreditation, Quality Improvement Director
Meg Taylor	Vice President, Community Integration; RAE Program Officer
Melanie Maddocks	Leif Associates, Inc.
Melissa Keele	Director of Medicare Compliance
Monika Tuell	Chief Operations Officer
Nicole Konkoly	RAE Network Relations Manager
Patrick Gordon	Chief Executive Officer
Rhonda Michaelson	Supervisor, Appeals and Grievances
Rose Stauffer	Chief Financial Officer
Shawna Sayers	Appeals and Grievance Coordinator
Sheila Worth	Medical Strategic Initiatives Administrator
Sue Baker	Manager, Customer Service
Terry Todd	Director, Credentialing and Recredentialing, Facilities and Support Management
Tiffany Kikta	Manager, Utilization Management
Todd Lessley	Vice President Clinical Services
Zach Kareus	Clinical Pharmacist, Pharmacy Department
Zach Snyder	Digital Analyst, Information Technology
Vikki Watkins	Claims Supervisor
Violet Willett	Director, Care Management
Department Observers	**Title**
Amy Ryan	CHP+ Contracts and Program Administrator
Audrey Keenan	Health Programs Office (HPO) Program Administrator
Emily Kelley	Quality and Health Improvement (QHI) Specialist, Cost Control & Quality Improvement
Gina Robinson	Program Administrator
Jeff Helm	Program Design and Policy

Department Observers	Title
Jeff Jaskunas	CHP+ Program Manager
Lindsey Folkerth	Managed Care Specialist
Nancy Mace	Program Specialist
Russ Kennedy	Quality & Compliance Specialist
Tyller Kerrigan-Nichols	Managed Care Contract Specialist

Appendix D. Corrective Action Plan Template for FY 2021–2022

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

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department and HSAG will: • Approve the planned interventions and instruct the health plan to proceed with implementation, or • Instruct the health plan to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan will have a time frame of 90 days (three months) to complete proposed actions and submit documents. The health plan will submit documents as evidence of completion one time only on or before the three-month deadline for all required actions in the CAP. (If necessary, the health plan will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.) If the health plan is unable to submit documents of completion for any required action on or before the three-month deadline, it must obtain approval in writing from the Department to extend the deadline.

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

HSAG identified no required actions; therefore, the CAP template is not included.

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across health plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided health plans with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary health plan contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and the review activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. • The health plans also submitted a list of all credentialing, recredentialing, and organizational provider records that occurred between January 1, 2021, and December 31, 2021 (to the extent available at the time of the 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 the review. HSAG notified the health plan five days following receipt of the lists of records regarding the sample records selected.

For this step,	HSAG completed the following activities:
	• The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the 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 review, HSAG provided health plan staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2021–2022 Department-approved Site Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft 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.