

Colorado Medicaid
Managed Care Program

FY 2011–2012 SITE REVIEW REPORT
for
Rocky Mountain Health Plans

April 2012

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



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Overview of FY 2011–2012 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations and contractual requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Medicaid managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the fourth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Managed Care Program. For the fiscal year (FY) 2011–2012 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 four performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The health plan's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to Medicaid member appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable health plan Medicaid appeals that were filed between January 1, 2011, and December 31, 2011. For the record review, the health plan received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each of the elements evaluated. For cases in which the reviewer was unable to determine compliance due to lack of documentation, a score of *U* (unknown) was used and did not impact the overall record review score. Compliance with federal regulations was evaluated through review of the four standards and appeal records. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2011–2012 site review activities for the review period—January 1, 2011, through the dates of the on-site review, January 24–27, 2012. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the health plan was successful in completing corrective actions required as a result of the 2010–2011 site review activities. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the appeals record review. 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 process the health plan will be required to complete for FY 2011–2012 and the required template for doing so.

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 BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key health plan personnel to determine compliance. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The four standards chosen for the FY 2011–2012 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*. Appendix E contains a detailed description of HSAG's site review activities as outlined in the CMS final protocol.

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 regulations and 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 health care 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 to improve the quality of the health plan's services related to the areas reviewed.

Summary of Results

Based on the results from the compliance monitoring tool and conclusions drawn from the review activities, HSAG assigned each requirement within the standards in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for enhancement for some elements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **Rocky Mountain Health Plans (RMHP)** for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V	Member Information	21	21	19	2	0	0	90%
VI	Grievance System	26	26	19	7	0	0	73%
VII	Provider Participation	13	13	11	2	0	0	85%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
Totals		66	66	55	11	0	0	83%

Table 1-2 presents the scores for **RMHP** for the Appeals Record Review. Details of the findings for the record review follow in Appendix B—Appeals Record Review Tool.

Description of Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals Record Review	60	52	48	4	8	92%

2. Summary of Performance Strengths and Required Actions *for Rocky Mountain Health Plans*

Overall Summary of Performance

For the four standards reviewed by HSAG, **RMHP** earned an overall compliance score of 83 percent. **RMHP**'s strongest performances were in Standard V—Member Information and Standard IX—Subcontracts and Delegation, with compliance scores of 90 percent and 100 percent, respectively. In addition, **RMHP** earned a score of 92 percent on the on-site appeals record review, due to strong compliance with appeal processing timelines. HSAG, however, identified significant required actions in Standard VI—Grievance System, (73 percent compliant) and Standard VII—Provider Participation and Program Integrity (85 percent compliant). **RMHP** demonstrated fair performance overall and a moderate understanding of the Medicaid managed care regulations.

Standard V—Member Information

Summary of Findings and Opportunities for Improvement

The Medicaid member materials, consisting primarily of the Medicaid Member Handbook and member newsletters, were written in easy-to-understand language and format, were available in non-English languages, and were available in formats for the visually impaired, upon request. The Customer Service contact information was displayed and referenced throughout the handbook. Corporate policies and procedures were in place to guide the appropriate production of materials and implementation of interpretive services. Most of the requirements of this standard were adequately addressed in the member handbook or other member information materials. Mailing of member materials and required written notifications to members were timely, and tracking processes were in place. The **RMHP** Web site included links to the member handbook, member newsletters, and important subsections of the handbook, such as member rights, appeals information, and advance directives. The Medicaid Provider Directory included all of the required provider information and characteristics, as well as additional information related to access to services. The provider directory was also available in a searchable format on the **RMHP** Web site.

HSAG staff noted several opportunities for improvement which were presented to the **RMHP** staff on-site and did not impact the scoring of the audit. Recommendations included:

- ◆ **RMHP** may be able to enhance the use of its Web site for members by making the information and related links more prominently displayed or accessible at a higher level, so that members do not have to click through multiple screens to discover the above-referenced links (for example, the member handbook). In addition, the Web site newsletter links were listed by dates but did not identify the subjects addressed in the newsletters. Therefore, development of a subject listing or library of articles would enhance the ease of navigation and provide members improved access to topics of interest. The Web site might also be used as a vehicle for distributing detailed policies and procedures that may only need to be accessed by select members or providers in special circumstances. The policies could be referenced in other materials. For example, “for more information on poststabilization payment policies, go to <website address>.”
- ◆ **RMHP** should clarify an apparent information conflict in the member handbook regarding reasons for voluntary disenrollment. The section which addressed termination of the member’s PCP stated that the member “may choose to leave the Plan,” which is not listed as one of the reasons for voluntary disenrollment.
- ◆ **RMHP** may want to develop a mechanism for communicating to the provider (e.g., via the provider manual) the expectation that advance directives should be provided to members who were incapacitated upon enrollment once they are no longer incapacitated, since the provider is the most reasonable source of this information.

Summary of Strengths

RMHP has extensive experience with the requirements and provision of information for the Medicaid population. Systems and communication materials reflect the ongoing efforts of working with this population. The Medicaid Member Handbook, which is the primary source of information to the members, was well organized, written in easy-to-understand language, and contained the majority of required information. Mechanisms for providing materials to meet the needs of non-English-speaking or special needs members were in place. Customer Service personnel appeared well-trained and were depicted as the primary source of providing information and assistance to members.

Summary of Required Actions

The Medicaid Member Handbook informed members in easy-to-understand language about the grievance system processes; however, the information was incomplete. **RMHP** must inform members of the rules that govern representation at the State fair hearing process, including the right to represent themselves or have a designated client representative (DCR), the right to present information or evidence, and the right to examine **RMHP** documentation related to the appeal.

RMHP must also address the poststabilization care financial responsibility rules as outlined in 42 CFR 422.113 (c) and make such information available to members. HSAG staff suggested that an internal policy specifying the payment criteria be developed and that members and providers be informed of how to access the policy.

Standard VI—Grievance System

Summary of Findings and Opportunities for Improvement

RMHP communicated the grievance system process to members via the member handbook and to providers via the provider manual. **RMHP** also communicated that assistance with filing grievances and appeals was available. **RMHP** informed members that they must follow an oral request to appeal with a written request. **RMHP** maintained a grievance and appeal database and individual appeal records, and reported grievances and appeals to the Department quarterly, as required.

The record review revealed that claims denials were auto generated from the system and sent to the member without medical review or verification of the reason for the denial. Upon appeal review, the reason for denial was found to be incorrect, or a medical necessity review was required. Seven of the 10 records reviewed were overturned due to inaccuracy of processing or initial reason code. HSAG recommends evaluation and revision of the claims edits to improve accuracy of payment denial reason codes. Several of these records involved services related to a paid emergency claim and were overturned on appeal. Therefore, if claims, as part of a paid ER visit, are denied by the claims processing system, **RMHP** should evaluate and/or revise edits in the claims processing system to ensure compliance with 42CFR438.114.

Claims denials of services already complete or not initially authorized contained continuation of previously authorized services language. The SFH language was contained in an appeal letter that was favorable to the member. To improve readability of the appeal resolution letters, **RMHP** should revise letters to include only applicable information.

Summary of Strengths

Ten of 10 appeals records reviewed on-site demonstrated that acknowledgment and resolution letters were sent within the required time frames. The records also demonstrated that providers filed on behalf of the member. The record review also demonstrated that members were provided the opportunity to submit additional documents in support of the appeal.

Summary of Required Actions

At the time of this review, **RMHP** had not sent grievance resolution letters for quality of care grievances. **RMHP** must send each member a notice of resolution for all grievances. According to CMS, if the provider has not consented to disclosure, the letter must indicate, minimally, that a complete review was conducted and that information about the provider cannot be given. Other member-focused resolution information should be included such as whether the member has changed providers, or other member-focused activities **RMHP** has completed from a customer service point of view. **RMHP** must also revise its procedures to accurately reflect the grievance resolution time frame as 15 working days.

As evident in the appeals record review, earlier in the review period, the time frame for filing an appeal was depicted in the preauthorization notices of action as 20 calendar days. The time frame was depicted correctly in later preauthorization notices of action but remained incorrect in the claims denials throughout the claims appeal records reviewed. **RMHP** must review claims denial letters and revise, as needed, to ensure accurate reflection of the appeal filing time frame and consistency of compliance with Medicaid managed care regulations among **RMHP**'s functional departments.

The Care Management (CM) Grievances and Appeals process included the three-working-day time frame for resolving expedited appeals but indicated that the written resolution notice would occur two calendar days following the decision, which would have occurred within three working days from the date of receipt of the appeal. This time frame is out of compliance with the requirement to provide written notice of expedited resolution within three working days of receipt of the appeal. **RMHP** must revise its applicable policies and procedures to accurately reflect that expedited appeals must be decided, with written notice to the member, within three working days from the date **RMHP** received the appeal.

In one appeal case reviewed on-site, the physician who decided the appeal was the same physician who had signed the original notice of action. **RMHP** must ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making. The member handbook accurately informed members of the 30-calendar-day filing time frame requesting the State fair hearing. Appeal resolution letters inaccurately stated that members may request a State fair hearing 30 days from the date of the appeal resolution letter. **RMHP** must clarify its policies to accurately reflect the time frame for requesting a State fair hearing as 30 calendar days from the notice of action and ensure that appeal resolution letters also accurately reflect the time frame.

The member handbook described the conditions for requesting continuation of benefits. **RMHP**'s notice of action letter templates also failed to include the appropriate context that members may have to pay for services only in cases related to the continuation of previously authorized services. Although the member handbook provided this context under the appeal section, it did not under the State fair hearing section. Both the member handbook and the claims denial letters included a stand-alone statement that the member will have to pay for the services received if the member loses the State fair hearing. This statement is particularly inappropriate in claims denial letters, as there are few situations in which Medicaid members may be held responsible for the entire cost of the services. In addition, the member handbook states that for any appeal, the member may receive services during the appeal. Given that **RMHP** has developed a template notice of action for use specifically in situations related to the termination or reduction of previously authorized services, **RMHP** should consider removing the applicable language from other notices of action and resolution templates. **RMHP** must revise applicable documents such as notice of action and appeal resolution template letters, claims denial letters, member and provider materials, and policies, procedures, and processes to accurately reflect that members may request the continuation of previously authorized services during the appeal or State fair hearing if:

- ◆ The appeal is filed timely—defined (only for continuing benefits) as within 10 calendar days of the date of the notice of action, or before the intended effective date of the action, whichever is later.

- ◆ The appeal involves the termination, suspension, or reduction of previously authorized services.
- ◆ The services were ordered by an authorized provider.
- ◆ The original period covered by the original authorization has not expired.
- ◆ The enrollee requests the extension of services.

RMHP documents must also clearly reflect the circumstances under which members may be held liable for the cost of services related to those services that were previously authorized and continued as required in 42CFR438.420. Claims denials must not contain the general statement that members must pay for the services, as the situations under which members may be held liable for the costs are limited.

While the section of the provider manual specific to Medicaid appeals included accurate filing time frames, page 39 of the manual stated that Medicaid appeals must be initiated within 20 days of the denial decision. **RMHP** must revise the provider manual to ensure that the 30-day filing time frame appears consistently in the manual. **RMHP** must also include in its provider materials the rules that govern representation at the State fair hearing. At a minimum, these include the fact that the member may represent himself/herself or may be represented by another individual. HSAG also recommends that **RMHP** inform members that they may present evidence of fact or law and may examine the case file.

Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

Credentialing and recredentialing policies and procedures were very comprehensive and robust. The QI program description and evidence provided on-site documented that provider quality, appropriateness, and medical records standards were being routinely monitored. Providers were not discriminated against or limited in their care of the member's needs. Providers and employees were routinely screened against regulatory databases, and providers were not offered inappropriate incentives. Provider services contracts were very thorough, included all regulatory requirements, and were consistently applied to all applicable lines of business. The corporate-wide compliance plan and related fraud and abuse policies and procedures were very thorough and robust, employee training was conducted annually, and policies were described in the provider manual and the Medicaid Member Handbook, including publication of methods for reporting suspected fraud and abuse. There were numerous committees and reporting structures for decision-making or oversight of the credentialing, quality improvement, and compliance activities. However, requested evidence of the actual performance of internal audits to detect fraud and abuse was not provided and **RMHP** staff stated that no monitoring reports were available for the review period. Therefore, HSAG was unable to verify that **RMHP** was actively engaged in audit processes described in policies.

Summary of Strengths

The credentialing and provider screening processes were very complete and thorough and appeared to be well documented within the internal systems. The written compliance plan and related fraud and abuse policies and procedures are also very robust. Because these policies and processes were corporate-wide, they could be applied consistently across all lines of business. In addition, the provider service agreements and applicable exhibits were very comprehensive and representative of all regulatory requirements and could similarly be consistently applied across all product lines.

Summary of Required Actions

Although fraud and abuse policies and procedures were robust, **RMHP** provided minimal evidence of specific auditing as described in the policies. **RMHP** should evaluate its policy that addresses internal auditing and monitoring for identification of potential fraud and abuse and should develop procedures for the threshold and frequency of auditing described in the policy. **RMHP** should maintain documentation of fraud and abuse deterrent activities, such as audits and fraud and abuse deterrent committee meetings.

RMHP must correct its reporting policies and guidelines to be in compliance with the time frames for reporting to the Department as specified in the contract. (**RMHP** policies incorrectly indicate a 10-day reporting time frame, while the requirement is to report suspicions of fraud immediately, verbally to the contract manager, submitting a preliminary written report within three days, and submitting a final written report 15 days after the initial identification of potential fraud.)

Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

RMHP provided clear evidence of oversight of its delegates and had a process for evaluating potential delegates prior to implementing delegation agreements. **RMHP** described a predelegation assessment that was completed prior to the review period. **RMHP** provided evidence that it had a written agreement with each delegate that included each of the required provisions. There was evidence that **RMHP** provided information about its grievance system processes to each delegate.

Summary of Strengths

RMHP had policies and procedures in place for monitoring delegates and provided evidence of having conducted both ongoing monitoring and formal review (annual audits) of each delegate. **RMHP** provided evidence of having required and followed up on required corrective actions, when necessary.

Summary of Required Actions

There were no corrective actions required for this standard.

3. Follow-Up on FY 2010–2011 Corrective Action Plan for Rocky Mountain Health Plans

Methodology

As a follow-up to the FY 2010–2011 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether the health plan successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP** until the health plan completed each of the required actions from the FY 2010–2011 compliance monitoring site review.

Summary of 2010–2011 Required Actions

In the Standard area of Coverage and Authorization of Services, **RMHP** was required to revise its policy related to several specific requirements. HSAG performed an on-site record review during the FY 2010–2011 Site Review process and determined that **RMHP**'s process for prior authorization and/or adverse determination was out of compliance with Medicaid managed care regulations. Policy revisions required were as follows:

- ◆ The Preauthorization of Services for Medicaid Members policy required that expedited preauthorization decisions be made within three *working* days, but there were also references in the policy to decisions within 72 hours. **RMHP** was required to ensure that its policies are internally congruent as to time frames (i.e., three working days would not represent 72 hours if the time frame included a weekend). **RMHP** was also required to ensure that it follows internal policies and federal health care regulations regarding decision time frames for authorization decisions.
- ◆ The Preauthorization of Services for Medicaid Members policy stated that the time period within which a determination would be made begins on the date the request is received by **RMHP**, and that in cases involving an extension, notification would be provided within 24 days (10 days plus the 14-day extension). However, another section of the policy stated that if the member or the member's provider failed to submit enough information necessary to make the determination, **RMHP** would give the member at least 30 days from the receipt of the notice to provide the specified information. The policy stated, "Rocky Mountain sets this timeframe. It is not a regulatory requirement." While allowing this time frame may be acceptable for retrospective requests or claims decisions, it is not compliant with federal requirements when applied to preservice requests. **RMHP** was required to ensure that its written policies, procedures, and processes adhere to federal managed care regulations—specifically, that time frames for authorization decisions can only be extended by up to 14 calendar days for both standard and expedited authorization decisions.

On-site review of 20 denials/notice of action records indicated **RMHP**'s failure to comply with Medicaid managed care regulations as follows:

- ◆ Of the 20 records reviewed on-site, one denial decision was not made by a health care professional with clinical expertise in treating the member's condition. Based on the record review, **RMHP** was required to ensure that it adheres to internal policy (and federal health care regulations) that denial decisions must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.
- ◆ One record had no indication that notification had been given to the provider or that written notice of the decision had been sent to the member. None of the 20 records reviewed on-site were compliant with the content requirements for the notification letter. The first paragraph of each letter reviewed stated, "You may have to pay the doctor yourself." None of the 20 letters reviewed stated specifically that a member's physician could file an appeal on his or her behalf. **RMHP** must ensure that adverse notices of an authorization decision (notices of action) are provided to members and providers, and that notices to members include information that the provider can file an appeal on the member's behalf. Letters to members should not state that the member may have to pay for the services.
- ◆ In addition, the on-site record review demonstrated that **RMHP** did not adhere to the time frames for making standard authorization decisions, with 47 percent, or eight of the 17 applicable records, having met the requirement. **RMHP** was required to ensure that it follows internal policies and federal health care regulations regarding decision time frames for authorization decisions.

Also related to Coverage and Authorization of Services, **RMHP** was required to revise policies and practices related to the following:

- ◆ While **RMHP**'s Emergency Services policy stated that services would be covered regardless of whether an emergency room provider, hospital, or fiscal agent notified the member's PCP or **RMHP** of the member's screening and treatment, the policy did not state that the services would be covered regardless of whether notification was provided within 10 days of presentation for emergency services. The "ER Physician/Urgent Care" chapter of the *Claims Medical Processing Manual* stated in the Types of Services: Initial Emergent/Urgent Care section that "**RMHP** must be notified within 48 hours of out-of-area emergency services."
- ◆ While **RMHP**'s policies stated that **RMHP** would not limit the definition of an emergency medical condition to a list of diagnoses or symptoms, and that reimbursement would be in accordance with the member's covered benefits, the "ER Physician/Urgent Care" chapter of the *Claims Medical Processing Manual* contained a list of emergent diagnoses. Although notes adjacent to the list stated, "the list is only a reference and may not include all diagnoses that could be involved in an emergent situation," a subsequent section in the chapter, "Types of Services: Initial Emergent/Urgent Care: Diagnoses," stated, "Refer to the Emergent Diagnoses list...If the claim appears to be emergent, but the diagnosis is not on the approved list, pend the claim UM60 to Medical Review." The "Out-of-Area" chapter of the *Claims Medical Processing Manual* and the Emergency Claims sections also stated that "if after checking Claims Inquiry, Prospective UM, and the Emergent Diagnoses lists, it is not clear if the claim is payable, pend the claim...to Medical Review for determination." The Emergency Services policy stated that emergency and urgent care claims are paid at the claims processor level except for services that

are benefit exclusions. The Medical Claims Review/Care Management policy stated that **RMHP** would authorize payment for emergency services necessary to screen and stabilize a covered person in accordance with the “Managed Care Rule 438.114(d)(2)” and that **RMHP** would not deny benefits for medical conditions that a prudent layperson would perceive as emergent. Two records included in the on-site record review were denials based on diagnoses of dental caries. These cases did not appear to have been through medical review. The determination letters were signed “Customer Services.” While it was clear that dental *treatment* was not a covered benefit, application of the prudent layperson standard requires that a person presenting to an emergency room with severe pain be screened to diagnose and ascertain whether infection or other underlying reasons are causing the pain.

RMHP was required to ensure that it does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s PCP, the contractor, or a State agency of the member’s screening and treatment within 10 days of presentation for emergency services and to ensure that it does not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms for Medicaid members. HSAG also recommended that emergency claims not initially paid by the system be escalated to medical review for application of the prudent layperson standard.

In the Standard area of Credentialing and Recredentialing, **RMHP** was required to revise its policies related to several specific requirements, and develop additional processes to ensure compliance with NCQA Standards and Guidelines for credentialing and recredentialing, as follows:

- ◆ The Reduction, Suspension, or Termination policy did not address reporting to the Colorado Department of Regulatory Agencies (DORA) for nonphysician practitioners. During the on-site interview, **RMHP** credentialing staff reported that sanction or termination information was reported only for physicians, not for nonphysician practitioners such as nurse practitioners or physician assistants. NCQA clarified that its requirement applies to all practitioners licensed or certified by the State to practice independently that have an independent relationship with the organization. **RMHP** was required to develop a process to report any actions taken against nonphysician practitioners for quality reasons to the appropriate authorities, and to include reporting to DORA, when applicable.
- ◆ **RMHP** did not provide adequate documentation and evidence of committee meetings or the content of discussion for cases that were deferred to the Medical Practice Review Committee (MPRC) for discussion and final decision. **RMHP** provided only an excerpt of one meeting stating that a physician was discussed. The excerpt did not indicate what was discussed or who was present (to determine that a range of practitioners was represented on the committee). Other sets of minutes were not provided to demonstrate regular meetings or the membership of the committees. **RMHP** was required to maintain documentation to demonstrate that its MPRCs function as the credentialing committees, use a peer review process, and represent a range of participating providers.
- ◆ **RMHP** provided evidence that the CMO approved a list of names determined to be clean files. **RMHP**, however, provided inadequate evidence and documentation of the credentialing committee’s review of credentials for practitioners who did not meet established thresholds. **RMHP** was required to maintain documentation to demonstrate that it complies with NCQA

requirements regarding credentialing committee review of practitioners who do not meet established thresholds.

- ◆ The Health Delivery Organizations policy did indicate that on-site assessment was part of the criteria for contracting with **RMHP**; however, the on-site interview and review of organizational provider records indicated that **RMHP** did not have a process, assessment criteria, or an organizational provider site visit form. **RMHP** credentialing staff reported that **RMHP** accepted a successful State survey in lieu of an on-site assessment by **RMHP**; however, **RMHP** had not determined its on-site assessment criteria or obtained the content of the State survey to determine if **RMHP**'s standards were evaluated during the State survey. **RMHP** was required to develop its own criteria for organizational provider assessment for each type of organizational provider and develop a process for conducting on-site quality assessments, when applicable. The process may include accepting a State survey in lieu of performing an on-site assessment if NCQA guidelines are followed.
- ◆ **RMHP** did not have a process in place for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners. **RMHP** was required to have a process for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners.

Summary of Corrective Action/Document Review

RMHP submitted a corrective action plan in July 2011. HSAG and the Department reviewed **RMHP**'s planned interventions and timelines and provided feedback that **RMHP** should resubmit several aspects of its planned interventions, as they were not deemed to be sufficient to bring **RMHP** into compliance with Medicaid managed care requirements. In September 2011 **RMHP** resubmitted its corrective action plan with revised planned interventions and timelines. At that time, **RMHP** also submitted a revised claims processing manual and preauthorization and medical claims review policies to address deficiencies in the Coverage and Authorization of Services standard. In October 2011, **RMHP** submitted a final revised corrective action plan and additional documents, which included department meeting agendas and sign-in sheets, revised credentialing policies and procedures and MPRC/Credentialing Committee meeting minutes. In October 2011, HSAG notified **RMHP** that its final revised CAP was approved by the Department in its entirety and that **RMHP** should proceed with planned interventions. In January 2012, HSAG informed **RMHP** that it had successfully completed all required actions related to the FY 2010–2011 Site Review process.

Summary of Continued Required Actions

RMHP successfully completed all FY 2010–2011 corrective actions. There were no required actions continued from FY 2010–2011.

Appendix A. **Compliance Monitoring Tool**
for Rocky Mountain Health Plans

The completed compliance monitoring tool follows this cover page.



Appendix A. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Compliance Monitoring Tool
for Rocky Mountain Health Plans

Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
<p>1. Written information provided to Members shall be written, to the extent possible, at the sixth (6th) grade level, unless otherwise directed by the Department.</p> <ul style="list-style-type: none"> ♦ The Contractor makes written information available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency and informs members of how to access those formats. <p align="right"><i>42CFR438.10(b)(1),(d)</i> <i>DH Contract: II.E.1.d.2</i> <i>RMHP Contract: II.F.1.d.2</i></p>	<p>Preparation of Medicaid Member Materials P&P Attached above is the Policy and Procedure owned by Government Programs regarding preparing documents at sixth grade reading level.</p> <p>Examples of documents for sixth grade reading level. Medicaid Handbook Welcome Letter Acknowledgement Letter Denial Letter Open Enrollment Letter Open Enrollment Letter Insert Other documents available throughout this tool.</p> <p>CS Procedure on Alternate Formats Attached above is the Customer Services Procedure on making written information available in other formats.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Preparation of RMHP Medicaid Member Materials procedure stated that RMHP would produce materials for Medicaid members that were written at the 6th grade reading level and in an easy-to-understand format and that, once approved by the Department, commonly used materials would be translated into Spanish and would be made available in alternative formats, including Braille, on request. The Alternate Language or Larger Print Document Requests standard operating procedure (SOP) outlined the detailed RMHP internal process for responding to member requests for translation of documents into another language or Braille or larger print, and stated that many common documents were already available in Spanish in the electronic Spanish Resource Library. The Medicaid Member Handbook was printed in both English and Spanish. Samples of member communications, including the member handbook, welcome letter, denial and appeals information letters, and open enrollment letters were all written in easy-to-understand language, included a statement in Spanish to call for assistance in Spanish (contact number included), and provided the TTY telephone number for the hearing impaired. The Medicaid Member Handbook (member handbook) informed members that the handbook was available in large print, Braille, another language, or on audiotape, and provided the Customer Service contact number and RMHP e-mail address for assistance (page 1).</p>		
<p>Required Actions: None.</p>		



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2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. <i>42CFR438.10(b)(3) DH Contract: II.E.1.d.9.a RMHP Contract: II.F.1.d.9.a</i>	Medicaid Handbook The RMHP Medicaid Handbook is attached with named links to covered benefits, excluded benefits, how to access care, preauthorization requirements, Member Rights and Responsibilities and all other requirements and benefits of the plan as addressed in the following requirements.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The Medicaid Member Handbook provided extensive information on covered benefits, including categories of covered benefits with a description of co-payments for each type of service, a detailed listing of benefits with a description of which services are paid through RMHP, which services are paid through Medicaid, and which services are not covered and must be paid by the member. The handbook also described emergency service access information, the pre-authorization process, preventive services, selection and use of the PCP, when referrals are or are not required, pharmacy services, community resources and care management services. The member handbook instructed members to call customer service for assistance in understanding their benefits and provided the customer service telephone number and e-mail address on every page of the handbook. The handbook was also available on the RMHP member Web site with a specific link to “covered services and benefits.”		
Required Actions: None.		
3. The Contractor makes its written information available in the prevalent non-English languages in its particular service area and notifies its members that written information is available in prevalent non-English languages and how to access those materials. <i>42CFR438.10(c)(3) and (5) DH Contract: II.E.1.d.2 RMHP Contract: II.F.1.d.2</i>	Spanish Handbook Medicaid Handbook Attached is the RMHP Spanish language handbook (Spanish is the prevalent non-English language in the RMHP Medicaid service-area) and the Medicaid handbook with a link to instructions on how to obtain written material in languages other than English.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: RMHP provided copies of the Medicaid Member Handbook written in English and Spanish. The handbook was also available on the RMHP Web site with a notation in Spanish to call the listed customer service number to obtain information in Spanish. The Alternative Language or Larger Print Document Requests SOP outlined the detailed RMHP internal process for responding to member requests for translation of documents into another language, and stated that many common documents were already available in Spanish in the electronic Spanish Resource Library. The member handbook and other documents contained instructions in Spanish for members to call to receive assistance or information in Spanish, stated that translation of materials into any language may be requested by the member, and stated that interpreter services were available for any language through the AT&T		



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<p>language line. The Preparation of RMHP Medicaid Member Materials procedure stated that RMHP had translated many commonly used member communications into Spanish, and outlined the detailed process for customer service personnel to request translation of any requested materials into any other language.</p>		
<p>Required Actions: None.</p>		
<p>4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services.</p> <p align="right"><i>42CFR438.10(c)(4)&(5)</i> <i>DH Contract: II.E.1.d.2</i> <i>RMHP Contract: II.F.1.d.2</i></p>	<p>CS SOP for Language Line Interpretation Medicaid Handbook (page 1) Attached is the Customer Service procedure for the language line for non-English language speakers. Also attached is the Member Handbook with a bookmark directing members on how to use the ATT language line.</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The AT&T Language Line SOP stated that when a non-English-speaking member calls Customer Service (CS), the customer service representative (CSR) will use the AT&T Language Line to help with their questions. The SOP provided instructions for the CSR to set up a 3-way call to request interpreter services for the language spoken by the member. The SOP also stated that the language line would be used by CS for any follow-up calls to members. The Medicaid Member Handbook, at several locations in the handbook, instructed members to call customer service for assistance with questions, concerns, or help with benefits. The handbook included a statement that Spanish-speaking CSRs were available and that RMHP used the AT&T language line interpreters for members who do not speak English or Spanish. During the on-site interview, RMHP staff members stated that when Customer Services becomes aware that the member speaks a non-English language, the information is entered into the FACETS database system and is accessible to other departments who may need to communicate with that member. Staff also stated that RMHP very rarely encounters a member who speaks any language other than Spanish or English within their service area.</p>		
<p>Required Actions: None.</p>		



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<p>5. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information, upon request (information required at 438.10(f)(6) and 438.10(g)(and (h) and Exhibit D in the Contract).</p> <p align="right"><i>42CFR438.10(f)(2)</i> <i>DH Contract: II.E.1.d.9</i> <i>RMHP Contract: II.F.1.d.9</i></p>	<p>Open Enrollment Letter Insert Open Enrollment Letter Government Operations has responsibility for content and Support Services sends annually to all RMHP Medicaid Members notice of their right to request a handbook. This is mailed as an insert with annual notice of open enrollment (also attached). The mailing list of members to receive open enrollment letters is received monthly from Maximus.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Open Enrollment Letter insert, included in the annual notice to members of the open enrollment period, stated that the member handbook provided important information on member benefits and member rights and informed members that they may request a copy of the handbook at any time by contacting RMHP Customer Service (contact information for multiple modes of access provided). During the on-site review, RMHP staff provided evidence of a tracking mechanism for assuring that members on the monthly mailing list were sent an open enrollment letter and insert annually.</p>		
<p>Required Actions: None.</p>		
<p>6. The Contractor gives written notice of any significant change (defined as the information listed in II.E.1.d.9.a–g) in the information (required at 438.10(f)(6) and 438.10(g) provided to members at least 30 days before the intended effective date of the change.</p> <p align="right"><i>42CFR438.10(f)(4)</i> <i>DH Contract: II.E.1.d.9</i> <i>RMHP Contract: II.F.1.d.9</i></p>	<p>Medicaid Notice of Co-pay change Mailing Instructions for Notice No plan changes of the kind enumerated in the contract at II.F.1.d.9.a-g have occurred during this review period. Attached is a copy of the last such notice to be distributed in 2010.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Staff reported that there have been no significant changes requiring member notification during the audit period. RMHP provided a sample mailing of a benefit change concerning copayments, which was mailed in July 2010 for an effective date of August 1, 2010. During on-site reviews, staff provided a report of the automated download of member addresses for the 2010 mailing, and a cross-walk to the postmarked and received dates of the bulk mailing, which indicated that members received the notices 30 days prior to the effective date of change.</p>		



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<p>Neither a policy nor the member handbook contained a statement that members will be notified 30 days in advance of any significant change to the benefits or health plan. HSAG staff provided an on-site recommendation that a written policy statement and/or a member notice in the handbook inform members that they will be notified 30 days in advance of any significant change.</p>		
<p>Required Actions: None.</p>		
<p>7. The Contractor makes a good faith effort to give written notice of the termination of a participating provider agreement within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary health care from, or was seen by, the terminated provider.</p> <ul style="list-style-type: none"> ◆ Such notice describes how the services provided by the participating provider will be replaced, and informs the members of disenrollment procedures. <p align="right"> <i>42CFR438.10(f)(5)</i> <i>DH Contract: II.F.9.b</i> <i>RMHP Contract: II.G.8.b</i> </p>	<p>Notice of PCP Termination Letter This is the letter sent by RMHP Customer Service when a PCP termination occurs.</p> <p>Notice of PCP Termination Letter 2 This letter is sent by RMHP Customer Service when there is no provider who has agreed to accept the Member, and if they have ever been dismissed by a doctor. RMHP does not auto assign members to a PCP in this situation.</p> <p>Provider Configuration Manual See bookmark V.7. (p.97) for member notification of provider termination.</p> <p>Care Management Process: Care Management assists when made aware (from any referral source) of a member who has received his or her health care from a terminated provider. When a notification is received via Professional Relations. Case management will review the cases in facets to see if current case managed members will be affected by the provider being termed. Case management calls the member to see if they have located a new provider. Case management sends the member a current list of providers accepting new patients. If deemed necessary case management will call provider on behalf of member.</p>	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>
<p>Findings: The Provider Configuration Manual described the policies and procedures for notification to members involved in treatment with a terminating provider. The manual defined the criteria for determining members involved in active treatment with ambulatory providers, hospitals, or pharmacies and stated that applicable members must be notified of any type of provider (i.e., ambulatory, physician, DME or O2 provider, hospital, and pharmacy) termination within 15 working days of receipt of provider termination information from any source. The manual also described the tracking and documentation process and stated that the Provider Configuration Department is responsible for receiving the provider termination information and generating a member listing for mailing; maintaining an Excel spreadsheet to track the dates of notification, actions taken, and dates of letters mailed; and maintaining copies</p>		



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<p>of communication documents in the MACCESS data system. The manual also stated that RMHP would notify the Department of any changes in physician participation in a bi-weekly report to the enrollment broker. The manual stated that RMHP Customer Service would prepare and mail letters to the members informing them of the date of their PCP termination and if another PCP has been assigned or if they must choose a PCP. The PCP Termination Letter template indicated the date that the physician termination will be effective, informed the member that they must select a new PCP, and instructed members on the process for selecting a PCP and notifying Customer Service. The member handbook informed members that RMHP would notify them in writing if their PCP left the health plan and that the member may either choose a new PCP or “may leave the health plan.” During the on-site interview, RMHP staff stated that PCP termination is not a valid reason for voluntary disenrollment outside of the open enrollment time frame, and that this language would be removed from the member handbook. RMHP provided a tracking report for notification to members of provider termination. The tracking report included the provider-identifying information, date notice of termination received, termination date, deadline for notification of members (set at 15 business days from receipt of provider termination), and the date the termination letters were mailed. Staff stated that a mailing list of members seeing the terminated provider was generated from the database system, and that letters were auto-generated from the system.</p>		
<p>Required Actions: None.</p>		
<p>8. The Contractor provides to all members, including new members, a member handbook that includes general information about services offered by the Contractor within a reasonable time after notification of the enrollment and includes:</p> <ul style="list-style-type: none"> ◆ Location of facilities/offices. ◆ The Contractor’s hours of service. <p align="right"><i>42CFR438.10(f)(3)</i> <i>DH Contract: II.E.1.d.1, Exhibit D</i> <i>RMHP Contract: II.F.1.d.1, Exhibit D</i></p>	<p>Medicaid Handbook</p> <ul style="list-style-type: none"> ◆ See bookmark Standard V.5. ◆ See bookmark Standard V.5. <p>The Medicaid Handbook is mailed as part of the enrollment package and members are made aware they can obtain one annually in the open-enrollment notice in addition to the Member Handbook.</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The member handbook, mailed to members in the welcome packet after enrollment, included RMHP hours of business operation and the physical address on page 1. The handbook is also available to members at any time on the RMHP Web site, and the RMHP Web site <i>Contact Us</i> page included the hours of operation and addresses and contact numbers for all RMHP office locations. The RMHP Medicaid Directory, included in the enrollment welcome packet, provided a listing of all contracted providers with the physical address and contact telephone numbers for each provider. RMHP provided the written procedure for automated production of the new enrollee mailing list (scrubbed for duplicates, etc.), which included the process of screening for accuracy against the number of welcome packets ordered for mailing.</p>		
<p>Required Actions: None.</p>		



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<p>9. The member handbook includes:</p> <ul style="list-style-type: none"> ◆ Procedures for obtaining the names, qualifications, and titles of professionals providing and/or responsible for members' care , including identification of providers who are not accepting new patients. ◆ How to obtain the names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the member's service area, including identification of providers who are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals. ◆ Information on, restrictions, if any, on the member's freedom of choice among network providers. <p align="right"><i>42CFR438.10(f)(6)(i) and (ii)</i> <i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i></p>	<p>Medicaid Handbook The RMHP Medicaid Member Handbook informs members about the RMHP Medicaid Provider Directory, attached below.</p> <p>Medicaid Directory (page 3)</p> <ul style="list-style-type: none"> ◆ Included in Medicaid Directory closed practices are indicated by a circle with s strike mark ◆ Language spoken is indicated for non English speaking providers. Primary physicians are indicated by each provider and specialty is listed for all providers ◆ Network and pre-authorization requirements are covered on pages ii and iii. 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Medicaid Directory of Participating Providers, distributing in the welcome packet to all members on enrollment, contained the listing of RMHP providers, including PCP and specialty physicians, hospitals and rehabilitation facilities, laboratories, pharmacies, DME providers, home health providers, and all other categories of providers, and included the name and credentials of each provider (e.g., MD, DO, NP), addresses and contact numbers, specialty area (e.g., Family Practice, Internal Medicine, Cardiology), whether the practitioner was a PCP, any non-English languages spoken, and whether the practitioner was accepting new patients. The directory instructed members to go the RMHP Web site for the most updated information, and instructed members on access issues, such as selecting or changing a PCP, how and when to use emergency and urgent care services, pre-authorization requirements for some services, how to access mental health services, and how to access covered services that are not provided by RMHP (with contact numbers). The directory provided the customer service contact information for members to ask questions or obtain assistance related to RMHP providers. The RMHP Web site provider directory allowed members to search for providers by benefit program, specialty, distance, sex, languages spoken, or whether accepting new patients.</p>		
<p>Required Actions: None.</p>		



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<p>10. The member handbook includes a complete statement of member rights and responsibilities as specified in 42CFR438.100(b)(2)–(3) and in the 10 CCR 2505.8.205.3. A member has the right to:</p> <ul style="list-style-type: none"> ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment and the right to a second opinion. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. ◆ Obtain family planning services from any provider duly licensed or certified to provide such services without regard to enrollment in the MCO, without referral. ◆ Request and receive a copy of his or her medical records, and request that they be amended or corrected (as specified in 45CFR part 164). ◆ Be furnished health care services in accordance with federal healthcare regulations for access and availability, care coordination and quality. ◆ Exercise his or her rights, without any adverse effect on the way he or she is treated. <p align="right"> <i>42CFR438.10(f)(6)(iii)</i> <i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i> </p>	<p>Medicaid Handbook</p> <p>All bullet points listed at left are included in the Member Rights and Responsibilities included in the handbook at the hyperlink; bookmark V.10.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>Findings: The member handbook described member rights including the right to be treated with respect and dignity, receive information on all treatment alternatives regardless of cost and coverage, accept or refuse treatment, participate in treatment decisions, be free of restraint or seclusion, obtain family planning services in- or out-of-network without a referral, request medical records and amendment of medical records, and exercise member rights without adverse effect. The member handbook also stated that RMHP provides services and benefits in accordance with State and federal equal opportunity laws, and does not discriminate on the basis of race, color, national origin, age, or disability. The RMHP member Web site also contained a link to the Medicaid member rights and responsibilities. The RMHP Provider Manual informed providers of the Medicaid member rights. During on-site review, RMHP staff stated that the member newsletter would include an article on member rights and responsibilities once each year. A sample member newsletter, sent quarterly to members of all lines of business, included a partial listing of Medicaid member rights in easy-to-understand language.</p>		
<p>Required Actions: None.</p>		
<p>11. The member handbook includes:</p> <ul style="list-style-type: none"> ◆ Covered services and any additional benefits and services offered by the Contractor (including EPSDT services). ◆ Excluded or non-covered services. ◆ Circumstances under which members may have to pay for care. ◆ Information about the Contractor’s standards for the availability and accessibility of services including points of access for primary care, specialty, hospital, and other services. ◆ Information about how to request accommodations for special needs. ◆ How to request information about the Contractor’s quality management and improvement program. <p align="right"><i>42CFR438.10(f)(6)(v) through (vii)</i> <i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i></p>	<p>Medicaid Handbook</p> <ul style="list-style-type: none"> ◆ For EPSDT see <u>Keeping your Child Healthy</u> pages 6 and 7 Bookmark V.2. ◆ For all bullets see bookmarks V.11 a) - f) 	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>
<p>Findings: The Medicaid Member Handbook provided a detailed description of services and benefits and indicated whether each service is covered by RMHP or by Medicaid. The handbook also provided a list of noncovered services, such as experimental treatments, chiropractic care, skilled nursing facility care, and</p>		



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<p>care provided outside the U.S. The handbook stated that care received from non-network providers was generally not covered; that any noncovered services would have to be paid by the member; and that when a third party is responsible for the payment, the member may have to pay if the third party coverage rules were not followed by the member. The handbook also stated that the member may have to pay for services received that were supposed to be pre-authorized and had not been. The member handbook described additional covered services available to Medicaid members, which included EPSDT program services, preventive health services, immunization services for children, and family planning services. The handbook described points of access to care as follows: the PCP is the source for primary care; access to women’s health specialists do not require referral; hospital care is covered in-network when arranged by a network physician; mental health services could be arranged through the behavioral health organization (BHO) contact number; and emergency services could be accessed when necessary through the nearest emergency facility. The handbook stated that new members with special health care needs may request to continue to see their out-of-network PCP for 60 days and other providers for 75 days after joining RMHP before transferring to an in-network provider. The handbook briefly described the RMHP quality improvement efforts and stated that RMHP would investigate quality of care complaints generated by members, and that members may request a copy of the QI plan through Customer Service.</p>		
<p>Required Actions: None.</p>		
<p>12. The member handbook includes:</p> <ul style="list-style-type: none"> ◆ Maximum number of days between appointment request and actual visit with appropriate provider, as follows: <ul style="list-style-type: none"> • Urgent care within 48 hours. • Non-urgent care and EPSDT screens within two weeks. • Adult non-symptomatic well-care physical examinations within four months. ◆ Policies on referral for specialty care. ◆ Family planning policies. ◆ Procedures for arranging transportation. ◆ Information on how members will be notified of any changes in services or service delivery sites. <p align="right"><i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i></p>	<p>Medicaid Handbook For all bullets lease see bookmarks V.12. a)-f) (yellow notes in document indicate subject matter)</p>	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>



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<p>Findings: The Medicaid Member Handbook described that physician services should be accessible within 30 minutes of the member’s home and defined appointment availability standards as follows: 48 hours for urgent illness or injury; 2 weeks for nonurgent illness or injury; and 4 months for preventive care, such as a routine physical exam (except for EPSDT exams which are scheduled within 2 weeks of calling for an appointment). The handbook stated that specialist physician services may be accessed without a referral, and that family planning services were covered through the physician’s office, Planned Parenthood, or the county health department. The handbook referred members to the county social service departments (contact numbers provided) to seek transportation to doctor’s appointments. The handbook stated that RMHP would notify members in writing of any changes to the health plan, including if the member’s PCP leaves the plan.</p>		
<p>Required Actions: None</p>		
<p>13. The member handbook includes the following information regarding the grievance, appeal, and fair hearing procedures (and includes a complaint form):</p> <ul style="list-style-type: none"> ◆ The right to file grievances and appeals. ◆ The requirements and time frames for filing a grievance or appeal. ◆ The right to a State fair hearing: <ul style="list-style-type: none"> • The method for obtaining a State fair hearing, and • The rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: <ul style="list-style-type: none"> • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing, and the service authorization has not expired. • The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. 	<p>Medicaid Handbook For all bullet points please see Appeals and Grievances section at bookmark V.13.</p>	<p> <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>



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<ul style="list-style-type: none"> ◆ The right that providers may file an appeal on behalf of the member with the member’s written consent. <i>42CFR438.10(f)(6)(iv) and 438.10 (g)(1)(i–vii)</i> <i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i> 		
<p>Findings: The Medicaid Member Handbook informed members in easy-to-understand language that they may make a complaint about anything they do not like about RMHP, which was defined as a grievance, and may appeal any action that RMHP has taken, providing the definition of action. Specific examples of both grievances and appeals were listed, and members were informed that they may give written permission for a designated client representative (DCR) to assist them in filing an appeal or grievance. The handbook stated that grievances or appeals may be filed through the complaint form included in the handbook, or members may receive assistance by calling the RMHP customer service toll-free number. The handbook also included contact information for the Medicaid ombudsman. The handbook included the requirements and time frames for filing, processing and resolving grievances and appeals. The handbook also described the expedited appeal processes. In addition, the handbook explained the State fair hearing process including requirements and time frames for requesting the hearing. The handbook described the member’s right to have benefits continue during an appeal or State fair hearing if the appeal and request for benefit continuation are filed within 10 days of the notice of action or prior to the effective date of the action taken and the original authorization of services has not expired. The handbook explained that the member may have to pay for services provided if the appeal decision is not in the member’s favor. During the on-site interview, RMHP staff confirmed that the rules that govern representation at the State fair hearing were not described in the member handbook or other written forms of member communication.</p>		
<p>Required Actions: RMHP must inform members of the rules that govern representation at the State fair hearing process, including the right to represent themselves or designate a DCR, the right to present information or evidence, and the right to examine RMHP documentation related to the appeal.</p>		



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Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
<p>14. The member handbook includes the extent to which and how after hours and emergency coverage are provided, including:</p> <ul style="list-style-type: none"> ◆ What constitutes an emergency medical condition, emergency services, and poststabilization care services with reference to the definitions in 42CFR438.114(a). ◆ The fact that prior authorization is not required for emergency services. ◆ The process and procedures for obtaining emergency and poststabilization services, including the use of the 911 telephone system or its local equivalent. ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services. ◆ The fact that the member has the right to use any hospital or other setting for emergency care. ◆ Appropriate use of and procedures for obtaining after-hours care and emergency care within the service area. ◆ Appropriate use of and procedures for obtaining after-hours and emergency care when out of the service area. ◆ Instructions about accessing urgently needed services. <p align="right"><i>42CFR438.10(f)(6)(viii)</i> <i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i></p>	<p>Medicaid Handbook Please see bookmark V.14 Urgent Emergent Care and V.14. Emergency Services/Post-Stabilization</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The member handbook defined examples of an emergency medical condition as a threat to life or limb, lack of consciousness, or severe pain and stated that emergency services and urgent care services were covered anywhere in the country on a 24-hour-per-day, 7-day-per-week basis. The handbook stated</p>		



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Standard V—Member Information		
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<p>that emergency services do not require prior approval and instructed members to call 911 or go to the nearest facility for an emergency situation. The handbook also defined nonemergency urgent care and instructed members to call the PCP for instructions regarding access to urgent care. The handbook stated that emergency care services were covered inside or outside the network until the member is stable enough for transfer or release; that accessing an emergency room for nonemergent services may result in member payment liability; and that services delivered after the emergency to help the member’s condition improve, defined as poststabilization services, were covered in-network or until the member could safely return to the service area. The Medicaid Provider Directory contained a duplicate explanation of emergency and urgent care services, and listed the locations and contact information for urgent care facilities and hospitals. Both documents directed members to the nearest emergency room or hospital for emergency care. The Winter 2010 quarterly member newsletter included an article defining the difference between emergency and urgent care and how to access emergency or urgent care services.</p> <p>The Emergency Services Claim Review policy stated that emergency services were covered as defined by a prudent layperson’s definition or if authorized by an RMHP representative and would be covered until the treating provider determines that the member is sufficiently stabilized for transfer or discharge. The policy also stated that emergency services do not require preauthorization or notification to RMHP.</p>		
<p>Required Actions: None.</p>		
<p>15. The member handbook includes enrollment procedures of the Contractor, including how to change primary care providers, and disenrollment information (as required in section III of the contract) to ensure that disenrollees who wish to file a grievance are afforded appropriate notice and opportunity to do so, and members are informed about how to access the Department concerning disenrollment.</p> <p align="right"><i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i></p>	<p>Medicaid Handbook Please see bookmark V.15.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Medicaid Member Handbook instructed members that they may change their PCP by selecting a PCP from the provider directory, confirming with the PCP office that they are accepting new patients, and notifying RMHP of the name of the new PCP before they seek care. The handbook also stated that RMHP would notify the member if their PCP was leaving the plan, and that the member could select a new PCP or “may choose to leave RMHP.” The handbook described circumstances under which the member may disenroll, including moving out of the service area, the right to opt out during the first 90 days of enrollment, or the right to choose a new plan during the annual open enrollment period. The handbook instructed members that they must</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>notify RMHP and HealthColorado if requesting disenrollment (contact information provided). During the on-site interview, RMHP staff stated that PCP termination is not a valid reason for voluntary disenrollment outside of the open enrollment time frame, and that this language would be removed from the handbook. The handbook stated that enrollment in RMHP is voluntary and encouraged members to file a grievance, as outlined in the handbook, if they are unhappy with any aspect of RMHP.</p>		
<p>Required Actions: None</p>		
<p>16. The member handbook includes information about the Contractor’s utilization management program and how it is used to determine medical necessity of services. Information includes:</p> <ul style="list-style-type: none"> ◆ Appropriate points of contact with the utilization management program. ◆ Contact persons or telephone numbers for information or questions. ◆ Information about how to initiate appeals related to utilization management decisions. <p align="right"><i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i></p>	<p>Medicaid Handbook For all bullet points please see bookmark V.16.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Care Management section of the Medicaid Member Handbook described the care management process and stated that RMHP care managers check to make sure care is needed and appropriate for the member’s situation (defined as medically necessary), and informed members that they should work with their PCP to obtain care, inform RMHP of admission to a hospital, and be aware that some procedures require prior authorization to be covered. The handbook also described that care managers could assist members in obtaining care after covered service ends and provided the customer service contact number for access to the care manager or to obtain more information. The Appeals section of the member handbook outlined that reasons for member appeals including denial of services requested by the physician, denial of payment for services received, termination or limitation of a previously approved service, or denial of out-of-network services for members residing in a rural area. The appeals section of the handbook described the appeals process in detail. The RMHP member Web site also included a link to “how you can appeal.”</p>		
<p>Required Actions: None.</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>17. Advance directives requirements: The Contractor maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the Contractor. Advance directives policies and procedures include:</p> <ul style="list-style-type: none"> ◆ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. ◆ The difference between institution-wide conscientious objections and those raised by individual physicians. ◆ Identification of the State legal authority permitting such objection. ◆ Description of the range of medical conditions or procedures affected by the conscientious objection. ◆ Provisions for providing information regarding advance directives to the member’s family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. ◆ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. ◆ Procedures for documenting in a prominent part of the member’s medical record whether the member has executed an advance directive. ◆ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. 	<p>RMHP Advanced Directives P&P The Contractor maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the Contractor. Advance directives policies and procedures include.</p> <p>All bullets are addressed in the attached P&P.</p> <p>Medicaid Handbook The member information materials regarding advance directives include:</p> <p>All bullets are addressed in the Medicaid Handbook at bookmark V.17.</p> <p>Provider Manual Please see standard V.17. Advance Directive Policy and Provider Manual.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<ul style="list-style-type: none"> ◆ Provisions for ensuring compliance with State laws regarding advance directives. ◆ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ◆ Provisions for the education of staff concerning the Contractor’s policies and procedures on advance directives. ◆ Provisions for community education regarding advance directives that includes: <ul style="list-style-type: none"> • What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual’s control over medical treatment. • Description of applicable state law concerning advance directives. <p>The member information materials regarding advance directives include:</p> <ul style="list-style-type: none"> ◆ The member’s right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. ◆ The Contractor’s policies respecting implementation of advance directives. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the Colorado Department of Public Health and Environment. <p align="center"><i>42CFR438.10(g)(2) and 42CFR422.128</i> <i>DH Contract:II.F.7, Exhibit D</i> <i>RMHP Contract: II.G.6, Exhibit D</i></p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>Findings:</p> <p>The RMHP Advance Directives policy and procedure stated that members have the right to receive written information explaining advance directives (AD), including RMHP’s policies concerning advance directives, the member’s right to file complaints with the State regarding noncompliance with advance directives, and that RMHP would provide AD information to the member through the member handbook and member newsletters. The policy stated that information provided to members would reflect any changes in State law within 90 days after the effective date of the change, and would explain that members have a right to be informed by providers of any conscientious objection to carrying out a member’s advance directives. The policy stated that members would be provided assistance finding a provider who will carry out their advance directives. The policy stated that RMHP required all providers (e.g., hospitals, home health agencies, skilled nursing facilities, hospices) to maintain policies and procedures on advance directives, provide such information to members on admission or prior to commencing services, and include a clear statement of limitations in carrying out advance directives, if applicable. The policy stated that provider requirements related to advanced directives would be included in the provider manual and reviewed at provider workshops, and that RMHP chart audits would include the presence/absence of AD in the medical record. The policy also stated that RMHP did not condition provision of care or otherwise discriminate against a member based on presence/absence of advance directives and would educate staff and the community regarding advance directives.</p> <p>The 2011 provider manual stated RMHP’s commitment to comply with State laws concerning advance directives and inform members of their rights related to AD and outlined the provider’s responsibility to include the member’s advance directives in the medical record, discuss advance directives with the member, and inform the member and RMHP by telephone or in writing of any practitioner limitations in implementing AD on the basis of conscientious objection. The manual stated that RMHP would assign the member to a new PCP or specialist that can accommodate the member’s AD and train staff on AD policies.</p> <p>The Medicaid Member Handbook provided extensive information on advance directives, including:</p> <ul style="list-style-type: none"> ◆ The purpose of advance directives. ◆ A description of the types of advance directives recognized by Colorado law, including living will, medical durable power of attorney, and CPR directive. ◆ The member’s right to accept or refuse treatment, develop advance directives (or not), and have the advance directive included in the medical record. ◆ Assurance that the provision of care is not dependent on whether the member has executed an advance directive. ◆ The member’s right to be informed of provider policies regarding advance directives, including notification of any limitations the provider may have in implementing an advance directive. ◆ Contact information for the Colorado Department of Public Health and Environment for members to complain regarding noncompliance with advance directives. ◆ A description of the role of a medical proxy in making medical decisions when the member is incapacitated and has no advance directive. ◆ Forms for designation of a medical Power of Attorney and for completing a living will. 		



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<p>The RMHP Web site included a link to advance directives. On-site, RMHP staff members provided the packet of materials that is distributed to members when they call Customer Service to request information on advance directives, which included an article explaining the purpose and components of advance directives, and instructions and sample forms for completing advance directives. Staff stated that customer service representatives receive annual refresher CS training, which includes information on AD. In addition, staff described and provided evidence that RMHP sponsors professional and community seminars regarding advance directives.</p> <p>During the on-site interview, RMHP staff members reported that case management assessments always include a question regarding the presence of advance directives, and that case managers would assist members whose provider had notified provider relations of conscientious objection to AD to transfer to a new provider. Staff members stated that medical record audits conducted during provider on-site visits included documentation of AD in the record. Staff members also stated that on-site visits to provider offices can be infrequent (although were conducted as required by the NCQA Credentialing Standards). Staff reported that, as a result, RMHP will incorporate AD in the routine annual medical record audit process beginning in 2012 (draft tool provided). RMHP staff stated that families of members who were incapacitated upon enrollment would receive the member handbook upon enrollment, and that providers would be responsible to provide the AD information once the member was no longer incapacitated. HSAG staff recommended that the provider manual instruct providers concerning the need to provide information to family or surrogates if the member is incapacitated when treatment is performed and to provide information to the member when he or she is no longer incapacitated.</p>		
Required Actions:		
None.		
<p>18. The member handbook includes:</p> <ul style="list-style-type: none"> ◆ Notice that additional information that is available upon request includes information on: <ul style="list-style-type: none"> • The structure and operation of the Contractor. • Physician incentive plans. <p align="right"><i>42CFR438.10(g)(3)</i> <i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i></p>	<p>Medicaid Handbook Please see bookmark V.18.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings:		
The Medicaid Member Handbook informed members that they may request information about the organization and operation of RMHP or about physician incentive plans by contacting the Customer Service number.		
Required Actions:		
None.		



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Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
<p>19. The member handbook includes information concerning:</p> <ul style="list-style-type: none"> ◆ The member’s responsibility for providing the Contractor with written notice after filing a claim or action against a third party responsible for illness or injury to the member. ◆ The member’s responsibility for following any protocols of a liable third party payor prior to receiving non-emergency services. <p align="right"><i>DH Contract: Exhibit D</i> <i>RMHP Contract: Exhibit D</i></p>	<p>Medicaid Handbook Please see bookmark V.19.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The member handbook defined third party responsibility for payment, such as Medicare or a private insurer, and described situations in which there may be third party liability for payment. The handbook informed members of possible liability for payment if they fail to cooperate or comply with third party payor rules. The handbook specified that the member must notify RMHP within 15 days (by certified mail or hand-delivery) of filing a third party claim, and stated that RMHP is not financially responsible when third party payment is involved. The RMHP Provider Manual included a description of RMHP financial liability when third party liability for auto injury, worker’s compensation, or other third party injury claims is involved, and provided instructions regarding how to file claims in such situations.</p>		
<p>Required Actions: None.</p>		
<p>20. Member information materials sent following enrollment must also include the poststabilization care services rules at 422.113(c) and include:</p> <ul style="list-style-type: none"> ◆ The Contractor’s financial responsibilities for poststabilization care services obtained within or outside the organization that are pre-approved by a plan provider or other plan representative ◆ The Contractor’s financial responsibilities for poststabilization care services obtained within or outside the organization that are not pre-approved by a plan provider or other plan representative, ◆ That charges to members for poststabilization 	<p>Medicaid Handbook Addressed at bookmark V.20.</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirement	Evidence as Submitted by Health Plan	Score
<p>services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the Contractor.</p> <ul style="list-style-type: none"> ◆ That the organization’s financial responsibility for poststabilization services it has not approved ends when: <ul style="list-style-type: none"> • A plan physician with privileges at the treating hospital assumes financial responsibility for the member’s care; • A plan physician assumes responsibility for the member’s care through transfer; • A plan representative and the treating physician reach an agreement concerning the member’s care; or • The member is discharged. <p align="center"><i>42CFR438.10(f)(6)(ix) and 42CFR422.113(c)</i> <i>DH Contract: NONE</i> <i>RMHP Contract: NONE</i></p>		
<p>Findings: The member handbook contained the following description of poststabilization coverage:</p> <ul style="list-style-type: none"> ◆ RMHP covers poststabilization care, defined as services and supplies necessary to maintain a stable or improved condition following emergency care. ◆ Poststabilization care must be obtained from in-network providers. If the member received emergency care out of the service area, poststabilization is covered only until the member is stable enough to be safely returned to the service area (transferred or released), as determined by the treating physician. <p>The handbook did not include detailed information on rules for determining when RMHP financial responsibility applies.</p> <p>The Emergency Services Claims Review policy stated that medically necessary poststabilization care would be covered in accordance with the member’s evidence of coverage. During the on-site interview, RMHP staff stated that there is no current written policy or procedure for determining poststabilization financial responsibility as defined in 42 CFR 422.113 (c).</p>		



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Standard V—Member Information		
Requirement	Evidence as Submitted by Health Plan	Score
Required Actions: RMHP must address the poststabilization care financial responsibility rules as outlined in 42 CFR 422.113 (c) and make such information available to members. (HSAG staff suggested that an internal policy specifying the payment criteria be developed and that members and providers be informed of how to access the policy.)		
21. Member information materials sent following enrollment must also include: <ul style="list-style-type: none"> How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract. <p align="right"><i>42CFR438.10(f)(6)(x) through (xii) DH Contract: NONE RMHP Contract: NONE</i></p>	Medicaid Handbook Please see handbook page 11 Community Resources and page 12 <u>Human Services Department in Your Area</u>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The Medicaid Member Handbook described that Medicaid covers some services that are not offered by RMHP, defined as wrap-around services, which may be accessed through the county public health department or the State Medicaid help line, and provided the contact telephone numbers for these entities. The handbook outlined some of the common Medicaid-covered wrap-around services, such as routine dental care for children, hearing aids for Children with Special Needs, long-term home health care, hospice care, mental health services, and transportation to the physician’s office. In addition, the handbook described special community resources and programs that may be available through the county human services departments (contact numbers provided), such as the Women with Infants and Children Food Program (WIC); Health Care Program for Children with Special Needs (HCP); Home and Community Based Services (HCBS); and additional hearing, dental, and pregnancy care programs.		
Required Actions: None.		

Results for Standard V—Member Information					
Total	Met	=	<u>19</u>	X	1.00 = <u>19</u>
	Partially Met	=	<u>2</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>21</u>	Total Score	= <u>19</u>
		Total Score ÷ Total Applicable	=	<u>90%</u>	



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Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
<p>1. The Contractor has a system in place that includes a grievance process, an appeal process, and access to the State fair hearing process.</p> <p align="right"><i>42CFR438.402(a)</i> <i>DH Contract: II.E.2.b</i> <i>RMHP Contract: II F.2.b</i> <i>Grievance and Appeal State Rule (version 11—January 2011): 8.209(DH: Exhibit I, RMHP Exhibit B)</i></p>	<p>Medicaid Handbook See bookmark V.2.</p> <p>Medicaid denial letter 2011.doc (entire document)</p> <p>Care Management Medicaid A&G Process (entire document) ../Docs from FTP/RMHP/RMHP Medicaid Desk Review/A Medicaid Review Tools and Supporting documents/Standard VI Grievance System/Acknowledgment Letter.doc Customer Service Member Grievances and Appeals (entire document)</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Customer Service Medicaid Member Grievances and Appeals procedure (CS Grievances and Appeals procedure) and the Care Management Medicaid Appeals and Grievances process (CM Appeals and Grievances process) described RMHP’s grievance process, appeal process, and access to the State fair hearing process. The member handbook description of RMHP’s internal grievances and appeals processes, grievance and appeal definitions, and directions on how to access the State fair hearing process were clear and easy to understand. Providers were informed about the grievance and appeal system processes via the RMHP Provider Manual (the provider manual).</p>		
<p>Required Actions: None.</p>		
<p>2. The Contractor defines Action as:</p> <ul style="list-style-type: none"> ◆ The denial or limited authorization of a requested service, including the type or level of service, ◆ The reduction, suspension, or termination of a previously authorized service, ◆ The denial, in whole, or in part, of payment for a service, ◆ The failure to provide services in a timely manner, ◆ The failure to act within the time frames for resolution of grievances and appeals. ◆ For a resident of a rural area with only one MCO or PIHP, the denial of a Medicaid member’s request to exercise his or her rights to obtain services outside 	<p>RMHP defines Action in the following documents:</p> <p>Provider Manual See bookmark VI.2.</p> <p>Customer Service Member Grievances and Appeals See document p.1.</p> <p>Care Management Medicaid A&G Policy See document p.3.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
<p>of the network under the following circumstances:</p> <ul style="list-style-type: none"> • The service or type of provider (in terms of training, expertise, and specialization) is not available within the network, • The provider is not part of the network, but is the main source of a service to the member—provided that: <ul style="list-style-type: none"> ○ The provider is given the opportunity to become a participating provider, ○ If the provider does not choose to join the network or does not meet the health plan’s qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. <p align="right"> <i>42CFR438.400(b)</i> <i>(42CFR438.52(b)(2)(ii))</i> <i>State Rule: 8.209.2</i> </p>		
<p>Findings: The CS Grievances and Appeals procedure and the CM Grievances and Appeals policy included the definition of action, which was consistent with the Medicaid managed care definition, as was the definition in the provider manual and the member handbook. The member handbook definition was easy to understand and provided good examples of actions.</p>		
<p>Required Actions: None.</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
3. The Contractor defines Appeal as a request for review of an Action. <p align="right"><i>42CFR438.400(b)</i> <i>State Rule: 8.209.2</i></p>	Provider Manual See bookmark VI.3. Care Management Medicaid A&G Policy Customer Service Member Grievances and Appeals	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The definitions of appeal in the CS Grievances and Appeals procedure, the CM Grievances and Appeals policy, and the member handbook were consistent with the Medicaid managed care definition of appeal. The member handbook definition was easy to understand, and the provider manual included definitions similar to that of the member handbook information and was written at the appropriate readability level for provider understanding.		
Required Actions: None.		
4. The Contractor defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action. <p align="right"><i>42CFR438.400(b)</i> <i>State Rule: 8.209.2</i></p>	Provider Manual See bookmark VI.4. Care Management Medicaid A&G Policy See document p.2. Customer Service Member Grievances and Appeals See document p.2.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The definitions of grievance in the CS Grievances and Appeals procedure, the CM Grievances and Appeals policy, and the member handbook, were consistent with the Medicaid managed care definition of grievance. The member handbook definition was easy to understand, and the provider manual included definitions similar to that of the member handbook information and was written at the appropriate readability level for provider understanding.		
Required Actions: None.		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>5. The Contractor has provisions for who may file:</p> <ul style="list-style-type: none"> ◆ A member may file a grievance, a health plan-level appeal, and may request a State fair hearing. ◆ A provider may file a grievance on behalf of a member, given that the State permits the provider to act as the member’s authorized representative. ◆ A provider, acting on behalf of the member and with the member’s written consent may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member, given that the State permits the provider to act as the member’s authorized representative. <p align="right"><i>42CFR438.402(b)(1)</i> <i>State Rule: 8.209.2</i></p>	<p>Provider Manual Bookmark VI.5. p. 48 appeal p.49.grievance p. 50 state fair hearing</p> <p>Care Management Medicaid A&G Process Document bottom p.2. top p.3. grievance p.5 paragraph 2 appeals p.11 bottom state fair hearing</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: RMHP’s policies and procedures included provisions regarding who may file grievances and appeals. The policies and procedures specified that a DCR may include a treating health care professional. The member handbook informed members that they, their provider, or a DCR may file a grievance or an appeal and informed members of the availability of the State’s fair hearing process. The handbook also informed members that they must designate the DCR in writing. Providers were informed via the provider manual of the grievance and appeal processes. There were examples in the on-site appeals record review of members and DCRs having filed the appeal.</p>		
<p>Required Actions: None.</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
6. The Contractor accepts grievances orally or in writing. <i>42CFR438.402(b)(3)(i) State Rule: 8.209.5.D</i>	Provider Manual See bookmark IV.6. Customer Service Member Grievances and Appeals Document bottom p.1. Care Management Medicaid A&G Process Document bottom p.5.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The CS Grievances and Appeals procedure and the CM Grievances and Appeals policy defined grievance as a written or oral expression of dissatisfaction. The member handbook stated that a grievance is a “verbal or written statement that says you are unhappy.” The provider manual described written or oral grievances at a readability level appropriate for providers.		
Required Actions: None.		
7. Members have 30 calendar days from the date of the incident to file a grievance. <i>42CFR438.402(b)(2) State Rule: 8.209.5.A</i>	Provider Manual See bookmark VI.7. Care Management Medicaid A&G Process RMHP is submitting the attached documentation that gives members at least 30 calendar days from the date of the incident to file a grievance. Bookmark “Req7” that reads “The Member or his/her Designated Client Representative (DCR) must make an oral or written request within thirty (30) calendar days from the date of the incident.” Customer Service Member Grievances and Appeals See document p.3	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The CS Grievances and Appeals procedure and the CM Grievances and Appeals process stated that the member has 30 calendar days from the date of the incident to file a grievance. The member handbook informed members of the 30-calendar-day filing time frame in easy-to-understand language. Providers were informed via the provider manual.		
Required Actions: None.		



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<p>8. The Contractor sends written acknowledgement of each grievance within two working days of receipt.</p> <p align="right"><i>42CFR438.406(a)(2)</i> <i>State Rule: 8.209.5.B</i></p>	<p>Provider Manual See bookmark VI.8.</p> <p>Care Management Medicaid A&G Process See document p.6 and 8.</p> <p>Customer Service Member Grievances and Appeals See document p.3.</p> <p>RMHP is submitting the above documentation to show that it sends a written acknowledgement of each grievance within two working days of receipt.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CS Grievances and Appeals procedure and the CM Grievances and Appeals process included the provision for RMHP to send grievance acknowledgement letters within two working days of receipt of the grievances. Members were informed via the member handbook about the grievance process, including the process of sending the grievance acknowledgement letter. RMHP provided a grievance acknowledgement letter template.</p>		
<p>Required Actions: None.</p>		
<p>9. The Contractor must dispose of each grievance and provide notice of the disposition in writing as expeditiously as the member’s health condition requires, not to exceed 15 working days from the day the health plan receives the grievance.</p> <p align="right"><i>42CFR438.408(b)(1) and (d)(1)</i> <i>State Rule: 8.209.5.D.1, 8.209.5.F</i></p>	<p>Provider Manual</p> <p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc</p> <p>Customer Service Member Grievances and Appeals</p> <p>RMHP is submitting the above documentation to show that we complete each grievance and provide notice of the disposition in writing as expeditiously as the member’s health condition requires, not to exceed 15 working days from the day RMHP receives the grievance.</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process included the provision for resolution of grievances within 15 working days of the receipt of the grievance; however, the CS Grievances and Appeals procedure included inaccurate time frames for resolution of grievances, citing 14 calendar days as the time</p>		



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<p>frame. The member handbook accurately informed members of the process to send written notice of resolution to members within 15 working days of receipt of the grievance. In addition, the CS Grievance and Appeals procedure indicated, and RMHP staff members confirmed, that if the grievance is related to quality of care, members do not receive a resolution notice. Staff members cited the protected nature of the peer review process as the reason members do not receive resolution notices.</p>		
<p>Required Actions: RMHP must revise its procedures to accurately reflect the grievance resolution time frame as 15 working days. RMHP must also send each member a notice of resolution for all grievances. Per CMS, if the provider has not consented to disclosure, the letter must indicate, minimally, that a complete review was conducted and that information about the provider cannot be given. Other member-focused resolution information should be included such as whether the member has changed providers, or other member-focused activities RMHP has completed from a customer service point of view.</p>		
<p>10. The written notice of grievance resolution includes:</p> <ul style="list-style-type: none"> ◆ The results of the disposition/resolution process. ◆ The date it was completed. <p align="right"><i>State Rule: 8.209.5.G</i></p>	<p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc</p> <p>Customer Service Member Grievances and Appeals</p> <p>MD-MCQI Grievance 05 letter RMHP is including the attached documents to show that its grievance resolution letter includes the disposition /resolution process and the date it was completed</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The CM Grievances and Appeals process included the required content for grievance resolution, which included the result of the review of the grievance and the date the review was completed, as well as how to request a review of the grievance by the Medicaid health plan manager. The grievance decision letter template included fields to insert the required information.</p>		
<p>Required Actions: None.</p>		



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11. Members may file an appeal within 30 calendar days from the date of the notice of action. <i>42CFR438.402(b)(2)</i> <i>State Rule: 8.209.4.B</i>	Provider Manual See bookmark VI.8. CM Process 7 2 11 Medicaid Complaints and Grievances.doc The document attached above states that members may file an appeal within 30 calendar days from the date of the notice of action.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The CM Grievances and Appeals process included the provision that members may file an appeal within 30 calendar days of the date of the notice of action. Members were notified of the filing time frame via the member handbook. The notice of action template letter also included the 30-calendar-day filing time frame. As evident in the appeals record review, earlier in the review period, the time frame for filing an appeal was depicted in the preauthorization notices of action as 20 calendar days. The time frame was depicted correctly in later preauthorization notices of action but remained incorrect in the claims denials throughout the claims appeal records reviewed.		
Required Actions: RMHP must review claims denial letters and revise, as needed, to ensure accurate reflection of the appeal filing time frame and consistency of compliance with Medicaid managed care regulations among RMHP’s functional departments.		
12. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). <i>42CFR438.402(b)(3)(ii)</i> <i>State Rule: 8.209.4.F</i>	Medicaid Handbook Please see bookmark V.13. <u>Appeal and Grievance Process</u> CM Process 7 2 11 Medicaid Complaints and Grievances.doc The P&P attached states that members may file an appeal either verbally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution)	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The CM Grievances and Appeals process stated that members may make a written or oral request for an appeal. The process included procedures for RMHP staff to include a summary of the appeal issue to attach to the acknowledgement letter and request that the member return the summary signed, as the written follow-up to the oral request. The on-site appeals record review demonstrated that the summary of the appeal and signature page were incorporated into the preauthorization notice of action letters reviewed on site.		
Required Actions: None.		



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<p>13. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms required, putting oral requests for a State fair hearing into writing, and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.</p> <p align="right"><i>42CFR438.406(a)(1)</i> <i>State Rule: 8.209.4.C</i></p>	<p>Provider Manual See bookmark VI.13.</p> <p>Customer Service Member Grievances and Appeals See document p.2.</p> <p>Audit Documents\Acknowledgment Letter.doc The document linked above shows that when RMHP handles a grievance and/or appeal, RMHP give members reasonable assistance in completing any forms required, putting oral requests for a State fair hearing into writing, and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability</p> <p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process stated that the assistance available to members during the grievance and appeal processes included answering questions about the process, arranging for interpreter service, completing forms, and putting requests for a State fair hearing into writing for the member. The appeal acknowledgement letter offered a contact telephone number for requesting assistance with the process. This was written in English and in Spanish and provided a TTY number. The member handbook offered help filing a grievance and completing the form to file an appeal. The handbook also stated that the customer service representative would help the member write the request for a State fair hearing upon request. The provider manual included information parallel to that found in the member handbook regarding handling of grievances and appeals. The preauthorization notice of action letters stated that the pages of the member handbook describing the grievance and appeal processes were attached. Staff members confirmed this practice for preauthorization notices. On-site appeals record review demonstrated that the pages were included for preauthorization notices of action.</p>		
<p>Required Actions: None.</p>		



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<p>14. The Contractor sends the member a written acknowledgement of each appeal within two working days of receipt, unless the member or the designated client representative (DCR) requests an expedited resolution.</p> <p align="right"><i>42CFR438.406(a)(2) State Rule: 8.209.4.D</i></p>	<p>Provider Manual See bookmark VI.14.</p> <p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc RMHP sends the member a written acknowledgement of each appeal within 2 working days of receipt, unless the member or the designated client representative (DCR) requests an expedited resolution (see bottom p.10.)</p> <p>Appeal Acknowledgement Letter (entire document)</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process included the procedures for sending an acknowledgement letter within two working days of receipt of the appeal. RMHP provided an appeal acknowledgement letter. The member handbook informed members about the appeal process including the process to send a written acknowledgement within two working days of receipt of the appeal. The on-site appeals record review demonstrated that RMHP sent appeals acknowledgement letters to members within two working days of receipt of the grievance, in nine of nine applicable cases reviewed.</p>		
<p>Required Actions: None.</p>		
<p>15. The Contractor’s appeal process must provide:</p> <ul style="list-style-type: none"> ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date). ◆ The member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member’s case file, including medical records, and any other documents considered during the appeals process. ◆ That included as parties to the appeal are: 	<p>Provider Manual Please see bookmark VI.15.</p> <p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc RMHP is submitting the following documentation to show (by bullet)</p> <ul style="list-style-type: none"> a) oral inquiries seeking to appeal an action, are treated as appeals (Bookmark “”Req15a) b) members are given an opportunity to present evidence, and allegations of fact or law, in person as well as in writing. c) RMHP informs the member of the limited time available for this in the case of expedited resolution (BookmarkReq15b) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<ul style="list-style-type: none"> The member and his or her representative; or The legal representative of a deceased member’s estate. <p align="right"><i>42CFR438.406(b)</i> <i>State Rule: 8.209.4.G, 8.209.4.H, 8.209.4.I</i></p>	<p>d) RMHP gives the member and his or her representative the opportunity, before and during the appeals process, to examine the member’s case file, including medical records, and any other documents consider during the appeals process. Bookmark “Req15c)</p> <ol style="list-style-type: none"> RMHP considers parties to the appeal, are: The member and his or her representative, or The legal representative of a deceased member’s estate. (Bookmark Req15d) <p>Medicaid Handbook Please see bookmark V.13. Appeals and Grievances</p>	
<p>Findings: The CM Grievances and Appeals process stated that verbal inquiries would be treated as appeals to establish the earliest possible filing date. The process also included the provision that members have the opportunity to review the case file and to present information in person or in writing. The member handbook stated that members may call or write to file an appeal, or use a form available at the back of the member handbook. The handbook also stated that Customer Service would complete the form at the member’s request. Members were informed via the notice of action letter and the member handbook of the right to present evidence related to the appeal. The member handbook also included information about the member’s right to examine the case records. The denial letter indicated that the grievance and appeal pages of the member handbook were attached (confirmed via on-site record review). Providers were informed of these processes via the provider manual. The on-site appeals record review demonstrated that the applicable parties to the appeal were copied on all correspondence.</p>		
<p>Required Actions: None.</p>		



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<p>16. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member’s health condition requires, but not to exceed the following time frames:</p> <ul style="list-style-type: none"> ◆ For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal. ◆ For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. <p align="right"><i>42CFR438.408(b)(2)&(d)(2)</i> <i>State Rule: 8.209.4.J, 8.209.4.L</i></p>	<p>Provider Manual Please see bookmark VI.16. Appeals and Grievances</p> <p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc</p> <p>RMHP CM is submitting the above documentation to show that for each appeal the member is provided with a written notice of the disposition, as expeditiously as the member’s health condition requires, but not to exceed the specified timeframes. Please see bookmarks Req. 16a. and 16b.</p> <p>Medicaid Handbook Please see bookmark V.13. Appeals and Grievances</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process included the 10-working-day time frame for standard appeals, for resolving and providing notice to the member. The process also included the three-working-day time frame for resolving expedited appeals but indicated that the written resolution notice would occur two calendar days following the decision, which would have occurred within three working days from the date of receipt of the appeal. This time frame is out of compliance with the requirement to provide written notice of expedited resolution within three working days of receipt of the appeal. The process included the provision to make reasonable efforts to verbally notify the member for expedited resolution of appeals. The member handbook included the 10-working-day time frame for providing written resolution of standard appeals to the member. The on-site record review demonstrated that all appeals reviewed had been decided, with notice provided to the member, within the required time frame. There were no expedited appeals reviewed on-site.</p>		
<p>Required Actions: RMHP must revise its applicable policies and procedures to accurately reflect that expedited appeals must be decided, with written notice to the member, within three working days from the date RMHP received the appeal.</p>		



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<p>17. The written notice of appeal resolution must include:</p> <ul style="list-style-type: none"> ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: <ul style="list-style-type: none"> ● The right to request a State fair hearing and how to do so, ● The right to request to receive benefits while the hearing is pending, and how to make the request, and ● That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor’s action. <p align="right"><i>42CFR438.408(e)</i> <i>State Rule: 8.209.4.M</i></p>	<p>Provider Manual Please see bookmark VI.17. Appeals and Grievances</p> <p>Medicaid Handbook Please see bookmark V.13. Appeals and Grievances</p> <p>CM 4.2.2.11 Discontinuation of Services Medicaid.doc, Bookmark “Benefits_Continue_During_Appeal”</p> <p>RMHP sends the members written notice of the appeal resolution, results of the resolution process and the date it was completed. That also includes</p> <ul style="list-style-type: none"> ◆ The right to request a State fair hearing, and how to do so, ◆ The right to request that benefits while the hearing is pending, and how to make the request, and ◆ That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor’s action <p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc bookmark “Req17a”,) states “The circumstances under which the Member’s current service level may continue throughout the entire Appeal process. The member may be held liable for the cost of the benefits if the hearing decision upholds the Contractor’s action.”</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process listed the required content for appeal resolution letters, which included all of the requirements. Although appeal resolution letters included all of the required information, information regarding the continuation of previously authorized services was incomplete (see requirement number 22).</p>		
<p>Required Actions: None.</p>		



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<p>18. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who:</p> <ul style="list-style-type: none"> ◆ Were not involved in any previous level of review or decision-making, and who, ◆ Have the appropriate clinical expertise in treating the member’s condition or disease if deciding any of the following: <ul style="list-style-type: none"> • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. <p align="right"><i>42CFR438.406(a)(3)(ii)</i> <i>State Rule: 8.209.4.E, 8.209.5.C</i></p>	<p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc See Bookmark “Req18” RMHP is submitting the above to demonstrate that individuals who make decisions on grievances and appeals are individuals who</p> <ol style="list-style-type: none"> 1. Were not involved in any previous level of review or decision-making, 2. Have the appropriate clinical expertise in treating the member’s condition or disease 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process stated that every decision to uphold an RMHP action or a grievance regarding the denial of expedited resolution will be evaluated by an RMHP medical director who was not previously involved with the case. In one case reviewed on-site, the physician who decided the appeal was the same as the physician who had signed the original notice of action.</p>		
<p>Required Actions: RMHP must ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making.</p>		



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<p>19. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if:</p> <ul style="list-style-type: none"> ◆ The member requests the extension; or ◆ The Contractor shows that there is need for additional information and how the delay is in the member’s interest. ◆ If the Contractor extends the time frames, it must—for any extension not requested by the member— give the member written notice of the reason for the delay. <p align="right"><i>42CFR438.408(c)</i> <i>State Rule: 8.209.4.K, 8.209.5.E</i></p>	<p>Customer Service Member Grievances and Appeals</p> <p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc</p> <p>RMHP is submitting the above to show that we extend the timeframes for resolution of grievances or appeals when,</p> <ul style="list-style-type: none"> ◆ The member requests the extension, or ◆ The Contractor shows that there is need for additional information and how the delay is in the member’s interest. ◆ If the Contractor extends the timeframes, it must—for any extension not requested by the member— give the member written notice of the reason for the delay. <p>See bookmark “Req19” that states “Rocky Mountain may extend the timeframes for resolution of appeals (both expedited and standard) by up to 14 calendar days if:</p> <ol style="list-style-type: none"> 1. The member requests the extension, or 2. Rocky Mountain shows that there is need for additional information and how the delay is in the member’s interest and inform the member in writing of the reason for the extension.” 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process included the provision to extend the time frames for resolution of grievances and for standard and expedited appeals. During the on-site interview, staff members reported that RMHP does not have a template extension letter, as it has never extended the decision time frame.</p>		
<p>Required Actions: None.</p>		



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<p>20. A member need not exhaust the Contractor’s appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action.</p> <p align="right"><i>42CFR438.402(b)(2)(ii)</i> <i>State Rule: 8.209.4.N</i></p>	<p>Provider Manual See bookmark VI.20</p> <p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc RMHP is submitting the above to show that we do not require the member to exhaust RMHP’s appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action See bookmark “Req20” that states “The Member or his/her DCR may request a State Fair Hearing 30 days following Rocky Mountain’s original notice of Action or Appeal determination at any point in the Appeal process. The member has the right to be represented by someone else during the hearing and they also have the right to present evidence during the hearing.”</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process stated that members may request a State fair hearing 30 days following RMHP’s original notice of action or appeal determination, or at any point in the appeal process. The member handbook informed members of the 30-calendar-day filing time frame requesting the State fair hearing. Appeal resolution letters inaccurately stated that members may request a State fair hearing 30 days from the date of the appeal resolution letter.</p>		
<p>Required Actions: RMHP must clarify its policies to accurately reflect the time frame for requesting a State fair hearing as 30 calendar days from the notice of action and ensure that appeal resolution letters also accurately reflect the time frame.</p>		



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<p>21. The Contractor maintains an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member’s life or health or ability to regain maximum function. The Contractor’s expedited review process includes:</p> <ul style="list-style-type: none"> ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member’s appeal. ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: <ul style="list-style-type: none"> • Transfer the appeal to the time frame for standard resolution, and • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow up within two calendar days with a written notice. <p align="right"><i>42CFR438.410</i> <i>State Rule: 8.209.4.P–R</i></p>	<p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc</p> <p>RMHP is submitting the above to show that we have an expedited review process for appeals. This policy also ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member’s appeal</p> <p>When RMHP denies a request for an expedited resolution we make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice., see bookmark “Req21”</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process described the expedited appeal process and included each of the required provisions. Members were informed via the member handbook of the right to request an expedited review and the short amount of time available to provide evidence and review records. There were no expedited appeals reviewed on-site. During the on-site interview, RMHP staff members explained that RMHP did not have a template letter for denial of the expedited process, as they process any appeal as an expedited appeal, if expedition was requested by the member.</p>		
<p>Required Actions: None.</p>		



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<p>22. The Contractor provides for continuation of benefits while the health plan-level appeal and the State fair hearing are pending if:</p> <ul style="list-style-type: none"> ◆ The member or the provider files timely*—defined as on or before the later of the following: <ul style="list-style-type: none"> • Within ten days of the Contractor mailing the notice of action. • The intended effective date of the proposed action. ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. <p><i>* This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.</i></p> <p align="right"><i>42CFR438.420(a) and (b)</i> <i>State Rule: 8.209.4.S</i></p>	<p>CM 4.2.2.11 Discontinuation of Services Medicaid.doc As demonstrated in the above document RMHP does not terminate, suspend, or reduce previously authorized services except in the case of fraud or abuse.</p> <p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc Please see _ Bookmark “Req22”</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process described the provisions for continuation of previously authorized services during the appeal or the State fair hearing; however, page 9 of the process included, as content of the appeal resolution letter, the provision that the member may have to pay for services if the State fair hearing decision upheld RMHP’s denial. The stated content did not include the appropriate context that members may have to pay for services following the State fair hearing decision only in cases in which previously authorized services were continued during the State fair hearing, at the member’s request. The Discontinuation of Services for Fraud policy stated that RMHP honors authorizations and does not discontinue services that had been authorized except in cases of fraud. The policy described the exceptions to the 10-day advance notice requirements as stated in 42CFR 431.213 and 431.214. The member handbook described the conditions for requesting continuation of benefits. RMHP’s notice of action letter templates also failed to include the appropriate context that members may have to pay for services only in cases related to the continuation of previously authorized services.</p>		



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	<p>Although the member handbook provided this context under the appeal section, it did not under the State fair hearing section. Both the member handbook and the claims denial letters included a stand-alone statement that the member will have to pay for the services received if the member loses the State fair hearing. This statement is particularly inappropriate in claims denial letters, as there are few situations in which Medicaid members may be held responsible for the entire cost of the services. In addition, the member handbook states that for <i>any</i> appeal, the member may receive services during the appeal. Given that RMHP has developed a template notice of action for use specifically in situations related to the termination or reduction of previously authorized services, RMHP should consider removing the applicable language from other notices of action and resolution templates.</p> <p>Required Actions: RMHP must revise applicable documents such as notice of action and appeal resolution template letters, claims denial letters, member and provider materials, and policies, procedures, and processes to accurately reflect that members may request the continuation of previously authorized services during the appeal or State fair hearing if:</p> <ul style="list-style-type: none"> ◆ The appeal is filed timely—defined (only for continuing benefits) as within 10 calendar days of the date of the notice of action, or before the intended effective date of the action, whichever is later. ◆ The appeal involves the termination, suspension, or reduction of previously authorized services. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The enrollee requests the extension of services. <p>RMHP documents must also clearly reflect the circumstances under which members may be held liable for the cost of services related to those services that were previously authorized and continued as required in 42CFR438.420. Claims denials must not contain the general statement that members must pay for the services, as the situations under which members may be held liable for the costs are limited.</p>	



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Requirement	Evidence as Submitted by Health Plan	Score
<p>23. If, at the member’s request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs:</p> <ul style="list-style-type: none"> ◆ The member withdraws the appeal. ◆ Ten days pass after the Contractor mails the notice providing the resolution (that is against the member) of the appeal, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. ◆ A State fair hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. <p align="right"><i>42CFR438.420(c)</i> <i>State Rule: 8.209.4.T</i></p>	<p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc</p> <p>RMHP is submitting the above to show that when a member requests that RMHP continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs:</p> <ul style="list-style-type: none"> ◆ The member withdraws the appeal. ◆ Ten days pass after the Contractor mails the notice providing the resolution (that is against the member) of the appeal, unless the member (within the 10-day timeframe) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. ◆ A State fair hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. <p>See bookmark “Req23” That states “At the member’s request, Rocky Mountain will continue or reinstate the Member’s level of care and/or benefits, while the appeal is pending. The benefits will continue until one of the following occurs:</p> <ul style="list-style-type: none"> • The member withdraws the appeal. • Ten days pass after Rocky Mountain mails a notice of adverse appeal resolution to the member or DCR, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. • A State fair hearing office issues a hearing decision adverse to the member. • The time period of service limits of a previously authorized service has been met.” 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirement	Evidence as Submitted by Health Plan	Score
<p>Findings: The CM Grievances and Appeals process included the provision for continuation of previously authorized services during the appeal or the State fair hearing and contained the correct information regarding the duration of continued services.</p>		
<p>Required Actions: None.</p>		
<p>24. Effectuation of Appeal Resolution:</p> <ul style="list-style-type: none"> ◆ If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor’s action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member’s health condition requires. <p align="right"><i>42CFR438.420(d), 42CFR438.424</i> <i>State Rule: 8.209.4.U–W</i></p>	<p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc</p> <p>Compliance Statement: RMHP is submitting to show that RMHP effectuates an appeal when “the ALJ at the State fair hearing rules that the member was not entitled to the services, then the Medicaid member will reimburse Rocky Mountain for the continued care costs from the effective date of the original Action until the date of the ruling of the ALJ. If the decision is reversed by Rocky Mountain or the ALJ and the member received services under dispute then Rocky Mountain will pay for those services.</p> <p>If Rocky Mountain or the ALJ reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Rocky Mountain will authorize or provide the disputed services promptly, and as expeditiously as the member’s health condition requires. (See bookmark “Req24”)</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The CM Grievances and Appeals process included the provision for continuation of previously authorized services during the appeal or the State fair hearing and contained the correct information regarding the effectuation of the appeal resolution provisions.</p>		
<p>Required Actions: None.</p>		



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Standard VI—Grievance System		
Requirement	Evidence as Submitted by Health Plan	Score
<p>25. The Contractor maintains records of all grievances and appeals and submits quarterly reports to the Department.</p> <p align="right"><i>42CFR438.416</i> <i>State Rule: 8.209.3.C</i></p>	<p>CM Process 7 2 11 Medicaid Complaints and Grievances.doc</p> <p>Please see bookmark “Req25” heading “APPEAL DETERMINATION TRACKING AND PROCEDURE MONITORING</p> <p>A. All Appeals and Grievances are documented and tracked with regard to the substance, investigation, and research in the Member Appeals and Customer Service Departments. This includes verbal and written Appeals and Grievances.</p> <p>B. Rocky Mountain will perform a quarterly review of all Appeals and will submit an analysis to HCPF in accordance with Exhibit F- “Complaints and Appeals Process-Contractor Reporting Tool.” This analysis will include the identification of trends and proposed resolution to correct issues that are raised by analysis of Appeals.</p> <p>C. Rocky Mountain will perform a quarterly chart audit of Medicaid Appeals and an analysis of this chart audit will be submitted as prescribed by HCPF. The audit will be used to assess if the Appeals were processed appropriately with regards to review by a Rocky Mountain Medical Director if required, if the appropriate timeframes were met, and list any trends. Trends will be evaluated with appropriate follow-up.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CM Grievances and Appeals process described sending quarterly grievance and appeals reports to the Department. During the on-site interview, RMHP staff described the use of the grievance and appeals database for tracking timelines and producing quarterly reports as required by the Department.</p>		
<p>Required Actions: None.</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>26. The Contractor must provide the information about the grievance system specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. The information includes:</p> <ul style="list-style-type: none"> ◆ The member’s right to file grievances and appeals. <ul style="list-style-type: none"> ● The requirements and time frames for filing grievances and appeals. ◆ The right to a State fair hearing: <ul style="list-style-type: none"> ● The method for obtaining a State fair hearing. ● The rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing processes. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: <ul style="list-style-type: none"> ● Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. ● If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The member’s right to have a provider file a grievance or an appeal on behalf of the member, with the member’s written consent. <p align="right"><i>42CFR438.414</i> <i>State Rule: 8.209.3.B</i></p>	<p>Provider Manual See Appeal and Grievance Process bookmark VI. 13. P.48.</p> <p>The entire process as represented in this requirement is captured in the Provider Manual Appeal and Grievance section.</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The provider manual included detailed information about the grievance system and RMHP’s processes, except to notify the provider of the rules that govern representation at the State fair hearing. While the section of the provider manual specific to Medicaid appeals included accurate filing time frames, page 39 of the manual stated that Medicaid appeals must be initiated within 20 days of the denial decision.</p>		



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Required Actions:		
RMHP must include in its provider materials the rules that govern representation at the State fair hearing. At a minimum, these include the fact that the member may represent himself/herself or may be represented by another individual. HSAG also recommends that RMHP inform members that they may present evidence of fact or law and may examine the case file. RMHP must also revise the provider manual to ensure that the 30 days filing time frame for filing appears consistently in the manual.		

Results for Standard VI—Grievance System					
Total	Met	=	<u>19</u>	X	1.00 = <u>19</u>
	Partially Met	=	<u>7</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>26</u>	Total Score	= <u>19</u>

Total Score ÷ Total Applicable		=	<u>73%</u>
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Appendix A. Colorado Department of Health Care Policy & Financing
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Standard VII—Provider Participation and Program Integrity		
Requirement	Evidence as Submitted by Health Plan	Score
<p>1. The Contractor has written policies and procedures for the selection and retention of providers.</p> <p>The Contractor has adopted NCQA credentialing and recredentialing standards and guidelines for provider selection.</p> <p align="right"><i>42CFR438.214(a)</i> <i>DH Contract: II.F.1.a and c</i> <i>RMHP Contract: II.G.1.a and c</i></p>	<p>QI VII 1. Provider Selection Retention Policies</p> <p>In addition to the QI Policies linked above, below are template agreements with Credentialing and Recredentialing standards incorporated in them.</p> <p>Hospital Services Agreement See bookmark VII.6.</p> <p>Physician Medical Services Agreement See bookmark Standard 7 #6</p> <p>Professional Services Agreement See bookmark VII.6.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings:</p> <p>The Credentialing Criteria and Process policy outlined the procedures and criteria for determining provider qualification for participation in the RMHP network. The policy included the roles of the Board of Directors (BOD) and the RMHP medical director and Medical Practice Review Committee (MPRC). Credentialing criteria were based on NCQA standards. The credentialing process included primary source verification of licensing, hospital privileges, DEA certification, training and board certification, liability insurance, work history, malpractice history, and sanctions. The Recredentialing policy stated that practitioners are recredentialed every 36 months, which includes all criteria of initial credentialing in addition to review of member complaints, quality management data, member satisfaction data, and medical record reviews. The Mid-Cycle Credentialing policy stated that credentialing staff screen providers against the OIG database, the Colorado Board of Medical Examiners database, and the Council for Affordable Quality Healthcare database, and conduct monthly internal quality of care reviews. The Delegated Credentialing/Reccredentialing policy stated that the primary source verification process may be delegated to qualified entities and described the pre-delegation evaluation and audit of delegated activities. Staff reported that credentialing activities were delegated to Montrose Community Health Plan in a part of RMHP’s service area.</p> <p>Numerous other credentialing policies addressed procedures for office site visit audits, accessing the National Practitioner Data Bank, annual revision of policies, credentialing committee functions, and credentialing of health delivery organizations. The Physician Medical Services Agreement and the Professional Services Agreement required the contracted providers to possess unrestricted professional licensure, to be certified participants in Title XVIII, and not be prohibited from participation in federal and State health care programs. The Hospital Services Agreement required that the hospital use credentialing requirements and standards as stringent as RMHP’s procedures.</p>		
<p>Required Actions:</p> <p>None.</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>2. The Contractor monitors covered services rendered by subcontract providers for:</p> <ul style="list-style-type: none"> ◆ Quality. ◆ Appropriateness. ◆ Patient outcomes. ◆ Compliance with: <ul style="list-style-type: none"> • Medical record requirements. • Reporting requirements. • Applicable provisions of the Contractor’s contract with the Department. <p align="right"><i>DH Contract: II.F.12</i> <i>RMHP Contract: II.G.11</i></p>	<p>QI VII 2_QI Program Description 2011_2012</p> <p>At RMHP, we take a number of approaches to monitor our providers for quality, appropriateness, patient outcomes, compliance with medical record requirements, and compliance with reporting requirements as well as applicable provisions of our contract with the Department when pertinent. Attached is our Quality Improvement Program Description which summarizes our corporate approach to ongoing review of the quality of health care services provided to our members. Various sections of this program description have been bookmarked to highlight the activities we use to monitor our providers to ensure compliance with our contract with the Department.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The RMHP 2011/2012 QI Program Description defined the structure and role of multiple Medical Practice Review Committees (MPRC) that function throughout the RMHP service area. The program description stated that the role of the MPRCs is to carry out specified quality management activities on a local level, which included physician office and medical record evaluations, same or similar physician review for UM determinations, investigation of complaints and quality of care concerns, and review and recommendations related to credentialing applications. The program description indicated that the RMHP medical directors direct the activities of the MPRCs and report recommendations to the RMHP Board of Directors (BOD). The program description stated that MPRCs review provider practices specifically through peer review of adverse events and UM review for appropriateness of care. The program description stated that on-site medical record reviews would be based on the trended patterns of ongoing clinical quality monitors and would review for the composition of medical records related to standards. The MPRCs may recommend corrective actions which could consist of education, follow-up monitoring, possible clinical restrictions, or contract termination. A sample set of MPRC minutes demonstrated committee review of detailed case information on individual quality of care reviews with conclusions and follow-up actions, review of provider chart review audit reports with conclusions, and actions taken on credentialing/recredentialing provider applications. Annual QI Committee minutes included quarterly reporting of outcomes of QI-related activities throughout the organization and review and approval of QI policies and procedures and work plans.</p> <p>The physician, hospital, and professional service agreements specified that each physician must maintain medical records meeting the documentation requirements of the Medicaid contract, and that records would be reviewed by RMHP to determine compliance with requirements, to assess quality of care or to determine medical necessity. During the on-site review, RMHP staff provided an overview of the medical record audit tool and a summary report of results from a physician practice review for compliance with the comprehensive medical records standards.</p>		
<p>Required Actions: None.</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>3. The Contractor’s provider selection policies and procedures include provisions that the Contractor does not:</p> <ul style="list-style-type: none"> ◆ Discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. ◆ Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. <p align="right"> <i>42CFR438.12(a)(1) and (2)</i> <i>42CFR438.214(c)</i> <i>DH Contract: II.F.1.f, II.F.11</i> <i>RMHP Contract: II.G.1.f, II.G.10</i> </p>	<p>QI VII 3. Provider Selection Non-Discrimination Policy</p> <p>Please see the non-discrimination clauses in each of the three template contracts as bookmarked below.</p> <p>Hospital Services Agreement See bookmark VII.3</p> <p>Physician Medical Services Agreement See bookmark Standard 7 #3</p> <p>Professional Services Agreement See bookmark VII.3.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The RMHP Provider Manual included a statement that RMHP does not discriminate based on “race, ethnicity, gender, age, sexual orientation, business category or type of procedures the practitioner specializes in.” The Non-Discriminatory Credentialing policy defined the procedure for reviewing all credentialing denials or terminations to assure that there was no discrimination in provider credentialing based on race, ethnicity, gender, age, sexual orientation, business category, or providers who serve high-risk populations or specialize in treatment of high-cost conditions.</p>		
<p>Required Actions: None.</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>4. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider’s patient, for the following:</p> <ul style="list-style-type: none"> ◆ The member’s health status, medical care or treatment options, including any alternative treatments that may be self-administered. ◆ Any information the member needs in order to decide among all relevant treatment options. ◆ The risks, benefits, and consequences of treatment or non-treatment. ◆ The member’s right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. <p align="right"> <i>42CFR438.102(a) DH Contract: IV.C.7 RMHP Contract: IV.B.10</i> </p>	<p>Hospital Services Agreement See bookmark VII.4 Para. T “Expressing Disagreement”</p> <p>Physician Medical Services Agreement See bookmark VII.4 Para. Q “Expressing Disagreement”</p> <p>Professional Services Agreement See bookmark VII.6. Para N, p.10 “Expressing Disagreement”</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The hospital, physician, and professional services agreements all specified that the provider was not prohibited from expressing disagreement with a policy or medical decision (e.g., utilization review) by RMHP and that RMHP encouraged open discussion of appropriate treatment alternatives between providers and members. The agreements also stated that contracted providers must recognize Medicaid recipients’ right to participate in decisions regarding their health care, including the right to refuse treatment and to express preferences about treatment decisions. The Appeals and Grievances section of the provider manual stated that the member, provider or a designated client representative (DCR) may register a complaint or appeal an action.</p> <p>The Medicaid Member Handbook described the member’s right to accept or refuse medical treatment, to participate in making decisions about his or her health care, and to have open discussion with health care providers about appropriate treatment options, regardless of cost or benefit coverage.</p>		
<p>Required Actions: None.</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>5. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover:</p> <ul style="list-style-type: none"> ◆ To the State. ◆ To members before and during enrollment. ◆ To members within 90 days after adopting the policy with respect to any particular service. <p align="right"><i>42CFR438.102(b)</i> <i>DH Contract: NONE</i> <i>RMHP Contract: NONE</i></p>	<p>QI VII 6.PR Initiating Credentialing OIG check.pdf</p> <p>QI VII 6.Provider OIG Monitoring.pdf</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The RMHP Provider Manual, applicable to all lines of business, directed practitioners to notify the member as well as the provider relations representative by telephone or in writing describing an objection to implementing an advance directive on the basis of conscience, if applicable, and that RMHP would request that a new PCP or specialist be assigned to that member. During the on-site interview, RMHP staff stated that RMHP does not object to providing any services on the basis of moral or religious grounds, but that if a contracted provider is known to object to the provision of any services requested or needed by the member, the case management staff will work with the provider and member to transfer the member to either an in-network or out-of-network provider to obtain necessary services. Staff reported that there were no known instances of such provider objections during the review period. HSAG staff recommended that RMHP consider making a policy statement regarding “no objection to providing services on moral or religious rounds” and a procedure that addresses the process of reassigning a member to a new provider if the provider objects to provision of services.</p>		
<p>Required Actions: None.</p>		



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<p>6. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either section 1128 or 1128 A of the Social Security Act. (This requirement also requires a policy.)</p> <p align="right">42CFR438.214(d) <i>DH Contract: (Amendment 3) II.F.5.m</i> <i>RMHP Contract: (Amendment 2) II.G.4.m</i></p>	<p>Compliance Plan Please view bookmark VII. D.</p> <p>Provider K Law Exhibit For providers please see Section III, paragraphs 2, 3, and 9B.</p> <p>QI VII 6 Provider OIG Monitoring</p> <p>QI VII 6 Provider Initialing Credentialing OIG Checklist Template contracts with language addressing exclusion of providers excluded by referenced sections in the Social Security Act.</p> <p>Hospital Services Agreement See bookmark VII.6.</p> <p>Physician Medical Services Agreement See bookmark Standard 7 #6</p> <p>Professional Services Agreement See bookmark VII.6.</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> N/A</p>
<p>Findings: The Physician Medical Services Agreement, Professional Services Agreement, and Hospital Services Agreement stated that the physician, health care professional, or contracted participating physician, respectively, will at all times be certified to participate in Title XVIII of the Social Security Act and not be prohibited from participation in any federal or State health care program. The Exhibit C (Law Exhibit) attachment to all provider services contracts stated that the provider represents that they have not been debarred, suspended or made otherwise ineligible to participate in any federal State health care program, and will not perform in a manner that would result in such actions during the term of the contract. The contract exhibit also stated that the provider will not employ or contract with a person who is debarred, suspended or made otherwise ineligible to participate in any State or federal health care program. The Credentialing Criteria and Process policy and the Recredentialing policy specified that the OIG database is used in the primary source verification process. The Process to Initiate Credentialing policy described that provider network personnel access the OIG database upon receipt of a completed provider application, and that the credentialing process is initiated only if the provider does not appear on the list of providers debarred from participation in federal health care programs. The Mid-cycle Credentialing policy described that the OIG database is screened monthly for information regarding providers excluded from participation in federal health care programs.</p> <p>During the on-site review, RMHP staff provided an example report of monthly screening of all participating providers against the OIG database. Staff described that the QI department manually initiates the automated processing of the provider database in the FACETS data system against the OIG database to identify any matches, which are then referred to provider relations staff to investigate and discontinue provider participation in the network.</p>		
<p>Required Actions: None.</p>		



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<p>7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, or owner (owning 5 percent or more of the Contractor’s equity) who is debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549.</p> <p align="right"><i>42CFR438.610</i> <i>DH Contract: (Amendment 3) II.F.5.m</i> <i>RMHP Contract: (Amendment 2) II.G.4.m</i></p>	<p>Compliance Plan Please view bookmark VII D.</p> <p>Human Resources HR OIG Process Doc Candidate and new Hire Check, (entire document)</p> <p>HR Provider K Law Exhibit For providers please see Section III, paragraphs 2, 3, and 9B. HR Non Provider Law Exhibit For contractors please see paragraphs 6 and 8).</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The RMHP Compliance Plan stated that RMHP will not knowingly engage a person or company that is excluded from participating in federally funded health care programs or government procurement programs, and that current and new RMHP employees, board members, independent contractors, and vendors must be screened against the Office of Inspector General’s List of Excluded Individuals and Entities and the General Services Administration’s List of Parties Excluded from Federal Procurement or Nonprocurement Programs (Lists). The OIG List—Candidate and New Hire Check process stated that RMHP Human Resources is required to check the OIG List of Excluded Individuals/Entities on the OIG Web site prior to hiring or contracting with individuals, entities, or Board Members and to periodically check the OIG Web site for the exclusion status of current employees. During the on-site interview, RMHP staff stated that current employees are screened monthly.</p>		
<p>Required Actions: None.</p>		
<p>8. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.</p> <p align="right"><i>42CFR438.12(a)(1)</i> <i>DH Contract: II.F.11</i> <i>RMHP Contract: II.G.10</i></p>	<p>QI VII 8. Provider Declined-Written Notification 1 of 2.pdf</p> <p>QI VII 8. Provider Declined-Written Notification 2 of 2.pdf</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Reduction, Suspension, or Termination Recredentialing policy described the process for evaluating the quality of medical care and utilization of services by a health care provider upon the application for credentialing or recredentialing. The policy stated that if the Medical Practice Review Committee (MPRC) makes an adverse determination, the MPRC will give written notice to the provider within 20 days of the decision and the notice will include: the reasons for the proposed action, the evidence upon which the proposed action is based, the provider’s right to a hearing, and a description of the hearing</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>process. The Credentialing Criteria and Process policy described the initial credentialing process and stated that a decision to deny the application would be provided by the medical director to the provider within 20 days. HSAG staff recommended that the Credentialing Criteria and Process policy also include the statement that the notice would be in writing and include the reasons for the decision. During the on-site interview, RMHP staff stated that there were no providers denied or terminated from participation in the network during the review period.</p>		
<p>Required Actions: None.</p>		
<p>9. The Contractor’s provider incentive plans meet the following requirements:</p> <ul style="list-style-type: none"> ◆ No specific payment can be made directly or indirectly under a provider incentive plan to a provider as an inducement to reduce or limit medically necessary services furnished to a member. ◆ The Contractor shall disclose to the Department or any member or member’s designated client representative, at the Department’s request, information on any provider incentive plan. ◆ The Contractor shall ensure that agreements containing physician incentives comply with 42 CFR Section 438.6. <p align="right"><i>42CFR438.6(h)</i> <i>DH Contract: II.F.3</i> <i>RMHP: NONE</i></p>	<p>MCPIPA base agreement (1) Executed MCPIPA base agreement from 1-1-08 (Underutilization: paragraph 4.J, page 28 ; Withhold: paragraph 4.B, begins page 24)</p> <p>Amendment to MCPIPA base agreement (2) Executed Amendment to MCPIPA base agreement from 11-10(attached to show most recent compensation, and current withhold language)</p> <p>Delta PHO base agreement (3) Executed Delta PHO base agreement from 08-07 (Underutilization: paragraph 4.J, page 12 ; Withhold: Exhibit B in its entirety and Exhibit C, paragraph 2)</p> <p>Executed Amendment to Delta PHO base (4) Executed Amendment to Delta PHO base agreement from 07-11 (attached to show most recent compensation, and current withhold language on Exhibit C)</p> <p>Executed Montrose PHO's new base agreement (5) Executed Montrose PHO's new base agreement, effective 1/1/12 (Underutilization: paragraph 4.L, page 14 ; Withhold: Exhibit B in its entirety and Exhibit C, paragraph 2)</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by Health Plan	Score
	<p>Template PMSA T PMSA exhibit A T PMSA exhibit B T PMSA exhibit C (6) Template PMSA and exhibits A, B and C thereto (Underutilization: paragraph 2.S, page 10 of base agreement; Withhold: Exhibit A, paragraph 3)</p> <p>42 CFR 422.208 (per 42CFR 438.6.(h)) (7) The CFR addressing Physician Incentive Plans</p> <p>-The reference in all of the above contracts to the language that addresses the prohibition against payments that "directly or indirectly" induce reductions or limitations on Medically Necessary services can be found above in the first paragraph/page shown directly after the text describing the document. (for example, in the executed MCPIPA agreement, it is paragraph 4.J, on page 28) The exact language in all the agreements reads as follows (it's just a different paragraph number in the different forms which are attached):</p> <p>"<u>Underutilization</u>. RME does not compensate for denials nor does it offer incentives that encourage denials. Incentives, including compensation for Health Care Services provided to any Covered Person, are not based on the quantity or type of denial decisions rendered. RME advises Contractor of the need for special concern about the risks of underutilization. Under no circumstances shall Contractor withhold the provision of Medically Necessary Health Care Services."</p> <p>The withholds in the Delta, Montrose and Mesa agreements and in the template do not exceed 25%. Consequently, the withhold</p>	



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	arrangements in the agreements attached hereto do not exceed the Risk Threshold. The definition of Risk Threshold from the CFR422.208: <i>Risk threshold</i> means the maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. This is set at 25 percent risk.)	
<p>Findings: The Physician Medical Services Agreement template and executed contracts with Montrose, Delta, and Mesa provider groups stated that RMHP does not compensate for denials or offer incentives or compensation based on the quantity or type of denial decisions rendered. The contracts stated that, under no circumstances, shall the provider withhold the provision of medically necessary services. The current provider contracts described withhold amounts from Medicaid allowable charges of 15 percent for the Contingency Reserve Account, which is in compliance with the maximum risk threshold (25 percent) defined in 42CFR 438.6.(h).</p>		
<p>Required Actions: None.</p>		
10. The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: <ul style="list-style-type: none"> ◆ Written policies and procedures and standards of conduct that articulate the Contractor’s commitment to comply with all applicable federal and State standards. ◆ The designation of a compliance officer and a compliance committee that are accountable to senior management. ◆ Effective training and education for the compliance officer and the Contractor’s existing and new employees for reporting violations. ◆ Effective lines of communication between the compliance officer and the Contractor’s employees. ◆ Enforcement of standards through well-publicized disciplinary guidelines. 	Generally see attached Fraud Waste and Abuse procedures: Compliance Plan <u>Bullet One:</u> See Compliance Plan bookmarks III.A, IV. and V.A. (see training also) <u>Bullet Two:</u> Compliance Plan bookmark VI.B. <u>Bullet Three:</u> Compliance Plan bookmark XIII. Internal Audit Department (entire document) Internal Audit Fraud Training Internal Audit Combined Training <u>Bullet Four:</u> See Compliance Plan, bookmark VI. and X. Internal Audit Dept.	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<ul style="list-style-type: none"> ◆ Provisions for internal monitoring and auditing. ◆ Provisions for prompt response to detected offenses and for development of corrective action initiatives. <p align="center"> <i>42CFR438.608</i> <i>DH Contract: II.F.5</i> <i>RMHP Contract: II.G.4</i> </p>	<p>Referral and Reporting</p> <p><u>Bullet Five:</u> See Compliance Plan, bookmarks V.A and V.B. and XII Human Resources</p> <p>Employee Acknowledgement of Compliance Plan Review</p> <p>Internal Audit</p> <p>Disciplinary Guidelines</p> <p><u>Bullet Six:</u> See Compliance Plan, bookmark IX</p> <p>Internal Audit Dept Internal Auditing and Monitoring (entire document)</p> <p><u>Bullet Seven:</u> See Compliance Plan bookmark X and XI. Internal Audit Department</p> <p>Fraud Process</p>	
<p>Findings:</p> <p>The RMHP Compliance Plan incorporated a code of conduct, and outlined corporate standards related to complying with applicable laws and regulations, avoiding conflicts of interest, maintaining confidentiality, and conducting business with honesty and integrity. The plan stated that the compliance officer (CO) directs compliance activities and reports to the CEO and the Finance and Executive Committees of the Board of Directors. The compliance plan defined the role and duties of the Compliance Committee. The Compliance Committee meeting minutes and Board of Director meeting minutes for June 2011 demonstrated review and approval of the 2011 compliance plan. During the on-site interview, RMHP staff confirmed that the designated compliance officer was the RMHP vice president of legal and government affairs. The provider manual described RMHP’s intent to comply with federal and State laws related to fraud and abuse, described fraud and abuse and the False Claims Act, and listed the contact number for the fraud auditor for provider reporting of suspected fraud and abuse. A sample quarterly member newsletter contained an article which informed members of how to report any fraud, waste, or abuse concerns to RMHP. The RMHP member Web site included an Insurance Fraud Frequently Asked Questions section which included contact information for reporting suspected fraud.</p> <p>RMHP had several Fraud and Abuse Deterrence Program policies and procedures, which articulated RMHP’s commitment to comply with federal and State standards applicable to fraud and abuse detection and prevention. The Fraud and Abuse Deterrence (FAD) Program Policy and Procedure for Training and</p>		



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	<p>Education stated that the fraud investigator (FI), responsible for FAD procedures and training, must have and maintain proper fraud and abuse training and credentials, including continuing education. The compliance plan stated that employee training takes place during employee orientation and includes distribution of the compliance plan. The Employee Acknowledgement of Receipt form was used for the employee to attest that he or she had received a copy of the Summary compliance plan and understood the responsibilities outlined in the plan. The compliance plan described ongoing training through the online Fraud and Abuse Awareness PowerPoint presentation, containing a more in-depth focus on high-risk areas. The RMHP Web site, employee handbook, provider manual, and member and provider newsletters were additional vehicles for communicating the FWA Compliance Plan. Staff members also confirmed that ongoing employee training regarding fraud and abuse policies was conducted annually during “Compliance Week,” which consisted of a daily focus on specific fraud and abuse topics to raise the level of employee awareness, as well as required completion of online training through the Fraud and Abuse Awareness PowerPoint presentation.</p> <p>The Compliance plan stated that RMHP maintains open lines of communication between the CO and employees and protects employees against retribution (except in the case of false accusations). In addition, the plan stated that RMHP maintains an anonymous hotline for reporting, encourages direct confidential reporting through the vice-chairman of the BOD, and communicates program information and reporting channels through the provider and employee newsletters. Disciplinary guidelines were communicated through the employee handbook and fraud and abuse training, which included corrective action and possible termination. The Fraud and Abuse Deterrence Program Policy and Procedure for Disciplinary Guidelines stated the fraud investigator would work with Human Resources and other departments to define disciplinary guidelines and incorporate guidelines into Fraud and Abuse training. The Fraud and Abuse Deterrence Program Policy and Procedures for Referrals and Reporting outlined the responsibility of the RMHP fraud investigator for reporting cases of fraud and abuse to appropriate agencies, which were listed.</p> <p>The Compliance plan stated that RMHP performs an annual risk analysis and conducts both routine and random focused audits of records, policies and procedures, and other documents. The plan stated that the Internal Auditing Department and the fraud investigator are responsible for prompt investigation and documentation of potential problems, for conducting routine audits to detect potential problems, and for reporting results to the Fraud and Abuse Deterrent Committee (FADC) for recommended actions. The plan also stated that the CO assures reporting to the compliance committee, the CEO, the BOD Executive Committee, and to appropriate authorities. During the on-site review, RMHP staff did not provide requested evidence of having completed internal audits as outlined in the Fraud and Abuse Deterrence Program Policy and Procedure for Internal Monitoring and Auditing and stated that there had been none conducted during the review period. Staff also stated that the Fraud and Abuse Deterrence Committee did not keep meeting minutes.</p>	
	<p>Required Actions: RMHP should evaluate its policy that addresses internal auditing and monitoring for identification of potential fraud and abuse and should develop procedures for the threshold and frequency of auditing described in the policy. RMHP should maintain documentation of fraud and abuse deterrent activities, such as audits and fraud and abuse deterrent committee meetings.</p>	



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<p>11. The Contractor’s Compliance program includes the following:</p> <ul style="list-style-type: none"> ◆ Approval of the Compliance plan by the Contractor’s CEO and Compliance Officer. ◆ Submission of the compliance plan to the Department for review. ◆ Provisions for monitoring members for improper prescriptions for controlled substances, inappropriate emergency care, or card-sharing. ◆ Effective processes to screen all provider claims collectively and individually for potential fraud, waste, or abuse. ◆ Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste, and abuse. ◆ Effective mechanisms to identify and report suspected instances of upcoding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided. <ul style="list-style-type: none"> • Effective processes for reporting fraud, which include: <ul style="list-style-type: none"> ○ The Contractor immediately reports indications or suspicions of fraud by giving a verbal report to the Contract Manager. The Contractor shall then investigate its suspicions and submit its written findings to the Contract Manager within three business days of the verbal report. If the investigation is not complete within three business days, the Contractor shall continue to investigate and submit a final report within 15 business days (further extension may be approved by the contract manager). 	<p>Compliance Plan Bullet One - Compliance Plan: bookmarks: I, VI. A and VI. B.</p> <p>Bullet Two- See attached RMHP Compliance Plan</p> <p>Bullet Three Care Management</p> <p>Complex CM ER Program Description This document demonstrates the ongoing efforts of Care Management to address inappropriate ER utilization in a P&P that is still in draft form.</p> <p>Pharmacy Department Pharmacy Lock-in Policy and Procedure (shown as draft as final formatting is not complete)</p> <p>Bullet Four Internal Audit Department</p> <p>FAD P&P Coding</p> <p>Bullet Five - See above linked Compliance Plan, bookmarks IX and X. Internal Audit Department</p> <p>FAD P&P Fraud Process</p> <p>Bullet Six – See linked Compliance Plan bookmarks X and XI. Internal Audit Department</p> <p>FAD Referral and Reporting</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirement	Evidence as Submitted by Health Plan	Score
<ul style="list-style-type: none"> o The Contractor reports known, confirmed intentional incidents of fraud and abuse to the Contract Manager and to the appropriate law enforcement agency, including the Colorado Medicaid Fraud Control Unit. <p align="right"><i>DH Contract: II.F.5 RMHP Contract: II.G.4</i></p>		
<p>Findings: The Compliance Committee meeting minutes and Board of Director minutes for June 2011 documented the attendance of the CO and CEO and presentation and approval of the 2011 compliance plan by the committee. During on-site interviews, RMHP staff stated that the annual compliance plan was not routinely submitted to the Department for review, but would be submitted if requested by the Department. RMHP staff reported that there had been no occurrences of suspected fraud and abuse during the audit period.</p> <p>The draft Controlled Substance Lock-in policy addressed the identification of members with potential inappropriate narcotic use through retrospective claims analysis software or referrals from care management, physicians, or pharmacies and described the “lock-in” program. During the on-site interview, RMHP staff described mechanisms for monitoring poly pharmacy and narcotic use through edits in the prescription drug system and reported that potential fraud cases may also be flagged by pharmacy or care management. Staff also described the “lock-in” program that could compel suspected members to receive services and controlled drugs from one provider and/or one pharmacy.</p> <p>Staff members described inappropriate emergency room use via daily monitoring of ER census and follow-up by case managers. Staff members also described working with a task force of ER physicians, physicians from the independent provider network, and community agencies to identify the root causes of ER overutilization and identify appropriate interventions. RMHP staff also stated that RMHP has waived copays for care at urgent and after-hours facilities to encourage alternatives to emergency room use when not needed. Staff reported that card-sharing may be identified through case management or pharmacy review activities.</p> <p>The RMHP Compliance Plan outlined the use of medical claims software to apply edits to claims transactions, third party software for monthly screening of the claims database, audits of hospital bills, and review of drug utilization patterns to identify possible patterns of fraud or abuse. The Fraud and Abuse Deterrence Program Policy and Procedure for Internal Monitoring and Auditing stated that the fraud investigator is responsible for conducting audits to detect potential fraud, which could include upcoding or unbundling charges, services charged but never rendered, fraudulent diagnosis, double billing, excessive prescribing of controlled drugs, fraudulent application submissions, kickbacks, or rebates. The Correct Coding Process for Evaluation and Management Codes (CCP) policy outlined the detailed procedures for post-payment analysis of evaluation and management codes on claims to detect potential upcoding by physicians, and reporting to the Fraud and Abuse Deterrence Committee for corrective action, possible provider termination, or reporting to regulatory authorities as appropriate.</p>		



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<p>The Fraud Process policy outlined the internal procedures for the investigation and documentation of possible fraudulent situations. Procedures included internal reporting of findings to the Fraud and Abuse Deterrent Committee for determination of the “likelihood” that fraud or abuse has occurred, and subsequent reporting of “likely” cases to appropriate regulatory agencies, including the State Medicaid Fraud Control Unit. The Fraud and Abuse Deterrence Program Policy and Procedures for Referrals and Reporting outlined the responsibility of the RMHP fraud investigator to report cases of fraud and abuse to appropriate agencies, including the Colorado Department of Insurance and the Department within 10 business days of receipt of information.</p> <p>RMHP staff reported that there had been no occurrences of suspected fraud or abuse during the review period.</p>		
<p>Required Actions: RMHP must correct its reporting policies and guidelines to be in compliance with the time frames for reporting to the Department as specified in the contract. (RMHP policies incorrectly indicate a 10-days reporting time frame, while the requirement is to report suspicions of fraud immediately, verbally to the contract manager, submitting a preliminary written report within three days, and submitting a final written report 15 days after the initial identification of potential fraud.)</p>		
<p>12. The Contractor’s compliance program includes written policies for employees, requiring all employees to be informed of and detailing compliance with:</p> <ul style="list-style-type: none"> ◆ The False Claims Act 31 USC 3729, et seq. ◆ Administrative remedies for false claims and statements. ◆ State laws relating to civil or criminal penalties for false claims and statements, if any. ◆ Whistleblower protection under such laws. <p align="right"><i>DH Contract: II.F.5</i> <i>RMHP Contract: II.G.4</i></p>	<p>Internal Audit Fraud Training</p> <p>Internal Audit Combined Training</p> <p>Regulatory Affairs Compliance Plan See pages 32-34, 62-63 and 77.</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The RMHP Compliance Plan included numerous references to the importance of employee understanding of the fraud and abuse policies, laws and regulations and the need for initial and ongoing training in fraud and abuse procedures. The Fraud and Abuse Deterrence (FAD) Program Policy and Procedure for Training and Education outlined the process by which RMHP employees would be educated regarding FAD policies and procedures through new employee orientation and periodic refresher courses. The Fraud, Waste, and Abuse online PowerPoint presentation for employees included the definition of fraud and abuse, the background of fraud and abuse concerns, and examples of fraud and abuse. The presentation also included instructions on how to report suspicions and a description of related regulations, such as False Claims Act, Whistleblower Protection, HIPAA, the Anti-Kickback Statute, and the Medicare Prescription Drug Program. The Employee Acknowledgement of Receipt form, signed annually, certified that the employee had received and understood the compliance information.</p>		
<p>Required Actions: None.</p>		



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Requirement	Evidence as Submitted by Health Plan	Score
<p>13. The Contractor provides that Medicaid members are not held liable for:</p> <ul style="list-style-type: none"> ◆ The Contractor’s debts in the event of the Contractor’s insolvency. ◆ Covered services provided to the member for which the State does not pay the Contractor. ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contract, referral, or other arrangement. ◆ Payments for covered services furnished under a contractual, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. <p align="right"><i>42CFR438.106</i> <i>DH Contract: VI.DD</i> <i>RMHP Contract: VI.EE</i></p>	<p>Template contracts with language addressing that no Medicaid member is held liable in these Act.</p> <p>Hospital Services Agreement See bookmark VII.6.</p> <p>Physician Medical Services Agreement See bookmark Standard 7 #6</p> <p>Professional Services Agreement See bookmark VII.6.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The physician, professional, and hospital services agreements stated that in no event will the provider seek payment from the member or member representative for the provision of covered services, with the exception of collecting allowed copayments. The agreements specifically stated that Medicaid recipients would not be held financially liable in any of the specific circumstances outlined above. The RMHP Provider Manual stated that providers may choose to collect appropriate copays from Medicaid recipients at the time of service, specifically listed types of patients in which no copayment is required, and stated that services may not be denied if the member is unable to make the copayment.</p> <p>During the on-site interview, RMHP staff stated that providers will occasionally bill or charge members, primarily by mistake of office staff, and that if the member notifies Customer Service, RMHP contacts the provider to remind them of the policy and resolves the issue with the member.</p>		
<p>Required Actions: None.</p>		



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Results for Standard VII—Provider Participation and Program Integrity					
Total	Met	=	<u>11</u>	X	1.00 = <u>11</u>
	Partially Met	=	<u>2</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>13</u>	Total Score	= <u>11</u>

Total Score ÷ Total Applicable		=	<u>85%</u>
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Standard IX—Subcontracts and Delegation		
Requirement	Evidence as Submitted by Health Plan	Score
1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. <i>42CFR438.230(a)(1)</i> <i>Contract: II.G.1</i> <i>RMHP Contract: II.H.1</i>	Standard IX Subcontracts and Delegation\QI IX 1,2. Delegated Cred-Recred Policy.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The Delegated Credentialing/Recredentialing policy and procedure (delegated credentialing policy) described the process for delegation of credentialing activities and stated that RMHP retains the accountability for activities performed under the delegation agreement. The Delegated Credentialing Audit Activities policy described oversight of delegated credentialing. The Delegated Credentialing/Recredentialing policy stated that the review of utilization data, complaints, quality data, and the credentialing decision may not be delegated, and is therefore performed by RMHP. The Delegated Utilization Management policy stated that RMHP will not abdicate responsibility for ensuring that the delegated function is performed according to standards set forth in the RMHP UM policies and procedures and applicable State and federal regulations. The policy also stated that RMHP would be ultimately accountable for the quality of the work performed. RMHP’s review of monitoring completed for each delegate provided evidence of RMHP’s accountability for delegated functions.		
Required Actions: None.		
2. Before any delegation, the Contractor evaluates the prospective subcontractor’s ability to perform the activities to be delegated. <i>42CFR438.230(b)(1)</i> <i>Contract: II.G.1</i> <i>RMHP Contract: II.H.1</i>	RMHP did not enter into any new Delegated Credentialing arrangements in the Medicaid service area in the audit period. The documents below cover the pre-delegation evaluation policies and tools utilized in the event we had. Standard IX Subcontracts and Delegation\QI IX 1,2. Delegated Cred-Recred Policy.pdf Standard IX Subcontracts and Delegation\QI IX 2,3,4. Delegated Cred-Recred Audit Activities.pdf Standard IX Subcontracts and Delegation\QI IX 2. Predelegation Eval Cover Memo.pdf Standard IX Subcontracts and Delegation\QI IX 2. Predelegation Evaluation Tool.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Standard IX—Subcontracts and Delegation		
Requirement	Evidence as Submitted by Health Plan	Score
<p>Findings: The Delegated Credentialing/Recredentialing policy included the procedures to perform predelegation review for potential credentialing delegates. The Delegated Credentialing Audit Activities policy/procedure (delegated credentialing audit policy) stated that predelegation review activities included review of the potential delegate’s credentialing policies and procedures and a file audit of 10 credentialing and 10 recredentialing files. The Predelegation Audit Tool (credentialing) and template cover letter demonstrated RMHP’s mechanism for predelegation assessment of potential credentialing delegates. The Delegated Utilization Management policy included the processes for predelegation assessment of potential UM delegates that would include a desk audit of documents to determine the delegate’s capacity to perform the specified UM activities. During the on-site interview, RMHP staff described the predelegation assessment performed prior to entering into a delegation agreement with CareCore in 2010 for specified UM activities. Staff stated that CareCore submitted UM policies and procedures for RMHP’s review, and that RMHP performed a chart audit on a sample of charts.</p>		
<p>Required Actions: None.</p>		
<p>3. The Contractor has written policies and procedures for the monitoring of subcontractor performance, monitors the subcontractor’s performance on an ongoing basis, and subjects it to a formal review according to a periodic schedule established by the State, consistent with industry standard.</p> <p align="right"><i>42CFR438.230(b)(3)</i> <i>Contract: II.G.3</i> <i>RMHP Contract: II.H.3</i></p>	<p>The RMHP policy and procedures for this standard as well as the outcomes of our oversight for the one delegated credentialing subcontract in our Medicaid service area are provided below.</p> <p>Standard IX Subcontracts and Delegation\QI IX 2,3,4. Delegated Cred-Recred Audit Activities.pdf</p> <p>Standard IX Subcontracts and Delegation\QI IX 3. 2011 Del Cred Oversight Audit Summary Letter Montrose.pdf</p> <p>Standard IX Subcontracts and Delegation\QI IX 3. 2011 Del Cred Oversight Audit Tool Montrose.pdf</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The Delegated Credentialing Audit Activities policy stated that prior to annual renewal of the delegation agreement, an audit is performed that includes a review of the delegate’s credentialing policies and procedures and a file audit of 10 credentialing and 10 recredentialing files. The Montrose Community Health Plan (Montrose CHP) Delegation Agreement stated that quarterly reports must be submitted, which must include details regarding credentialing activities completed, actions taken, audits conducted, quality measures, and a provider roster. The Montrose Memorial Hospital Audit Summary letter and completed Audit tool included results of the annual audit for Montrose Memorial Hospital’s (dba Montrose CHP’s) credentialing program in October 2011. RMHP provided examples of quarterly reports submitted by Montrose PHO, which</p>		



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Standard IX—Subcontracts and Delegation		
Requirement	Evidence as Submitted by Health Plan	Score
included information or fields for including all of the required information. During the on-site interview, RMHP stated that the credentialing department staff members reviewed reports submitted throughout the review period for content and completeness.		
The Delegated Utilization Management policy stated that the delegated entity must submit reports regarding the delegated activity to RMHP at least quarterly. The policy also stated that an on-site or desk audit of the delegated UM activities would be completed annually. The CareCore Specialty Benefit Management Services Agreement (CareCore Agreement) specified the required reporting and indicated that RMHP would review CareCore policies and procedures and CareCore’s UM program description. RMHP submitted Joint Operating Committee (JOC) meeting minutes for 2011 as evidence that the RMHP management and CareCore jointly reviewed the required reports that were submitted. Staff members reported that quarterly reports reviewed during the 2011 JOC meetings included utilization data reports, review of overturned cases, status reports, and turnaround time reports. Staff also reported that 2011 annual (formal) review included a review of CareCore’s UM policies and procedures, an audit of charts, and verification of continued NCQA accreditation. Staff also stated that a copy of the NCQA accreditation would be obtained when renewal has occurred (three-year intervals).		
The Express Scripts Prescription Drug Program Agreement required Express Scripts to maintain a data warehouse with real-time pharmacy benefit management (PBM) information. RMHP staff members reported that during the review period, RMHP monitored PBM activity by accessing the data warehouse, as often as weekly. RMHP staff members also described weekly meetings between RMHP and Express Scripts that occurred during the review period. Staff members reported that discussion topics included benefits and operational issues. RMHP provided minutes of those meetings with action plan logs for follow-up related to the discussions that occurred.		
Required Actions: None.		



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Standard IX—Subcontracts and Delegation		
Requirement	Evidence as Submitted by Health Plan	Score
<p>4. If the Contractor identifies deficiencies or areas for improvement in the subcontractor’s performance the Contractor and the subcontractor take corrective action.</p> <p align="center"><i>42CFR438.230(b)(4)</i> <i>Contract: II.G.4</i> <i>RMHP Contract: II.H.4</i></p>	<p>Standard IX Subcontracts and Delegation\QI IX 2,3,4. Delegated Cred-Recred Audit Activities.pdf</p> <p>No deficiencies were identified as part of the annual oversight audits performed for the one delegated credentialing subcontract in our Medicaid service area. The RMHP policy and procedures for performing oversight of delegated credentialing subcontracts is attached.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Delegated Credentialing Audit Activities policy stated that audit findings will be presented to the delegate organization with recommendations for changes with a deadline for completion. The policy also stated that the RMHP chief medical officer may be involved with input to suggested actions or consultation regarding the organization’s responses. The Delegated UM policy stated that if the delegated entity for UM did not meet the terms of the contractual agreement or deficiencies were noted through audit activities, RMHP and the delegated entity would develop an action plan to improve performance or correct deficiencies.</p> <p>While there were no deficiencies noted through 2011 monitoring activities of Montrose CHP, RMHP provided documentation of requests and follow-up regarding corrective actions for another credentialing delegate, which was applicable to a different line of business for RMHP. This provided evidence of RMHP having implemented processes for corrective actions related to delegated credentialing activities. During the interview, RMHP staff members reported that during the 2011 RMHP/CareCore JOC meetings, a potential issue was identified with the number and trend of overturned denials for advanced imaging requests. Staff reported that as a result, the JOC began reviewing overturned cases during the JOCs with follow-up as indicated. Express Scripts/RMHP JOC meeting minutes with action plan logs provided evidence of follow-up on issues that arose during 2011 for pharmacy benefit management.</p>		
<p>Required Actions: None.</p>		



Appendix A. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Compliance Monitoring Tool
for Rocky Mountain Health Plans

Standard IX—Subcontracts and Delegation		
Requirement	Evidence as Submitted by Health Plan	Score
5. There is a written agreement with each delegate. <i>42CFR438.230(b)(2)</i> <i>Contract: II.G.2</i> <i>RMHP Contract: II.H.2</i>	Standard IX Subcontracts and Delegation\QI IX 5,6. Del Cred Agreement 1 of 2.PDF Standard IX Subcontracts and Delegation\QI IX 5,6. Del Cred Agreement 2 of 2.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: RMHP provided a signed provider agreement between Montrose Community Health Plan and RMHP and a signed delegation agreement between Montrose Community Health Plan and RMHP, as well as signed delegation agreements between RMHP and the following organizations that were applicable to RMHP’s Medicaid population: <ul style="list-style-type: none"> ◆ Express Scripts—Pharmacy benefits management ◆ CareCore—Authorization of advanced imaging services 		
Required Actions: None.		
6. The written delegation agreement: <ul style="list-style-type: none"> ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor’s performance is inadequate. ◆ Provides for access to all records by the Secretary of the U.S. Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. <i>42CFR438.230(b)(2)</i> <i>Contract: II.G.2, II.G.7</i> <i>RMHP Contract: II.H.2, II.H.7</i>	Standard IX Subcontracts and Delegation\QI IX 5,6. Del Cred Agreement 1 of 2.PDF Standard IX Subcontracts and Delegation\QI IX 5,6. Del Cred Agreement 2 of 2.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The Montrose Community Health Plan Delegation Agreement specified activities and reporting responsibilities and included a provision for revocation of the agreement for noncompliance with the terms. The Physician Hospital Organization Services Agreement between Montrose Community Health Plan, Inc., and RMHP included the provision to allow access to records in compliance with 45CFR Part 74. The delegation agreements with Express Scripts and CareCore included all of the required provisions.		
Required Actions: None.		



Appendix A. **Colorado Department of Health Care Policy & Financing**
FY 2011–2012 Compliance Monitoring Tool
for Rocky Mountain Health Plans

Results for Standard IX—Subcontracts and Delegation					
Total	Met	=	<u>6</u>	X	1.00 = <u>6</u>
	Partially Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>6</u>	Total Score	= <u>6</u>

Total Score ÷ Total Applicable	=	<u>100%</u>
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Appendix B. **Appeals Record Review Tool**
for Rocky Mountain Health Plans

The completed record review tool follows this cover page.



Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Rocky Mountain Health Plans

Review Period:	January 1, 2011–December 31, 2011
Date of Review:	January 24, 2012–January 27, 2012
Reviewer:	Barbara McConnell
Participating Health Plan Staff Member:	Carolyn Bentley

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknowledgment Letter	Acknowledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
1	*****	2/18/11	2/18/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> U <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	2/18/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: The member was sent a claims denial letter with the reason code of no preauthorization. The member initially contacted RMHP on 1/19/11. Upon review of file, the issue was actually a medical necessity issue. The appeal could not be processed as a claims dispute with the provider's office. RMHP requested a signed DCR, which the member sent on 2/18/11. RMHP did not provide information regarding the change of determination that the reason was medical necessity instead of no authorization, and who made that decision. The denial was overturned.												
2	*****	1/28/11	1/28/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> U <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	3/2/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: Claims denial auto-generated from the system without medical review before sent. Was a denial of particular test performed as part of ER visit, which had been paid. Denying tests required to diagnose an emergency medical condition is out of compliance with 42CFR38.114(d). HSAG recommends medical review before denying the service, if claims as part of a paid ER visit are denied by the claims processing system. Also recommend evaluating/revising edits in the claims processing system. The denial was overturned.												
3	*****	2/17/11	2/18/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> U <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	3/2/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: Claims denial auto-generated from the system without medical review before sent. Was a denial of particular test performed as part of ER visit, which had been paid. Denying tests required to diagnose an emergency medical condition is out of compliance with 42CFR38.114(d). HSAG recommends medical review before denying the service, if claims as part of a paid ER visit are denied by the claims processing system. Also recommend evaluating/revising edits in the claims processing system. The denial was overturned.												
4	*****	2/24/11	2/25/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/> U <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	3/9/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/>
Comments: Dr. D.S. signed the notice of action and made the appeal resolution decision. The reason for the decision in the appeal resolution letter was unclear and only referred to attached pages of the member handbook. The attached pages were the benefit list. Members would not clearly understand the interpretation of why the request could not be considered part of the benefit package. RMHP must describe the reason in a more understandable manner. This was a DME request and the denial was upheld.												
5	*****	3/9/11	3/10/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> U <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	3/22/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: Claims denial auto-generated from the system for out-of-network provider. Upon appeal, review was a dual eligible situation and the denial was overturned. Recommend evaluation/revision of system edits to identify dual eligible members before the denial.												
6	*****	3/17/11	3/18/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> U <input checked="" type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>		M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: Claims denial auto-generated from the system for ambulance transportation. At denial was determined to be routine transportation; upon appeal, review was determined to be emergency transportation and the denial was overturned. Unclear what level of clinical staff originally determined to be routine. NOA letter signature space was generic with no actual signature. Although the reason "not covered under your plan" in the claims denial was true if the assumption that the ambulance was used for non-emergency transportation, the decision was a decision of medical necessity. Recommend medical review for emergency claim denials, if assumptions were made for processing.												



Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Rocky Mountain Health Plans

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknowledgment Letter	Acknowledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
7	*****	3/29/11	3/30/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> U <input checked="" type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	3/30/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input checked="" type="checkbox"/>

Comments: Claims denial of ambulance services. The original denial stated as a reason in the front of the letter, “not a Medicaid covered service.” On the second page of the denial, the reason stated, “bill auto insurance.” The appeal resolution letter upheld the denial and stated that the reason was, “because the ambulance company was a volunteer company, which is prohibited by the State.” The letter also stated that the member must pay the provider. This is not a situation under which the member may be held responsible for the cost of the services.

8	*****	4/12/11	4/14/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	4/25/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
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Comments: Claims denial of ambulance services, overturned on appeal. HSAG recommends medical review of emergency claims denials before they go to appeal.

9	*****	4/26/11	4/27/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input type="checkbox"/> N <input type="checkbox"/> U <input checked="" type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	5/9/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
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Comments: Claims denial. RMHP staff were unable to find the original denial. It was unclear what service was denied.

10	*****	5/23/11	5/24/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	6/6/11	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>	M <input checked="" type="checkbox"/> N <input type="checkbox"/>
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Comments: Denial of Chantix, for non-involvement in treatment. Overturned after member entered treatment.

General Comments: Appeal resolution letter for preauthorization of DME and for claims denials of services already complete or not initially authorized contained continuation of previously authorized services language. The SFH language was contained in the appeal letter that was favorable to the member. To improve readability of the appeal resolution letters, RMHP should revise letters to include only applicable information.

Claims denials contain the general statement, “you will have to pay” and, “this is not a covered service under this plan; you are responsible for paying the provider.” Although RMHP may not be responsible, there were situations in the record review in which the member could not be held liable for the cost of the services. For example, if the service was not a covered service, but the responsibility was with the provider for failing to preauthorize, the member may not be held liable.

There were denials which initially cited one reason for the denial, and the reasons changed with processing the appeal. RMHP should refine its denial codes and revise for accuracy and understandability.

Claims denials contained stated reason codes such as “not covered under your plan”—although the denial involved a clinical decision of how to process the claims.

Three of four emergency-related claims were overturned and, overall, seven of 10 cases were overturned. Given the high percentage of overturned denials, HSAG recommends that RMHP evaluate claims system edits for appropriateness/accuracy and apply medical review to potential claims denials until accuracy of claims denials can be ensured.

# Applicable Elements		10	3	9					10	10	10
# Compliant Elements		10	2	8					10	10	8
Percent Compliant		100%	67%	89%					100%	100%	80%

Note: M = Met, N = Not met, U = Unknown, Y = Yes, N = No

Total # Applicable Elements	52
Total # Compliant Elements	48
Total Percent Compliant	92%

Appendix C. **Site Review Participants**
for Rocky Mountain Health Plans

Table C-1 lists the participants in the FY 2011–2012 site review of **RMHP**.

Table C-1—HSAG Reviewers and Health Plan Participants	
HSAG Review Team	Title
Barbara McConnell, MBA, OTR	Project Director
Katherine Bartilotta, BSN	Project Manager
RMHP Participants	Title
David Klemm	Manager, Government Operations
Steve Nolan	Director, Pharmacy
Jim Quillin	Auditor, Internal Audit Department
Dale Renzi	Director, Provider Network Management
Carriann Connor	Representative, Provider Network Management
Kenny Yeung	Manager, Internal Audit
Jerry Spomer	Director, Internal Audit
Melissa Bashara	Manager, Member Benefit Administration
Michael Luedtke	Staff Attorney
Chantelle Madrid	Supervisor, Customer Service
Nora Foster	Process Analyst, Customer Service
Carol Ann Hendrikse	Manager, Case Management
Lori Stephenson	Director, Quality Improvement
Sandy Dowd	Director, Case Management
Jackie Hudson	Manager, Quality Improvement
Terri Wright	Manager, Quality Improvement
Carolyn Bentley	Supervisor, Member Appeals
Sheila McNeely	Supervisor, Pharmacy Help Desk
Laurel Walters	Chief Operating Officer
Patrick Gordon	Director, Government Programs; Director, CO Beacon Consortium
Nora Foster	Supervisor, Customer Service
Lesley Reeder	Senior Manager, Government Programs
Kele Geisler	Manager, Contract Implementation
Sheila Worth	Analyst, Senior Corporate Management
Mike Huotari (by telephone)	Vice President, Legal and Government Affairs
LeAnna Stortz (by telephone)	Manager, Provider Relations
Department Observers	Title
Russell Kennedy	Quality and Compliance Specialist
Valerie Baker-Easley (by telephone)	Contract Manager

Appendix D. Corrective Action Plan Process for FY 2011–2012 for Rocky Mountain Health Plans

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

Table D-1—Corrective Action Plan Process	
Step 1	Corrective action plans are submitted
	<p>If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting to HSAG and the Department. The health plan will submit the CAP using the template provided.</p> <p>For each of the elements receiving a score of <i>Partially Met</i> or <i>Not Met</i>, 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.</p>
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
	<p>Following review of the CAP, the Department or HSAG will notify the health plan via e-mail whether:</p> <ul style="list-style-type: none"> ◆ The plan has been approved and the health plan should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	Documentation substantiating implementation
	Once the health plan has received Department approval of the corrective action plan, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	Progress reports may be required
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	Documentation substantiating implementation of the plans is reviewed and approved
	<p>Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the health plan must submit additional documentation.</p> <p>The Department or HSAG will inform each health plan in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the health plan into full compliance with all the applicable federal Medicaid managed care regulations and contract requirements.</p>

The template for the CAP follows.

Table D-2—FY 2011–2012 Corrective Action Plan *for* RMHP

Standard V—Member Information		
Requirement	Findings	Required Actions
<p>Requirement 13: The member handbook includes the following information regarding the grievance, appeal, and fair hearing procedures (and includes a complaint form):</p> <ul style="list-style-type: none"> ◆ The right to file grievances and appeals. ◆ The requirements and time frames for filing a grievance or appeal. ◆ The right to a State fair hearing: <ul style="list-style-type: none"> • The method for obtaining a State fair hearing, and • The rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: <ul style="list-style-type: none"> • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing, and the service authorization has not expired. • The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The right that providers may file an appeal on behalf of the member with the member’s written consent. 	<p>During the on-site interview, RMHP staff confirmed that the rules that govern representation at the State fair hearing were not described in the member handbook or other written forms of member communication.</p>	<p>RMHP must inform members of the rules that govern representation at the State fair hearing process, including the right to represent themselves or designate a DCR, the right to present information or evidence, and the right to examine RMHP documentation related to the appeal.</p>
<p>Planned Interventions:</p>		

Table D-2—FY 2011–2012 Corrective Action Plan *for* RMHP

Standard V—Member Information

Person(s)/Committee(s) Responsible and Anticipated Completion Date:

Training Required:

Monitoring and Follow-up Planned:

Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard V—Member Information		
Requirement	Findings	Required Actions
<p>Requirement 20: Member information materials sent following enrollment must also include the poststabilization care services rules at 422.113(c) and include:</p> <ul style="list-style-type: none"> ◆ The Contractor’s financial responsibilities for poststabilization care services obtained within or outside the organization that are pre-approved by a plan provider or other plan representative ◆ The Contractor’s financial responsibilities for poststabilization care services obtained within or outside the organization that are not pre-approved by a plan provider or other plan representative, ◆ That charges to members for poststabilization services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the Contractor. ◆ That the organization’s financial responsibility for poststabilization services it has not approved ends when: <ul style="list-style-type: none"> • A plan physician with privileges at the treating hospital assumes financial responsibility for the member’s care; • A plan physician assumes responsibility for the member’s care through transfer; • A plan representative and the treating physician reach an agreement concerning the member’s care; or • The member is discharged. 	<p>The handbook did not include detailed information on rules for determining when RMHP financial responsibility applies.</p> <p>The Emergency Services Claims Review policy stated that medically necessary poststabilization care would be covered in accordance with the member’s evidence of coverage. During the on-site interview, RMHP staff stated that there is no current written policy or procedure for determining poststabilization financial responsibility as defined in 42 CFR 422.113 (c).</p>	<p>RMHP must address the poststabilization care financial responsibility rules as outlined in 42 CFR 422.113 (c) and make such information available to members. (HSAG staff suggested that an internal policy specifying the payment criteria be developed and that members and providers be informed of how to access the policy.)</p>
<p>Planned Interventions:</p>		

Table D-2—FY 2011–2012 Corrective Action Plan *for* RMHP

Standard V—Member Information

Person(s)/Committee(s) Responsible and Anticipated Completion Date:

Training Required:

Monitoring and Follow-up Planned:

Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VI—Grievance System		
Requirement	Findings	Required Actions
<p>Requirement 9: The Contractor must dispose of each grievance and provide notice of the disposition in writing as expeditiously as the member’s health condition requires, not to exceed 15 working days from the day the health plan receives the grievance.</p>	<p>The CM Grievances and Appeals process included the provision for resolution of grievances within 15 working days of the receipt of the grievance; however, the CS Grievances and Appeals procedure included inaccurate time frames for resolution of grievances, citing 14 calendar days as the time frame. The member handbook accurately informed members of the process to send written notice of resolution to members within 15 working days of receipt of the grievance. In addition, the CS Grievance and Appeals procedure indicated, and RMHP staff members confirmed, that if the grievance is related to quality of care, members do not receive a resolution notice. Staff members cited the protected nature of the peer review process as the reason members do not receive resolution notices.</p>	<p>RMHP must revise its procedures to accurately reflect the grievance resolution time frame as 15 working days. RMHP must also send each member a notice of resolution for all grievances. Per CMS, if the provider has not consented to disclosure, the letter must indicate, minimally, that a complete review was conducted and that information about the provider cannot be given. Other member-focused resolution information should be included such as whether the member has changed providers, or other member-focused activities RMHP has completed from a customer service point of view.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VI—Grievance System		
Requirement	Findings	Required Actions
<p>Requirement 11: Members may file an appeal within 30 calendar days from the date of the notice of action.</p>	<p>The CM Grievances and Appeals process included the provision that members may file an appeal within 30 calendar days of the date of the notice of action. Members were notified of the filing time frame via the member handbook. The notice of action template letter also included the 30-calendar-day filing time frame. As evident in the appeals record review, earlier in the review period, the time frame for filing an appeal was depicted in the preauthorization notices of action as 20 calendar days. The time frame was depicted correctly in later preauthorization notices of action but remained incorrect in the claims denials throughout the claims appeal records reviewed.</p>	<p>RMHP must review claims denial letters and revise, as needed, to ensure accurate reflection of the appeal filing time frame and consistency of compliance with Medicaid managed care regulations among RMHP’s functional departments.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VI—Grievance System		
Requirement	Findings	Required Actions
<p>Requirement 16: The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member’s health condition requires, but not to exceed the following time frames:</p> <ul style="list-style-type: none"> ◆ For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal. ◆ For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. 	<p>The process also included the three-working-day time frame for resolving expedited appeals but indicated that the written resolution notice would occur two calendar days following the decision, which would have occurred within three working days from the date of receipt of the appeal. This time frame is out of compliance with the requirement to provide written notice of expedited resolution within three working days of receipt of the appeal.</p>	<p>RMHP must revise its applicable policies and procedures to accurately reflect that expedited appeals must be decided, with written notice to the member, within three working days from the date RMHP received the appeal.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VI—Grievance System		
Requirement	Findings	Required Actions
<p>Requirement 18: The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who:</p> <ul style="list-style-type: none"> ◆ Were not involved in any previous level of review or decision-making, and who, ◆ Have the appropriate clinical expertise in treating the member’s condition or disease if deciding any of the following: <ul style="list-style-type: none"> • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. 	<p>The CM Grievances and Appeals process stated that every decision to uphold an RMHP action or a grievance regarding the denial of expedited resolution will be evaluated by an RMHP medical director who was not previously involved with the case. In one case reviewed on-site, the physician who decided the appeal was the same as the physician who had signed the original notice of action.</p>	<p>RMHP must ensure that the individuals who make decisions on grievances and appeals are individuals who were not involved in any previous level of review or decision-making.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VI—Grievance System		
Requirement	Findings	Required Actions
<p>Requirement 20: A member need not exhaust the Contractor’s appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action.</p>	<p>The CM Grievances and Appeals process stated that members may request a State fair hearing 30 days following RMHP’s original notice of action or appeal determination, or at any point in the appeal process. The member handbook informed members of the 30-calendar-day filing time frame requesting the State fair hearing. Appeal resolution letters inaccurately stated that members may request a State fair hearing 30 days from the date of the appeal resolution letter.</p>	<p>RMHP must clarify its policies to accurately reflect the time frame for requesting a State fair hearing as 30 calendar days from the notice of action and ensure that appeal resolution letters also accurately reflect the time frame.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VI—Grievance System		
Requirement	Findings	Required Actions
<p>Requirement 22: The Contractor provides for continuation of benefits while the health plan-level appeal and the State fair hearing are pending if:</p> <ul style="list-style-type: none"> ◆ The member or the provider files timely—defined as on or before the later of the following: <ul style="list-style-type: none"> • Within ten days of the Contractor mailing the notice of action. • The intended effective date of the proposed action. ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. 	<p>The CM Grievances and Appeals process described the provisions for continuation of previously authorized services during the appeal or the State fair hearing; however, page 9 of the process included, as content of the appeal resolution letter, the provision that the member may have to pay for services if the State fair hearing decision upheld RMHP’s denial. The stated content did not include the appropriate context that members may have to pay for services following the State fair hearing decision only in cases in which previously authorized services were continued during the State fair hearing, at the member’s request. The Discontinuation of Services for Fraud policy stated that RMHP honors authorizations and does not discontinue services that had been authorized except in cases of fraud. The policy described the exceptions to the 10-day advance notice requirements as stated in 42CFR 431.213 and 431.214. The member handbook described the conditions for requesting continuation of benefits. RMHP’s notice of action letter templates also failed to include the appropriate context that members may have to pay for services only in cases related to the continuation of previously authorized services. Although the member handbook provided this context under the appeal section, it did not under the State fair hearing section. Both the member handbook and the claims denial letters included a stand-alone statement that the member will have to pay for the services received if the member loses</p>	<p>RMHP must revise applicable documents such as notice of action and appeal resolution template letters, claims denial letters, member and provider materials, and policies, procedures, and processes to accurately reflect that members may request the continuation of previously authorized services during the appeal or State fair hearing if:</p> <ul style="list-style-type: none"> ◆ The appeal is filed timely—defined (only for continuing benefits) as within 10 calendar days of the date of the notice of action, or before the intended effective date of the action, whichever is later. ◆ The appeal involves the termination, suspension, or reduction of previously authorized services. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The enrollee requests the extension of services. <p>RMHP documents must also clearly reflect the circumstances under which members may be held liable for the cost of services related to those services that were previously authorized and continued as required in 42CFR438.420. Claims denials must not contain the general statement that members must pay for the services, as the situations under which</p>

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VI—Grievance System		
Requirement	Findings	Required Actions
	<p>the State fair hearing. This statement is particularly inappropriate in claims denial letters, as there are few situations in which Medicaid members may be held responsible for the entire cost of the services. In addition, the member handbook states that for <i>any</i> appeal, the member may receive services during the appeal. Given that RMHP has developed a template notice of action for use specifically in situations related to the termination or reduction of previously authorized services, RMHP should consider removing the applicable language from other notices of action and resolution templates.</p>	<p>members may be held liable for the costs are limited.</p>
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VI—Grievance System		
Requirement	Findings	Required Actions
<p>Requirement 26: The Contractor must provide the information about the grievance system specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. The information includes:</p> <ul style="list-style-type: none"> ◆ The member’s right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. ◆ The right to a State fair hearing: <ul style="list-style-type: none"> • The method for obtaining a State fair hearing. • The rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing processes. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: <ul style="list-style-type: none"> • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. • If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The member’s right to have a provider file a grievance or an appeal on behalf of the member, with the member’s written consent. 	<p>The provider manual included detailed information about the grievance system and RMHP’s processes, except to notify the provider of the rules that govern representation at the State fair hearing. While the section of the provider manual specific to Medicaid appeals included accurate filing time frames, page 39 of the manual stated that Medicaid appeals must be initiated within 20 days of the denial decision.</p>	<p>RMHP must include in its provider materials the rules that govern representation at the State fair hearing. At a minimum, these include the fact that the member may represent himself/herself or may be represented by another individual. HSAG also recommends that RMHP inform members that they may present evidence of fact or law and may examine the case file. RMHP must also revise the provider manual to ensure that the 30 days filing time frame for filing appears consistently in the manual.</p>
<p>Planned Interventions:</p>		
<p>Person(s)/Committee(s) Responsible and Anticipated Completion Date:</p>		

Table D-2—FY 2011–2012 Corrective Action Plan *for* RMHP

Standard VI—Grievance System		
Requirement	Findings	Required Actions
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VII—Provider Participation and Program Integrity

Requirement	Findings	Required Actions
<p>Requirement 10: The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include:</p> <ul style="list-style-type: none"> ◆ Written policies and procedures and standards of conduct that articulate the Contractor’s commitment to comply with all applicable federal and State standards. ◆ The designation of a compliance officer and a compliance committee that are accountable to senior management. ◆ Effective training and education for the compliance officer and the Contractor’s existing and new employees for reporting violations. ◆ Effective lines of communication between the compliance officer and the Contractor’s employees. ◆ Enforcement of standards through well-publicized disciplinary guidelines. ◆ Provisions for internal monitoring and auditing. ◆ Provisions for prompt response to detected offenses and for development of corrective action initiatives. 	<p>During the on-site review, RMHP staff did not provide requested evidence of having completed internal audits as outlined in the Fraud and Abuse Deterrence Program Policy and Procedure for Internal Monitoring and Auditing and stated that there had been none conducted during the review period. Staff also stated that the Fraud and Abuse Deterrence Committee did not keep meeting minutes.</p>	<p>RMHP should evaluate its policy that addresses internal auditing and monitoring for identification of potential fraud and abuse and should develop procedures for the threshold and frequency of auditing described in the policy. RMHP should maintain documentation of fraud and abuse deterrent activities, such as audits and fraud and abuse deterrent committee meetings.</p>
<p>Planned Interventions:</p>		
<p>Person(s)/Committee(s) Responsible and Anticipated Completion Date:</p>		
<p>Training Required:</p>		

Table D-2—FY 2011–2012 Corrective Action Plan *for* RMHP

Standard VII—Provider Participation and Program Integrity

Requirement	Findings	Required Actions
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Monitoring and Follow-up Planned:

Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VII—Provider Participation and Program Integrity

Requirement	Findings	Required Actions
<p>Requirement 11: The Contractor’s Compliance program includes the following:</p> <ul style="list-style-type: none"> ◆ Approval of the Compliance plan by the Contractor’s CEO and Compliance Officer. ◆ Submission of the compliance plan to the Department for review. ◆ Provisions for monitoring members for improper prescriptions for controlled substances, inappropriate emergency care, or card-sharing. ◆ Effective processes to screen all provider claims collectively and individually for potential fraud, waste, or abuse. ◆ Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste, and abuse. ◆ Effective mechanisms to identify and report suspected instances of upcoding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided. <ul style="list-style-type: none"> ● Effective processes for reporting fraud, which include: <ul style="list-style-type: none"> ○ The Contractor immediately reports indications or suspicions of fraud by giving a verbal report to the Contract Manager. The Contractor shall then investigate its suspicions and submit its written findings to the Contract Manager within three business days of the verbal report. If the investigation is not complete within three business days, the Contractor shall continue to investigate 	<p>The Fraud and Abuse Deterrence Program Policy and Procedures for Referrals and Reporting outlined the responsibility of the RMHP fraud investigator to report cases of fraud and abuse to appropriate agencies, including the Colorado Department of Insurance and the Department within 10 business days of receipt of information.</p>	<p>RMHP must correct its reporting policies and guidelines to be in compliance with the time frames for reporting to the Department as specified in the contract. (RMHP policies incorrectly indicate a 10-days reporting time frame, while the requirement is to report suspicions of fraud immediately, verbally to the contract manager, submitting a preliminary written report within three days, and submitting a final written report 15 days after the initial identification of potential fraud.)</p>

Table D-2—FY 2011–2012 Corrective Action Plan for RMHP

Standard VII—Provider Participation and Program Integrity

Requirement	Findings	Required Actions
<p>and submit a final report within 15 business days (further extension may be approved by the contract manager).</p> <ul style="list-style-type: none"> o The Contractor reports known, confirmed intentional incidents of fraud and abuse to the Contract Manager and to the appropriate law enforcement agency, including the Colorado Medicaid Fraud Control Unit. 		

Planned Interventions:

Person(s)/Committee(s) Responsible and Anticipated Completion Date:

Training Required:

Monitoring and Follow-up Planned:

Documents to be Submitted as Evidence of Completion:

Appendix E. Compliance Monitoring Review Activities for Rocky Mountain Health Plans

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS’ final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	Planned for Monitoring Activities
	<p>Before the compliance monitoring review:</p> <ul style="list-style-type: none"> ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the health plan to set the dates of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department’s review and approval of the tool and report template and other review activities. ◆ HSAG staff attended the Medical Quality Improvement Committee (MQUIC) meetings to discuss the FY 2011–2012 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the health plans were prepared for the compliance monitoring review.
Activity 2:	Obtained Background Information From the Department
	<ul style="list-style-type: none"> ◆ HSAG used the BBA Medicaid managed care regulations and the health plan’s Medicaid managed care contract with the Department to develop HSAG’s monitoring tool, on-site agenda, record review tool, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific managed care regulations or contract requirements. ◆ HSAG considered the Department’s responses when determining compliance and analyzing findings.
Activity 3:	Reviewed Documents
	<ul style="list-style-type: none"> ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the desk review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document 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.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
	<ul style="list-style-type: none"> ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	Conducted Interviews
	<ul style="list-style-type: none"> ◆ During the on-site portion of the review, HSAG met with the health plan’s key staff members to obtain a complete picture of the health plan’s compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan’s performance.
Activity 5:	Collected Accessory Information
	<ul style="list-style-type: none"> ◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.) ◆ HSAG reviewed additional documents requested as a result of the on-site interviews.
Activity 6:	Analyzed and Compiled Findings
	<ul style="list-style-type: none"> ◆ Following the on-site portion of the review, HSAG met with health plan staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2011–2012 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions required of the health plan to achieve full compliance with Medicaid managed care regulations and associated contract requirements.
Activity 7:	Reported Results to the Department
	<ul style="list-style-type: none"> ◆ HSAG completed the FY 2011–2012 Site Review Report. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan’s and Department’s comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.