CHP+

Child Health Plan *Plus*

Fiscal Year 2024–2025 Compliance Review Report

for

Rocky Mountain Health Plans

April 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Summary of Results

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

Rocky Mountain Health Plans (RMHP) showed a strong understanding of the federal regulations by achieving a 100 percent score for all standards reviewed. RMHP also scored 100 percent for these standards during the prior review.

Table 1-1 presents the scores for RMHP for each of the standards. Findings for all requirements are summarized in Section 2—Assessment and Findings. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* are included in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%~
IV. Member Rights, Protections, and Confidentiality	5	5	5	0	0	0	100%~
VIII. Credentialing and Recredentialing	32	31	31	0	0	1	100%~
Totals	**47**	**46**	**46**	**0**	**0**	**1**	**100%**

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

^ Indicates that the score increased compared to the previous review year.

v Indicates that the score decreased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	75	75	75	0	0	100%~
Recredentialing	52	52	52	0	0	100%~
Totals	**127**	**127**	**127**	**0**	**0**	**100%**

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

^ Indicates that the score increased compared to the previous review year.

v Indicates that the score decreased compared to the previous review year.

~ Indicates that the score remained unchanged compared to the previous review year.

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

RMHP provided evidence of its care coordination program structure. The care coordination program included a team of registered nurses, behavioral health specialists, social workers, and care coordinators. RMHP described how outreach campaigns were built and resulted in referrals to appropriate services for members. Members in need of care coordination were identified through admission, discharge, and transitions of care transfer alerts; community outreach; new member initial screenings; and referrals. Once a member identified with a need and was enrolled into the care coordination program, RMHP reported that the member received ongoing support, resources, and communications from their assigned care coordinator and care manager.

RMHP described procedures for providing care coordination to members with general and complex needs. RMHP implemented Impact Pro (IPro) in addition to the National Committee for Quality Assurance (NCQA) stratification model. IPro is a predictive risk modeling program used to stratify members based on over 1,000 data markers. For members with special health care needs (SHCN), additional screenings were administered to determine ongoing treatment and monitoring. Once needs were identified, the coordinator developed a care plan that was unique to the CHP+ member with consideration and feedback from the member's family/caregiver and other providers involved in the member's care. Policies and procedures outlined that RMHP regularly monitored care plans to establish the most appropriate care.

RMHP attempted member outreach multiple times through phone calls and mail. A member's assigned care coordinator's contact information was provided in a letter to the member. RMHP staff members outreached pregnant members to ask a variety of questions from an evidence-based assessment. All contact with members was documented and tracked in Essette (a care management software platform), which was also accessible to Community Mental Health Centers (CMHCs) for referrals and care coordination. By using Essette and other tools, RMHP shared information between providers, care coordinators, and other care team members to ensure that services were not duplicated.

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

RMHP staff members reported providing members with information pertaining to their rights and responsibilities through the CHP+ member handbook. Members were provided access to rights information through the website and could receive a free copy of their rights upon request. The CHP+ member handbook listed the rights and responsibilities that are required in accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.100. In addition, during the interview, RMHP noted that staff members and providers were trained on member rights to ensure they could assist CHP+ members with their rights and responsibilities. RMHP provided a member rights policy that its staff members and providers could regularly access.

RMHP provided evidence to support nondiscrimination against individuals including patients, members, or visitors based on race, color, religion, sex, gender identity, sex stereotyping, sexual orientation, national origin, age, physical or mental disability, veteran status, or other basis that is protected by federal, State, or local law. RMHP staff members confirmed during the review that any reported member rights issue would be investigated.

RMHP submitted a policy describing how it ensured the confidentiality of protected health information (PHI) when creating, maintaining, and sharing information. The Confidentiality and Retention of Member Records policy included a process to identify, investigate, document, and report security and privacy incidents. RMHP staff members reported that any incident reported to RMHP would be thoroughly investigated and that remediations would be put into place.

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

RMHP demonstrated compliance with NCQA standards through comprehensive credentialing and recredentialing policies and procedures for both practitioners and organizations. RMHP provided detailed descriptions of credentialing departments, associated software systems, credentialing committee composition, and the thorough application and criteria review process. Throughout the interview, RMHP demonstrated that practitioners and organizations were consistently reviewed for credentialing and recredentialing in accordance with established policies and procedures.

During the interview, RMHP described two processes for credentialing: medical and surgical practitioners and organizations were credentialed through UnitedHealthcare's credentialing department, while behavioral health practitioners and organizations were credentialed through Optum's credentialing department. Credentialing staff members described that although the credentialing processes were performed by different teams, the same criteria that meet NCQA requirements for credentialing were used by both entities. RMHP described an open network, where providers can request participation through the UnitedHealthcare website. Once an application was received, credentialing team members completed a thorough file verification, including primary source verification of information within the file. RMHP described the evaluation process for files, depending on the level of review required. Clean files were approved by the medical director daily, while more complex files, such as files that did not meet criteria, required in-depth review and discussion by the appropriate credentialing committee.

RMHP described that credentialing committees for UnitedHealthcare and Optum met bimonthly. Credentialing committees were multidisciplinary and comprised of medical directors, physicians, and participating external clinicians. Credentialing policies extensively detailed the process for conducting credentialing and recredentialing in a nondiscriminatory manner.

RMHP reported meeting internal goals for the review and decision-making of initial credentialing files with a six-day turnaround time for medical and surgical providers and a 15-day turnaround time for behavioral health providers. HSAG reviewed a sample of initial credentialing files and found that RMHP processed all records in a timely manner. Initial credentialing files included Council for Affordable Quality Healthcare (CAQH) applications; evidence of license and education verification; verification of work history in the most recent five years; professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner in the most recent five years; and Drug Enforcement Administration (DEA) verification and board certification verification, if applicable. HSAG also reviewed a sample of recredentialing files and found that RMHP appropriately recredentialed providers and organizations within the 36-month time frame. RMHP described that the National Practitioner Data Bank (NPDB) was reviewed for license exclusions during initial credentialing and recredentialing. Credentialing staff members queried State board license actions and Medicare and Medicaid sanction lists on an ongoing basis to ensure providers were not sanctioned or excluded between credentialing cycles. RMHP further described how adverse events and quality of care (QOC) concerns were integrated into the credentialing committee review and decision process.

RMHP delegated credentialing and recredentialing to 10 contracted organizations. Staff members described oversight and monitoring completed by the Delegated Oversight Committee, which consisted of annual audits of policies and procedures, credentialing systems, and a sample of records. During the interview, RMHP indicated full compliance of its delegated credentialing organizations.

Recommendations and Opportunities for Improvement

During the interview, RMHP described its process for the annual monitoring of delegated credentialing organizations. HSAG requested Delegated Oversight Committee meeting minutes as supporting evidence. RMHP described the Delegated Oversight Committee as a national committee, and as the audits completed by RMHP indicated full compliance, results were not reviewed or discussed within the committee. HSAG recommends that RMHP include review of delegated credentialing organization audit results in its Delegated Oversight Committee to ensure a governance-level monitoring of risk, controls, and compliance.

Required Actions

HSAG identified no required actions.

3. Background and Overview

Background

Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act (the Act) in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) to comply with provisions of Title 42 of the Code of Federal Regulations (42 CFR) Medicaid and CHIP managed care regulations published May 6, 2016, which became applicable to CHIP MCOs effective July 1, 2018. Additional revisions were released in December 2020, February 2023, and May 2024. The Department of Health Care Policy & Financing (the Department) administers and oversees the Child Health Plan *Plus* (CHP+) program (Colorado's implementation of CHIP).

The CFR requires that states conduct a periodic evaluation of their MCOs and PIHPs (collectively referred to as managed care entities [MCEs]) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department has elected to complete this requirement for Colorado's CHP+ MCOs by contracting with an external quality review organization (EQRO), HSAG.

To evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2024–2025 was calendar year (CY) 2024. This report documents results of the FY 2024–2025 compliance review activities for RMHP. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2024–2025 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2023–2024 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists the HSAG, CHP+ MCO, and Department personnel who participated in the compliance review process. Appendix D describes the corrective action plan (CAP) process the CHP+ MCO will be required to complete for FY 2024–2025 and the required template for doing so. Appendix E contains a detailed description of HSAG's compliance review activities consistent with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[1] Appendix F contains details of care coordination special focus topic discussions that took place during the virtual compliance review.

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 12, 2025.

Overview of FY 2024–2025 Compliance Monitoring Activities

For the FY 2024–2025 compliance review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools for the three chosen standards:

- Standard III—Coordination and Continuity of Care
- Standard IV—Member Rights, Protections, and Confidentiality
- Standard VIII—Credentialing and Recredentialing.

Compliance with applicable federal managed care regulations and related managed care contract requirements was evaluated through review of the three standards.

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the CHP+ MCOs' contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY 2024. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key CHP+ MCO personnel to determine compliance with federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix E contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The three standards chosen for the FY 2024–2025 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard V—Member Information Requirements; Standard VI—Grievance and Appeal Systems; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the CHP+ MCO regarding:

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

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

FY 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 compliance review, each CHP+ MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the CHP+ MCO 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 CHP+ MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with the CHP+ MCO until it completed each of the required actions from the FY 2023–2024 compliance monitoring review.

Summary of FY 2023–2024 Required Actions

For FY 2023–2024, HSAG reviewed Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems.

Related to Standard V—Member Information Requirements, HSAG found no required actions for this standard.

Related to Standard VII—Provider Selection and Program Integrity, HSAG found no required actions for this standard.

Related to Standard IX—Subcontractual Relationships and Delegation, RMHP was required to complete one required action:

- RMHP must ensure, via revisions or amendments, subcontractor agreements include:
  - The State, CMS, the U.S. Department of Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer, or other electronic systems of the subcontractor or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.
  - The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems related to members.
  - The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

- If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

Related to Standard X—QAPI, Clinical Practice Guidelines, and Health Information Systems, HSAG found no required actions for this standard.

Summary of Corrective Action/Document Review

RMHP submitted a proposed CAP in May 2024. HSAG and the Department reviewed and approved the proposed CAP and responded to RMHP. RMHP submitted final documentation and completed the CAP in September 2024.

Summary of Continued Required Actions

RMHP successfully completed the FY 2023–2024 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements procedures to deliver care to and coordinate services for all members. These procedures meet State requirements, including: • Ensuring timely coordination with any of a member's providers for the provision of covered services (for example, emergency, urgent, and routine care). • Addressing the needs of those members who may require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. • Ensuring that all members and authorized family members or guardians are involved in treatment planning and consent to any treatment. • Criteria for making referrals and coordinating care with specialists, subspecialists, and community-based organizations. • Providing continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. *42 CFR 438.208* Contract: Exhibit B—10.5.1, 10.5.2, 10.5.3.3	**Bullet 1:** *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 2, section 4.1.4 states that RMHP receives referrals and prioritizes follow-up in a timely manner. Page 13, section 6.7.2. indicates that all referrals are sent to the respective RMHP team and responded to within 7 days or as urgently as the situation requires. Pages 19, section 6.8.8.3.6.2, indicates that care planning identifies services that a Member receives from another MCO, FFS CHP+, Community or support providers and any other entity that is involved in the Member's plan. **Bullet 2:** *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Pages 3-4, section 6.1, describes RMHP's stratification Page 5, section 6.4, describes Clinical Event Management Pages 6-12, section 6.4.5 "Special Populations" describes RMHP response to members with specific needs These provisions demonstrate that RMHP provides care coordination to Members who require services from multiple providers, facilities, and agencies; and who require complex coordination of benefits and services. **Bullet 3:** *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 21, section 6.8.11.8 indicates that RMHP ensures that the Member's authorized family members or guardians are involved in treatment planning and consent to the medical treatment when appropriate. *III_1,3,9,11_CM10_SpcialHlthCareNeeds.2_24* Page 5, states that RMHP will ensure involvement of all Members and or family Members or guardians as applicable in the care planning, establishment of goals and consent for care. **Bullet 4:** *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 2, section 4.1.4 establishes RMHP's commitment to receive referrals and prioritize follow-up in a timely manner as well as to coordinate with outside partners as needed. *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Pages 20, section 6.8.11.2 demonstrates that care plan interventions include coordination of appropriate resources for care by specialist, subspecialist and community-based organizations, including a follow-up process to determine whether the members act on referrals. **Bullet 5:** *III_1_3_CM-UM 6 Continuity_Coordination_Care_Transitions 10.24.2024V2*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 5-8, Medicaid and CHP+ Members, documents the policy and process to ensure continuity of care when new Members are enrolled to prevent disruption in the provision of medically necessary services. *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 20, section 6.8.9, Continuity of Care and Transitions of Care describes the process for providing continuity of care and transitions of care to avoid barriers to care to assure continuity of services when a member is transitioning from one system to another. *III_1_Referral Campaign Workflow 11042024 V2* This document shows RMHP's referral workflow process. The documents listed below demonstrate procedures to deliver care to and coordinate services for RAE, PRIME and CHP+ members. *III_1_Care Plan Workflow* *III_1_Essette Documentation* Additionally, this Essette Documentation Screen Shot contains a view of a Member's Care Plan in Essette. RMHP care coordination works collaboratively with the Member and caregivers (if applicable) to create an individualized care plan that includes documentation of the Member's desired health outcomes and identifies other providers of that member's care coordination team.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor ensures that each member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract: Exhibit B—10.5.3.1	*III_2_CO-RMHP-CHP+-Handbook-EN* Page 39 tells Members how to contact a care coordinator. Page 68 tells members how a care coordinator can help the member. *II_2_CO_RMHP-CHP Member-Welcome-Letter-EN* Page 5, "Help with your care," tells members how care coordinators can assist them with their care and how to contact them. *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 15, section 6.8.8.1.5.2 indicates that for Members identified as Persons with Special Health Care Needs, an assessment will be initiated within 30 days to identify any ongoing special conditions that require a course of treatment or regular monitoring. Page 23, section 6.8.13.3.6 shows that RMHP ensures that each member has an ongoing source of care appropriate to his or her needs by providing the Member with ongoing information about choices of settings, providers, treatment option and resources as needed and appropriate. Page 13, section 6.8.2, states that RMHP is exclusively responsible for ensuring that appropriate care coordination is provided for all Medicaid and CHP+ members. Page 20, section 6.8.10.1 indicates the care plan identifies a lead care coordinator who is formally	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	designated as primarily responsible for coordinating covered services furnished to the member. Page 16, section 6.8.8.1.6.3 states that once a member is engaged with their local Care Coordinator the member is provided with the direct contact information for the Care Coordinator. *III_2,5_CHP OB Screening tool* This OB screening tool is used with all newly enrolled prenatal members to assess their needs and identify if further supports are needed. *III_2,5_CHP OB Screen Follow Up Ltr* After a care coordinator connects with a member they will send out this letter to remind the member that they are their point of contact for any needs they may have regarding their pregnancy or other benefits.	
3. The Contractor implements procedures to coordinate services the Contractor furnishes the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)*	*III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 5, section 6.4.3.4, states that RMHP care coordinators will provide assistance during care transitions from hospitals or other care institutions, to home or community-based settings, or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. Page 21, sections 6.8.9.1 - 6.8.9.1.5 describe the procedures for coordinating services to Members under the circumstances listed. *III_1,3,9,11_CM10_SpcialHlthCareNeeds.2_24*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract: Exhibit B—10.5.3.2.1, 10.5.3.2.1.1–2, 10.5.3.2.1.4	This document describes RMHP's comprehensive policy for serving People and Children with Special Health Care Needs (P/CSHCN), which includes ensuring that members are referred to community-based resources and that care coordinators support communication across all members of the health care team. Page 5, section Case Management Coordination Specific to Children with SHCN, describes RMHP's process for coordinating services for children with special healthcare needs with other agencies, and for linking these members with community-based services. *III_1_3_CM-UM 6 Continuity_Coordination_Care_Transitions 10.24.2024V2* Page 7, Section 6.11 demonstrates that RMHP will coordinate services when a member is transitioning from one managed care plan to RMHP to ensure continuity of services.	
4. The Contractor provides best efforts to conduct an initial screening of each new member's needs within 90 days of enrollment, including: • Subsequent attempts if the initial attempt to contact the member is unsuccessful. • An assessment for special health care needs, including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems. • Using the results of the assessment to inform member outreach and care coordination activities.	*III_ 4_CO_CHP_Welcome_Script.1* Member Services representatives make outbound Welcome Calls to all new members. These scripts show an example of the initial Member services portion of the welcome call, that then leads into the Welcome Screener Script. Whether the Member call is outgoing or incoming, the initial Member conversation introduces care coordination and screens the Member for social, medical and behavior heath needs. When a Member is reached and a screener is completed the information is housed in Essette. **Bullet 1:**	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b)(3) Contract: Exhibit B—10.4.1, 10.4.1.1, 10.4.1.2, 10.4.1.4	*III_4_Sorry We Missed You CHP Child English_3041_Template* *III_4_Sorry We Missed You CHP YA English_3027_Template* These letters show a subsequent attempt to reach CHP+ Members when the initial attempt is unsuccessful. III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024 Pages 15-16, sections 6.8.8.1 - 6.8.8.1.6.5 describe RMHP's procedures for conducting initial screenings. **Bullet 2:** *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 15, section 6.8.8.1.1 describes that RMHP conducts screenings for qualifying Members based on their stratification and/or line of business. Screenings may take the form of a welcome call from Member Services or Care Management, outreach after an event such as an ER visit or inpatient stay, a Health Risk Assessment (HRA), or other screening specific to a line of business. Section 6.8.8.1.2 describes that screenings may occur in-person, telephonically, via Interactive Voice Response (IVR) or live voice, web-based, or in paper form sent through the mail. Alternative methods may be used to encourage completion of screenings as long as they protect the privacy of the Member and assure accessibility. Alternatives include home visits for those enrolled in a clinical program, mailings or electronic	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	outreach for those Members who have requested not to be called or live in a group or facility setting. Section 6.8.8.1.3 describes that outreach attempts are made to encourage each Member to participate in the screening process. Outreach attempts can include phone calls, e-mails, a mailed letter the Member's last known address. Section 6.8.8.1.4 describes that the screening tools contain components that attempt to assess the medical, functional, cognitive, mental health, cultural and psychosocial needs of the Member. If and when needs are identified, the goal is to create or update the Member's care plan. *III_4_High Risk_Prenatal_Postpartum_Workflows 2024* This workflow demonstrates the process for assessing for special health care needs including mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems that prenatal or postpartum members may experience. *III_4_OB Screening* The Screening Tool used by care coordinators to assess for needs. **Bullet 3:** *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 16, section 6.8.8.2.1. describes that RMHP deploys a care management comprehensive assessment which assesses the Member's health and behavioral health risks, medical and nonmedical needs, social determinants of health needs including determining if a care plan exists and creating a care plan if one does not exist and is needed. *III_4_OB_assessment_potential HR* After the initial welcome call screener is completed, if further needs are identified, a campaign is initiated where a care coordinator would reach out to the member and use this comprehensive assessment to identify if any further care coordination activities are needed.	
5. The Contractor shall complete an evidence-based risk assessment for all pregnant members (unless member declines or is unable to be reached) within seven business days of identifying a pregnant member. • Contractor must conduct outreach to initiate service coordination activities within seven business days of designating a high-risk pregnancy. Contract: Exhibit B— 10.1.6.1, 10.1.6.2	*III_2,5_CHP OB Screening Tool* CHP+ members identified as pregnant are called within 7 business days of their enrollment in order to administer the CHP OB Screening tool. If a member is identified as high risk through the screener, a campaign is initiated so that service coordination activities can be started. *III_5_Ex_Daily_Notification_Nely_Enlld_CHP+OB* This document is an example of the daily notification of newly enrolled CHP+ prenatal members. This information is ingested into the Essette platform so that a risk can be conducted within 7 business days of enrollment.	*Information Only*

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_2,5_CHP OB Screen Follow Up Ltr After a care coordinator connects with a member they will send out this letter to remind the member that they are their point of contact for any needs they may have regarding their pregnancy or other benefits. *III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 6, section 6.4.5.1.2.1 describes that RMHP completes a risk assessment screener for all CHP+ Members within 7 business days of identifying a pregnant Member. Page 6, section 6.4.5.1.2.2 describes that RMHP outreaches Members identified as having a high-risk pregnancy will be outreached within 7 business days of identification for service coordination activities.	
6. The Contractor shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract: Exhibit B—10.4.1.3	*III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 2, section 4.2 explains that RMHP utilizes a care management system platform named Essette to achieve distribution of all of the members identified by stratification, ADT alerts, Special Populations and Referrals to RMHP. Screening, assessment, care planning, and follow up are all managed through Essette. The sharing and integration of Essette allows coordination of the many entities that may be providing care/services to a members resulting in better member outcomes and less duplication of care and services. Page 21, section 6.8.11.6. describes the activities that ensure, to the extent possible, that all communications and interventions have been established and describes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	activities of sharing assessments and identified needs of the Member with other providers serving the member in order to prevent duplication of activities.	
7. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract: Exhibit B—10.5.6	*III_7_PNM_2024 Provider Manual* Page 93 describes all aspects of Medical Records and Release of Information and Transfer of Records including how each provider needs to make health service records available to the Member and to other participating providers and authorized individuals in accordance with HIPAA and the terms of the RMHP Provider Agreement. Page 62, 87 and 93 describe Member confidentiality Page 93 includes detailed information to PCP's and page 94 includes detailed information to specialists about what office records should include. Providers are responsible for the maintenance of adequate medical records, which are to be secure, complete, legible, accurate, accessible, organized, and maintained in a format that facilitates retrieval of information and assures confidentiality. *III_7_PNM_Physician Medical Services Agreement(Primary Care-all inclusive)_CHP+* Page 14-15, Section Q. Records: (4) This section specifies medical records requirements in accordance with professional, state and law requirements, including paragraph (7) which requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_7_PNM_Physician Medical Services Agreement (Not Primary Care) _CHP+ Page 13-14, Section N. Records: (4) This section specifies medical records requirements in accordance with professional, state and law requirements, including paragraph (7) which requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law.	
8. The Contractor ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent applicable. *42 CFR 438.208(b)(6)* Contract: Exhibit B—10.5.5.9, 13.1.2	*III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 21-22, section 6.8.11.8 provides that any communication with a non-Member representative will require the appropriate Appointment of Representative/HIPAA paperwork to be filled out. *III_8_RMHP ROI English 2024* *III_8_RMHP Spanish ROI 2024* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR requirements to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *III_8_CM14_Confidentiality-Retention_MemberRecords2024* Page 1, section I, states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our members. All information obtained in an official capacity is	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	confidential and staff will comply with HIPAA Privacy Regulations.	
9. The Contractor implements mechanisms to comprehensively assess each CHP+ member identified by the State as having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. • The assessment must be completed within 30 calendar days from the completion of the initial screening, if the initial screening identified special health care needs. *42 CFR 438.208(c)(2)* Contract: Exhibit B—10.5.9.1.1	*III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* RMHP conducts comprehensive assessments of Members identified as having special health care needs whether they are identified through screeners or referrals. Page 13, section 6.7.1 lists Examples of referral sources, which includes FFS CHP+. Page 15, section 6.8.8.1.5.2 indicates that for Members identified as Persons with Special Health Care Needs, an assessment will be initiated within 30 days to identify any ongoing special conditions that require a course of treatment or regular monitoring. Page 16-17, section 6.8.8.2.3. lists the elements of the comprehensive assessment. *III_9_CM 12 Complex Case Management Process* This document describes the process for complex care management when a member has been identified as having any ongoing special conditions of the member that requires a course of treatment or regular care monitoring. Page 11 indicates an assessment of the Member's specific needs is initiated. Page 11, indicates that assessments will be completed within 30 days when a member is determined eligible for Complex Case Management.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_9_CM_Complex Assessment_24 This assessment is used with persons identified as having special health care needs. *III_1,3,9,11_CM10_SpcialHlthCareNeeds.2_24* Pages 4, "Newly Enrolled Members" section describes how RMHP Care Managers proactively assess individuals with special healthcare needs for conditions that require ongoing treatment and monitoring. RMHP will assess the member with special healthcare needs within 30 days of the referral to the Care Management team.	
10. The Contractor produces a treatment or service plan for members with special health care needs who are determined, through assessment, to need a course of treatment or regular care monitoring. The treatment plan must be: • Approved by the Contractor in a timely manner (if such approval is required by the Contractor). • In accordance with any applicable State quality assurance and utilization review standards (for example, if approval is required due to prior-authorization requests). • Reviewed and revised upon reassessment of functional need, at least every 12 months, when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR 438.208(c)(3)* Contract: Exhibit B—10.5.9.1.2-3	*III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* **Bullet 1:** Approval by RMHP is not required. **Bullet 2:** Page 19, section 6.8.8.4.2. indicates that RMHP care plans use the SMART goal method for creating care plan goals, which means each goal should be: Specific, Measurable, Attainable, Realistic and Timely. Any services specified in the care plan would comport with any applicable limits or standards established by the State, if any. **Bullet 3:** Page 22-23, section 6.8.13.1 and 6.8.13.3 states that Care Coordinators must assign a reasonable timeframe for re-evaluation to facilitate a progressive plan of care. The Care Coordinator will document a schedule for follow-up and communication with the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Appropriateness of goals and interventions are re-evaluated bi-annually at a minimum according to acuity level and/or when changes in member's health or care are identified.	
11. For members with special health care needs determined to need a course of treatment or regular care monitoring, the Contractor must have a mechanism in place to allow members direct access to a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR 438.208(c)(4)* Contract: Exhibit B—10.5.9.1.4	*III_1-6,8-11_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 15, section 6.8.8.1.5.2 provides that if the member has been identified as a Person with Special Health Care Needs, an assessment will be initiated within thirty (30) days to identify any ongoing special conditions that require a course of treatment or regular monitoring. NOTE: RMHP does not require referrals to any contracted provider. Members have direct access to specialists. *III_1,3,9,11_CM10_SpcialHlthCareNeeds.2_24* Pages 4-5, Continuation of Care, explain the process for providing continuity of care and minimizing disruptions for newly enrolled members with special health care needs	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract: Exhibit B—7.3.6.1	*IV_1,3,4_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* This Policy and Procedure documents RMHP's written policy regarding a Prime, RAE, or CHP+ Member's Right ad Responsibilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., nondiscrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract: Exhibit B—15.10.9.2	*IV_2_CI_CSCO23HM0085174_000_CO_CHIP_NonDiscrim_ShortForm-PRNC* *IV_2_CI_UHCO24HM0167938_001_Eng_CO_CHIP_NonDiscrim_LongForm-PRNC* *IV_2_CI_UHCO24HM0167939_001_SP_CO_CHIP_NonDiscrim_LongForm-PRNC* *IV_2_CI_UHCO24HM0167940_001_EngSP_CO_CHIP_NonDiscrim_LongForm-PRNC* The CRN/MLIS documents listed above (4 versions) demonstrate that RMHP complies with applicable federal and state laws that pertain to member rights. *IV_2,4_PNM_2024 Provider Manual* Page 96-97 of the Provider Manual describes Prime, RAE and CHP+ Member rights to network providers. Page 85 informs providers of the values and tenents of the RMHP Compliance Plan/Code of conduct which demonstrate compliance with Federal and State laws that pertain to Member rights. *IV_2_4_ PNM_Law Exhibit to Services Agreements_CHP+* See Page 8-9, numbers 19 & 20 : Medicaid/CHP+ Recipient Rights and Medicaid and CHP+ Contracts	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Statutes and Regulations lists the federal and State laws with which RMHP, providers and subcontractors shall comply with. *IV_2_PNM_Law Exhibit-NonProv_CHP+* This Law Exhibit is attached to all non-provider contracts that are executed with RMHP. It includes requirements for compliance with all applicable federal and state law that pertain to member rights. *IV_2,5_CM14_Confidentiality-Retention_MemberRecords2024* Page 1-2, Purpose statement identifies that RMHP complies will all federal and state regulations that pertain to member activity and confidentiality. *IV_2_5_RMHP English ROI 2024* *IV_2_5_RMHP Spanish ROI 2024* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract: Exhibit B—7.3.6.2-6	*IV_3_CO-RMHP-CHP-Member-Welcome_Letter_EN* Members are directed how to find information online to learn more about their Member rights and responsibilities in these Welcome Kits that are sent to all new members. *IV_3_CM89 Member Annual Notice-CHP-2024* These mailed Member Annual Notices advise Members how to find information online to learn more about their Member rights and responsibilities. *IV_1,3,4_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* Page 2, Section 6 describes Member rights as specified in state and federal regulation	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the Contractor, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract: Exhibit B—7.3.6.3.7	*IV_4_CO-RMHP-CHP+-Handbook-EN* Page 29, bullet #8 indicates to Members that they are able to exercise their rights without being treated differently. *IV_1,3,4_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* Page 2, bullet #9 indicates that the member is able to exercise their rights without being treated differently. *IV_2,4_PNM_ 2024 Provider Manual* Page 96 includes the Members right to freely exercise their rights without being treated differently *IV_2_4_ PNM_Law Exhibit to Services Agreements_CHP+* Page 8, Number 19: Medicaid Recipient Rights, paragraph C states that "Contractor shall ensure that Medicaid Recipients have the rights set forth in 42 C.F.R. section 438.100(b)(2), including but not limited to the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, consistent with 42 C.F.R., section 438.100.(b)(2)(v).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. For medical records and any other health and enrollment information which identify a particular member, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: Exhibit B—10.5.5.9, 13.1.2	*IV_2,5_CM14_Confidentiality-Retention_MemberRecords2024* Page 1-2, Purpose statement identifies that RMHP complies will all federal and state regulations that pertain to member activity and confidentiality. *IV_2_5_RMHP English ROI 2024* *IV_2_5_RMHP Spanish ROI 2024* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract: Exhibit B—9.2.3, 9.2.3.1	Note: UHC currently holds a National CR Accreditation from NCQA through January 2026. *VIII_1_NCQA_United_Healthcare_Services__Inc_Cred Accred Cert 2023-2026* *VIII_1-12,14-18_2024 CRM Program_PH* This Document defines a consistent credentialing and recredentialing process for Physical Health practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for credentialing of its providers. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 7, section 4.1 Page 10, section 5.2 These sections describe the process for evaluating and selecting licensed independent practitioners to provide care to its members, using NCQA standards and guidelines. The following documents demonstrate RMHP has a well defined credentialing and recredentialing process for evaluating and selecting licensed practitioners: *VIII_1-18_Credentialing Plan_BH* *VIII_1,2_CO Addendum_CredPolicies_BH* Page 1, Policy Statement and Purpose *VIII_1-12,14-18_2024 CRM Program_PH* This Document defines a consistent credentialing and recredentialing process for Physical Health practitioners applying to the RMHP panel in compliance with federal	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	regulation and NCQA standards for credentialing of its providers.	
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. *42 CFR 438.214(a–b1)* NCQA CR1—Element A1	*VIII_1-12,14-18_2024 CRM Program_PH* PDF page 6 "Licensed Independent Practitioner or Provider (LIP)" describes the type of PH practitioners that the contractor credentials and recredentials. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 3, section 2.0 - Definitions - Licensed Independent Practitioner (LIP) This defines the types of health care professionals who can be credentialed or re-credentialed. Page 7, section 4.1 This section describes the written policies and procedures for the selection and retention of the types of practitioners, it credentials and recredentials. *VIII_2, 2A._P&Ps for selection-retention on websites* This document demonstrates where P&Ps for selection-retention of providers can be found on the various RMHP-UHC website locations. *VIII_1-18_Credentialing Plan_BH* PDF Pages 10-12, section 4.2 - Administrative Review This section outlines the types of BH practitioners	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.B. The verification sources it uses. NCQA CR1—Element A2	*VIII_1-12,14-18_2024 CRM Program_PH* Page 14, sections 3.4 - Recredentialing Process and 3.5 - Primary Source Verification (PSV) of Credentials These describe the verification sources used for credentialing and recredentialing.	☒ Met ☐ Partially Met ☐ Not Met

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025 Page 7, section 4.2 Page 10, section 5.2, #1 These describe the verification sources it uses for credentialing and recredentialing. *VIII_1-18_Credentialing Plan_BH* PDF pages 11-13, section 4.2, B - Verification of Credentials PDF pages 15-16, section 6.1 - Criteria for Credentialing Organizational Provider These sections describe the verification sources used.	☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	*VIII_1-12,14-18_2024 CRM Program_PH* Pages 12-14, section 3.2 - Credentialing Criteria of Providers This section outlines the criteria used for credentialing and recredentialing. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 7, section 4.2 Page 10, section 5.2 These sections describes the criteria for credentialing and recredentialing. *VIII_1-18_Credentialing Plan_BH* PDF pages 8-13, section 4.0 Initial Credentialing of licensed Clinicians PDF pages 13-15, section 5.0 Recredentialing of Participating Clinicians These sections describe the criteria used for these activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_1,2_CO Addendum_CredPolicies_BH This policy supplements the Credentialing Plan to describe criteria used.	
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	*VIII_1-12,14-18_2024 CRM Program_PH* Pages 16-17, sections 3.8 - Clean Application Process and 3.9 - CRM Clinical Review and 4 - CRMC Review and Decision-Making These describe the process for making credentialing and recredentialing decisions *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 5, section 3.3 describes the process for making credentialing and recredentialing decisions. *VIII_1-18_Credentialing Plan_BH* PDF page 13, section 4.3 - Credentialing Committee Review Page 14, section 5.2, A - ""UBH Review Criteria"" last paragraph and section 5.2, B - "Credentialing Committee Action" These describe the process for making credentialing and recredentialing decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	*VIII_1-12,14-18_2024 CRM Program_PH* Page 16, section 3.8 - Clean Application Process describes the process for managing credentialing/recredentialing files. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Pages 7-9, sections 4.2-4.4 Page 10, section 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These describe the process for managing credentialing/recredentialing files that meet the Contractor's established criteria. *VIII_1-18_Credentialing Plan_BH* Section 4.3 Credentialing Committee Review, ""A Credentialing Committee Action 1,"" PDF page 13 and Section 5.2 Recredentialing Criteria of Participating Clinicians, ""A UBH Review Criteria"" - last paragraph, PDF pages 14-15 describe the process for managing cred/recred files.	
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* *42 CFR 438.214(c)* NCQA CR1—Element A6	*VIII_1-12,14-18_2024 CRM Program_PH* Page 7, section 2.2 - Statement of Non-Discrimination describes that RMHP-UHC's cred/recred practices are conducted in a non-discriminatory manner. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Pages 5-6, section 3.4 describes the process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *VIII_1-18_Credentialing Plan_BH* PDF page 4, section 1.1 - Purpose, 2nd paragraph PDF page 18, section 7.1 - Confidentiality of Applicant and Participating Clinician and Participating Organizational Provider Information These describe UBH's credentialing and recredentialing are conducted in a non-discriminatory manner.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	*VIII_1-12,14-18_2024 CRM Program_PH,* Page 8, section 2.3 - Provider Rights in the Credentialing Process, paragraph B -"Notice of Erroneous Information," informs that an applicant will be notified if information obtained varies substantially from the information provided by the applicant. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.2 describes the process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. *VIII_1-18_Credentialing Plan_BH* PDF page 18, section 7.2 ""Applicant Rights"" paragraph B-(b) describes the process for notifying applicant if information obtained varies substantially from the information provided by the applicant.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	*VIII_1-12,14-18_2024 CRM Program_PH* Page 19, section 4.6 Notice of CRMC Decisions, (A,B) Page 36, Colorado, (2) These indicate that initial credentialing will be completed within 60 days and approval for recredentialing will be sent as required by regulatory and accreditation requirements. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.2 describes the process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_1,2_CO Addendum_CredPolicies_BH Page 2, section 5, A, demonstrates the process for notifying practitioner of the credentialing decision.	
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	*VIII_1-12,14-18_2024 CRM Program_PH* Page 8, section 2.5 - Credentialing Risk Management Committee (CRMC) describes responsibilities of the medical director/designee *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 5, section 3.2 describes the direct responsibilities and participation of the medical director or other designated physicians in the credentialing program. *VIII_1-18_Credentialing Plan_BH* PDF page 7, section 3.2 - Credentialing Committee describes the responsibility and participation in the credentialing committee of the medical director or other designated physician.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	*VIII_1-12,14-18_2024 CRM Program_PH* Page 7, section 2.1 - Confidentiality describes the process for securing the confidentiality of all information obtained during the credentialing process, except as otherwise provided by law. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.1 describes the process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. *VIII_1-18_Credentialing Plan_BH*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	PDF pages 18-19, section 7.0 - Confidentiality and Applicant Rights describes the process for securing the confidentiality of all information obtained during the credentialing process, except as otherwise provided by law.	
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	The following documents describe the various processes used to ensure provider information in provider directories are consistent with credentialing data. *VIII_2K_NCC P-P 110 Initial Cred Proc for LIP* Describes the process of collecting applicant information such as education, training, board certification and this information is electronically sent to NDB and completed profile shall be posted and attached to the Credentialing Cycle (CC) in Salesforce so inclusion in the provider directories occurs. See page 3, 5.5. *VIII_2K_E2E Non Del Contract-NDM Process flow chart* This chart demonstrates the End to End process for inputting provider data into PhyCon, which feeds the data to the provider directories. *VIII_2K_PhyCon Contract_Amendmnt_Execution SOP* This document describes the process of execution of a contract/amendment for a provider which includes ensuring demographic information such as education, training, specialties, etc. so that it is populated in the directory. *VIII_2.K_PDA Attestation Process SOP* This SOP document describes the process to complete attestation review of provider directory accuracy to ensure credentialing/recredentialing information is included in the directory.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025 NCC P-P 110 Initial Credentialing Procedures for Licensed Independent Practitioners Credentialing/Recredentialing Data Flow to Directories	
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	*VIII_1-12,14-18_2024 CRM Program_PH* Page 8, section 2.3 - Provider Rights in the Credentialing Process describes how providers have the right to review information submitted to support their cred or recred application as well as indicating that references, recommendations, or peer-review protected information is not available to the applicant. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.2 describes the process the Contractor notifies practitioners about their rights to review information submitted to support their credentialing or recredentialing application. *VIII_1-18_Credentialing Plan_BH* PDF page 18, section 7.2 - Applicant Rights describes how providers have the right to review information submitted to support their cred or recred application as well as indicating that UBH is not required to allow the applicant to review personal or professional references, internal UHB documents, or any other information that is peer review protected or restricted by law.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.B. To correct erroneous information. NCQA CR1—Element B2	*VIII_1-12,14-18_2024 CRM Program_PH* Page 8, section 2.3 - Provider Rights in the Credentialing Process B describes how the provider will be notified if any erroneous information is found and that the notice does not need to disclose the source of the discrepancy but must include: -the time frame to submit corrections and/or changes -the format for submitting corrections -the person to whom the corrections or explanation must be submitted -documentation of receipt of any corrections *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.2 describes the process the applicant has to correct erroneous information. Page 13, section 8.3 describes the Appeals process from adverse credentialing or sanctions monitoring decision *VIII_1-18_Credentialing Plan_BH* PDF page 18, section 7.2 - Applicant Rights, Paragraph B (b) describes how the provider will be notified if the information that varies substantially from the information provided by applicant.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	*VIII_1-12,14-18_2024 CRM Program_PH* Page 8, Section 2.3 ""Provider Rights in the Credentialing Process"", paragraph D ""Status in the Credentialing Process"" describes application status information. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 13, section 8.2 describes the process the applicant to receive the status of their credentialing or recredentialing application, upon request. *VIII_1-18_Credentialing Plan_BH* Page 15, section 7.2, "Applicant Rights," paragraph B.a describes application status information.	
4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	*VIII_1-12,14-18_2024 CRM Program_PH* Page 8, section 2.4 Quality Improvement Committee (QIC) and Optum Physical Health of California Quality Management & Improvement Committee (QMIC)., 2.5 Credentialing Risk Management Committee (CRMC) describes the credentialing committee and peer-review process. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 14, section 9.2 describes how the Contractor establishes a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. *VIII_1-18_Credentialing Plan_BH* Page 1, section 1.1, "Purpose" -1st and 2nd paragraphs describes the designated credentialing committee and peer review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds.	*VIII_1-12,14-18_2024 CRM Program_PH* Page 10, section 2.9 describes committee membership *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A1–3	Page 5, sections 3.2, 3.3, 3.4, describe how the Credentialing Committee reviews files to provide credentialing decisions for clean files and practitioners who do not meet established thresholds. *VIII_1-18_Credentialing Plan_BH* Page 4, Sections 3.2 Credentialing Committee Page 10, Section 4.3, A, Credentialing Committee Review & Committee Action Pages 11-12, Section 5.2, A& B, Recredentialing Criteria of Participating Clinicians,UBH Review Criteria and B Credentialing Committee Action Page 14, section 6.3, Credentialing Committee Responsibilities These sections in this document describe the responsibilities of the credentialing committee	
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits: • A current, valid license to practice (verification time limit is 180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit is prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing decision; if board certification, time limit is 180 calendar days).	*VIII_1-12,14-18_2024 CRM Program_PH* Page 11, section 3.1 - Application, C. and D for Liability; Page 12, section 3.2 - Credentialing Criteria of Providers; Pages 14-15, sections 3.5 - Primary Source Verification (PSV) of Credentials and 3.6 - Verification Time Limit. Pages 60-61, Attachment D, sections 1 and 9 Professional Liability History; Section 6 and 14, Gaps in Employment/Practice History *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 7-8, section 4.2, describes the credentialing criteria and primary source verification requirements for credentialing and recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.* NCQA CR3—Element A	*VIII_1-18_Credentialing Plan_BH* Pages 8-9, sections 4.2 Administrative Review B Verification of Credentials; Page 11, section 5.2 Recredentialing Criteria of Participating Clinicians A UBH Review Criteria	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. *42 CFR 438.214(d)(1)* NCQA CR3—Element B	*VIII_1-12,14-18_2024 CRM Program_PH* Page 12, section 3.2 describes credentialing criteria to include sanctions and restriction/limitations. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Pages 8-9, section 4.2, describes the primary source verification requirements for state sanctions, restrictions on licensure, or limitations on scope of practice as well as Medicare and Medicaid sanctions for credentialing and recredentialing. *VIII_1-18_Credentialing Plan_BH* Page 9-12, section 4.2, Administrative Review, section B - Verification of Credentials, Items 5-6 describe verification processes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate).	*VIII_1-12,14-18_2024 CRM Program_PH* Page 11, section 3.1 Application; describes the information included in the application *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Pages 7-9, section 4.2 describes the verification requirements for affirmative responses to disclosure questions, maintaining current malpractice insurance coverage, and current and signed attestation. *VIII_1-18_Credentialing Plan_BH* Pages 5-6, section 4.1 Clinician Application Criteria B Application Form 1-10, describes the information included in the application	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C		
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	*VIII_1-12,14-18_2024 CRM Program_PH* Page 14, section 3.4 Recredentialing Process indicates a 36 month review *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 10, section 5.1, describes the process for recredentialing practitioners within a 36 month time frame. *VIII_1-18_Credentialing Plan_BH* Page 14, Section 5.1 Recredentialing Participating Clinicians, A indicates a 36 month review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. *42 CFR 438.214(d)(1)*	*VIII_1-12,14-18_2024 CRM Program_PH* Page 20, section 5.2 Ongoing Monitoring, Paragraph C describes the collection and review of Medicare and Medicaid sanctions or limitations on licensure. Page 21, Paragraph F describes the review of quality concerns and/or adverse events *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 14, section 9.1, describes the process for collecting and reviewing Medicare and Medicaid sanctions, sanctions or limitations on licensure, complaints, adverse events as well as implementing appropriate interventions when necessary.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
NCQA CR5—Element A	*VIII_1-18_Credentialing Plan_BH* Pages 16-17, section 8.0 ON-GOING MONITORING AND REPORTING describes processes for ongoing monitoring	
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	*VIII_1-12,14-18_2024 CRM Program_PH* Page 21, section 5.3 Action Based on Ongoing Monitoring Page 22, section 6 Appeal Process These describe the appeals process. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13-14, sections 8.2 and 9.2 describes the process for taking action against a provider who does not meet quality standards. Page 16, section 8.3 describes the appeals process. *VIII_1-18_Credentialing Plan_BH* Pages 18-19, section 9.0 QUALITY IMPROVEMENT OF LICENSED PARTICIPATING CLINICIANS AND PARTICIPATING ORGANIZATIONAL PROVIDERS describes processes for taking action against practitioner when applicable.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm good standing—*	*VIII_1-12,14-18_2024 CRM Program_PH* Pages 11-16, section 3 - Credentialing Process describes the initial and ongoing assessment. Page 14, section 3.4 Recredentialing Process describes the recredentialing process and specifies at least every 36 months. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 12, section 7.1 and 7.2, describe written policies and procedures for the initial and ongoing assessment of	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable. *42 CFR 438.214(d)(1)* NCQA CR7—Element A1	organizational health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter. *VIII_1-18_Credentialing Plan_BH* Pages 12-14, section 6.0 Credentialing and Recredentialing of Organizational Providers Pages 16-17, section 8.0 On-going Monitoring and Reporting These describe processes to ensuring ongoing assessments every 36 months	
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	*VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 12, section 7.1 describes the process for confirming that the organizational provider has been reviewed and approved by the accrediting body. *VIII_1-18_Credentialing Plan_BH* Page 12, section 6.1 Criteria for Credentialing Organizational Providers, A, details organizational provider must be in good standing with state and federal regulatory bodies.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following*	*VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 26, Attachment D describes how the contractor conducts an on-site quality assessment if the organizational provider is not accredited. *VIII_1-18_Credentialing Plan_BH* Pages 13-14, sections 6.2 Organizational Providers that are Not Accredited or Certified describes how the contractor	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.) NCQA CR7—Element A3	conducts a site review if the organizational provider is not accredited.	
13. The Contractor's organizational provider assessment policies and processes include: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory • For physical health, at least the following providers: – Hospitals – Home health agencies – Skilled nursing facilities – Free-standing surgical centers NCQA HP CR7—Elements B and C	*VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 24, Attachment C describes that the PH providers indicated are part of the credentialing process and have required credentialing. *VIII_1-18_Credentialing Plan_BH* Page 3, "Organizational Providers" provides the definition of provider types.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor has documentation that it assesses providers every 36 months. NCQA HP CR7—Elements D and E	*VIII_1-12,14-18_2024 CRM Program_PH* Page 14, section 3.4 Recredentialing Process, indicates assessments every 36 months *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 10, section 5.1 Page 12, section 7.2 These describe the documentation that the Contractor assesses providers every 36 months. *VIII_1-18_Credentialing Plan_BH* Page 11, section 5.1 General A Page 14, section 6.4 Recredentialing of Participating Organizational Provider, A These describe that the contractor assess providers every 36 months.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
15. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners,	*VIII_1-12,14-18_2024 CRM Program_PH* Page 27, section 9 - DELEGATED CREDENTIALING describes requirements for written delegation document with delegate. *VIII_1-18_Credentialing Plan_BH* Page 24, section 13.2 Delegation Agreement describes requirements for delegation agreements	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
providers, and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A		
16. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *The requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	*VIII_1-12,14-18_2024 CRM Program_PH* Pages 27-31, section 9 - Delegated Credentialing describes processes applicable *Note: For Medical delegated agreements, there have not been any agreements in effect less than 12 months.* *VIII_16-18_Del Cred Oversight Policy* Page 1, Purpose, indicates that the contractor evaluates the delegates capacity to meet NCQA requirements. *VIII_1-18_Credentialing Plan_BH* Pages 25-26, section 13.4 Pre-Assessment Responsibilities of UBH describes the contractor evaluates the delegates capacity to meet NCQA requirements	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. • At least annually, monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegates policies and procedures. • At least annually, acts on all findings from above monitoring for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. NCQA CR8—Element C	*VIII_1-12,14-18_2024 CRM Program_PH* Page 27, section 9 - DELEGATED CREDENTIALING describes requirements for written delegation document with delegate. *VIII_16-18_Del Cred Oversight Policy* Page 4, Section D, Describes the annual delegated credentialing review process. *VIII_1-18_Credentialing Plan_BH* Page 26, sections 13.5 Annual Evaluation and 13.6 Review of Oversight and Monitoring Reports describe processes for annual evaluations of delegates	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	*VIII_1-12,14-18_2024 CRM Program_PH* Page 27, section 9 - DELEGATED CREDENTIALING describes requirements for written delegation document with delegate. *VIII_16-18_Del Cred Oversight Policy* Page 5-6, section H describes ongoing oversight and reviews/reporting to include improvements as applicable *VIII_1-18_Credentialing Plan_BH* Page 26, section 13.7 Required Follow-Up describes activities to review and develop improvement plans as applicable.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	31
				Total Score ÷ Total Applicable		=	100%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Rocky Mountain Health Plans CHP+

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Keli Deemer, Toni McIntire, and Alicia Muellner
Date of Review:	January 29, 2025
Reviewer:	Sara Dixon
Participating MCE Staff Member During Review:	Jeri Applegate, Keli Deemer, Toni McIntire, and Alicia Muellner

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	****	****	****	****	****	****	****	****	****	****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LPC	PA	LCSW	LCSW	MD	APN	NP	LAC/LPC	LPC	APN/RN
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Professional Counselor	Physician Assistant	Social Worker	Social Worker	Pain Management	Nurse with RX	Nurse Practitioner	Alcohol/Drug Counselor	Masters Level Counselor	Nurse with RX
Date of Completed Application [MM/DD/YYYY]	1/24/2024	3/1/2024	4/10/2024	5/14/2024	6/11/2024	4/26/2024	8/26/2024	9/19/2024	10/7/2024	10/24/2024
Date of Initial Credentialing [MM/DD/YYYY]	1/26/2024	3/6/2024	4/11/2024	5/14/2024	6/14/2024	4/29/2024	8/30/2024	9/23/2024	10/9/2024	10/25/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met		Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA	NA	NA	NA	Yes	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	NA	NA	NA	NA	Met	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	Yes	NA	NA	Yes	Yes	Yes	NA	NA	Yes
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	Met	NA	NA	Met	Met	Met	NA	NA	Met
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Comments: **N/A**										

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Rocky Mountain Health Plans CHP+

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Applicable Elements	7	8	7	6	8	9	8	7	7	8
Compliant (Met) Elements	7	8	7	6	8	9	8	7	7	8
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**75**									
Total Compliant Elements	**75**									
Total Percent Compliant	**100%**									

Notes:

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

Prior to Credentialing Decision
- DEA or CDS certificate
- Education and training

180 Calendar Days
- Current, valid license
- Board certification status
- Malpractice history
- Exclusion from federal programs

365 Calendar Days
- Signed application/attestation
- Work history

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Rocky Mountain Health Plans CHP+

Review Period:	January 1, 2024 – December 31, 2024
Completed By:	Keli Deemer, Toni McIntire, and Alicia Muellner
Date of Review:	January 29, 2025
Reviewer:	Sara Dixon
Participating MCE Staff Member During Review:	Jeri Applegate, Keli Deemer, Toni McIntire, and Alicia Muellner

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	****	****	****	****	****	****	****	****	****	****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LAC/LPC	LPC	MS	LCSW	LPC	LCSW	LPC	LCSW	LPC	NP
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Masters Level Counselor	Masters Level Counselor	Certified Nurse Midwife	Social Worker	Masters Level Counselor	Social Worker	Masters Level Counselor	Social Worker	Masters Level Counselor	Family Nurse Practitioner
Date of Last Credentialing [MM/DD/YYYY]	12/29/2021	1/7/2022	6/23/2021	8/4/2021	5/13/2022	7/1/2022	6/20/2022	8/29/2022	5/13/2022	2/17/2022
Date of Recredentialing [MM/DD/YYYY]	1/30/2024	3/5/2024	4/18/2024	5/15/2024	6/17/2024	7/12/2024	8/6/2024	8/29/2024	9/24/2024	10/28/2024
Months From Initial Credentialing to Recredentialing	25	25	33	33	25	24	25	24	28	32
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	NA	Yes	NA	NA	NA	NA	NA	NA	Yes
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	NA	Met	NA	NA	NA	NA	NA	NA	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Comments:
N/A

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Rocky Mountain Health Plans CHP+

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Total Applicable Elements	5	5	6	5	5	5	5	5	5	6
Total Compliant (Met) Elements	5	5	6	5	5	5	5	5	5	6
Total Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**52**									
Total Compliant Elements	**52**									
Total Percent Compliant	**100%**									

Notes:

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

   Prior to Credentialing Decision
   - DEA or CDS certificate

   180 Calendar Days
   - Current, valid license
   - Board certification status
   - Malpractice history
   - Exclusion from federal programs

   365 Calendar Days
   - Signed application/attestation
9. Within 36 months of previous credentialing or recredentialing approval date

Appendix C. Compliance Review Participants

Table C-1 lists the participants in the FY 2024–2025 compliance review of RMHP.

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

HSAG Reviewers	Title
Gina Stepuncik	Associate Director
Sara Dixon	Project Manager III
Crystal Brown	Project Manager I
RMHP Participants	**Title**
Alicia Muellner	Behavioral Health Credentialing Specialist
Ashley Murphy	Utilization Management Director
Audrey Oldright	Care Coordination Manager
Billie Bemis	Long-Term Services and Supports Vice President
Chasity Hackbarth	Network Contract Manager
Chris Miller	Behavioral Health Provider Relations Director
Christine Foreman	Senior Product Manager, Optum Physical Health
Dale Renzi	Provider Network Strategy and Operations Vice President
Deborah Sanborn	Clinical Grievances Associate Director
Doug Bolton	Population Health Manager
Glen McDaniel	Chief Information Officer
Jennifer Farrar	Behavioral Health Executive Director
Jeremiah Fluke	Contract Administration Director
Jeri Applegate	Regulatory Associate Director, Credentialing
Jim Hart	Compliance Consultant, Audit Management United HealthCare
Kanoe Maunakea	Behavioral Health Utilization Management Manager
Keli Deemer	Regulatory Analyst, Credentialing
Kendra Peters	Child Health Plan Plus Contract Manager
Kevin Prouty	Senior Program Monitoring and Audit Specialist
Kim Herek	Director of Quality
Kimberly Nordstrom	Chief Marketing Officer
Kristyn Brown	Senior Clinical Quality Analyst, Delegated Credentialing Oversight
Linda Kasten	Business Operations Manager
Liz Mullin	Network Program Manager

RMHP Participants	Title
Meg Taylor	Regional Accountable Entities Program Officer, Vice President Behavioral Health
Monika Tuell	Chief Operating Officer
Patrick Gordon	Chief Executive Officer
Peggy Gaudet	Optum Exam Management Associate Director
Rhonda Michaelson	Appeals and Grievance Supervisor
Rose Stauffer	Chief Financial Officer
Shanna Hauser	Regulatory Adherence Analyst
Sue Baker	Customer Service Manager
Todd Lessley	Clinical Services Vice President
Toni McIntire	Network Program Specialist, Provider Data Operations
Violet Willett	Care Management Director
Department Observers	**Title**
Russell Kennedy	Quality and Compliance Specialist
Jerry Ware	Quality Contract Manager
Tom Franchi	Accountable Care Collaborative Program Specialist
Sandi Wetenkamp	Health Network Accountability Specialist
Lauren Landers	Care Coordination Policy Specialist

Appendix D. Corrective Action Plan Template for FY 2024–2025

If applicable, the MCE 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 MCE must identify the planned interventions, training, monitoring and follow-up activities, and proposed documents in order to 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 MCE must submit documents based on the approved timeline.

Table D-1—CAP Process

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

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

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

Appendix E. Compliance Monitoring Review Protocol Activities

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the review to assess compliance with federal managed care regulations and Department contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop desk request forms, compliance monitoring tools, report templates, agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all reviewers to ensure consistency in scoring across MCEs.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided MCEs with proposed review dates, group technical assistance, and training, as needed. • HSAG confirmed a primary MCE contact person for the review and assigned HSAG reviewers to participate in the review. • Sixty days prior to the scheduled date of the review, HSAG notified the MCE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and review agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the three standards and the review activities. Thirty days prior to the review, the MCE provided documentation for the desk review, as requested. • Documents submitted for the review consisted of the completed desk review form, the compliance monitoring tool with the MCE's section completed, credentialing, recredentialing, and organizational provider credentialing record review tool, sample records, policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and applicable documents to support the special focus topic. • The HSAG review team reviewed all documentation submitted prior to the review and prepared a request for further documentation and an interview guide to use during the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct the Review**
	• During the review, HSAG met with groups of the MCE's key staff members to obtain a complete picture of the MCE's compliance with federal healthcare regulations and contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the MCE's performance. • HSAG requested, collected, and reviewed additional documents as needed. • At the close of the review, HSAG provided MCE staff and Department personnel an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the Department-approved FY 2024–2025 Compliance Review Report template to compile the findings and incorporate information from the pre-review and review activities. • HSAG analyzed the findings and calculated final scores based on Department-approved scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the Department-approved report template. • HSAG submitted the draft Compliance Review Report to the MCE and the Department for review and comment. • HSAG incorporated the MCE and Department comments, as applicable, and finalized the report. • HSAG included a pre-populated CAP template in the final report for all elements determined to be out of compliance with managed care regulations. • HSAG distributed the final report to the MCE and the Department.

Care Coordination

The purpose of the CHP+ Special Focus Topic: Care Coordination interview was to explore the trends, strengths, and challenges that each Colorado CHP+ plan has experienced with the evolution of its care coordination program. A sample of topics covered in each CHP+ discussion included the rate of completion for initial screenings, specifically among members with high-risk pregnancies; addressing health-related social needs and equity; describing successful partnerships and barriers; coordinating chronic disease management; and handoff processes for transitions of care. For the interview session, RMHP provided a slide presentation detailing its CHP+ care coordination program. In the slideshow, RMHP highlighted its team of 25 care coordination staff members and described the core components of its care coordination model: member stratification, clinical event management, special population management, and referral processing. RMHP indicated that its goals for care coordination include integrating care across settings; increasing the alignment of program benefits; improving the member experience of care; and reducing fragmentation.

Screenings and Assessments; Maternal and Postpartum Care

Regarding special populations, RMHP described how it tailors care for specific groups, such as members with high-risk pregnancies or those transitioning out of correctional facilities, ensuring appropriate care alignment. Its maternity program included comprehensive member identification and stratification across the prenatal, high-risk, and postpartum stages.

HSAG inquired about RMHP's engagement with members experiencing high-risk pregnancies. RMHP noted that it tracked this information in Essette. RMHP described its monthly outreach process and noted that most members are receptive to engagement, apart from some facing substance use challenges. RMHP stated that it has peer support specialists and a substance use disorder (SUD) coordinator to help build trust, engage pregnant members, and connect them with necessary resources.

HSAG inquired about other potential barriers to care, such as domestic violence or unplanned pregnancies. RMHP explained that its intensive maternal screening tool includes specific questions addressing these issues, with follow-up questions based on member responses. The assessment tool contained embedded prompts to guide care coordinators during member engagement. RMHP also emphasized the ongoing motivational interviewing training provided to its care coordination team.

Regarding postpartum engagement, RMHP explained that it emphasizes the continued availability of services and resources for both mother and baby. A postpartum screener also initiates contact to ensure continued care. RMHP noted that common postpartum social needs that it addresses include access to food, diapers, car seats, strollers, and rental assistance.

Looking ahead, RMHP outlined its goals of further refining population stratification to ensure data-driven care coordination interventions. RMHP also discussed developing a fourth trimester care model, recognizing the importance of supporting not just the baby but also the parents and the entire family.

Complex Care and Chronic Disease Management

RMHP reported that care coordinators conduct monthly outreach to the top 3 percent of members identified as high risk. RMHP described its health information exchange, noting that Essette facilitates real-time notifications to care coordinators, enabling prompt follow-up and communication with hospital planners. RMHP emphasized its positive relationships and open communication channels with all 26 hospitals in its network.

RMHP identified rural/frontier members as a priority population, recognizing the numerous barriers this population faces, and described its efforts to maximize access to resources. RMHP detailed its care coordination follow-up process, which includes connecting members with behavioral health resources, local care coordination teams, dental and vision providers, community resources for food and housing, case conferences, appointment attendance, and coordination with hospitals and providers.

RMHP also shared information on additional support programs, including High Fidelity Wraparound and the Children and Youth Mental Health Treatment Act (CYMHTA). RMHP shared a success story about a child with autism spectrum disorder (ASD) who lost Medicaid coverage and transitioned to the CHP+ program. Through CYMHTA, RMHP facilitated a seamless transition to needed care.

Care Coordination Toolkit

RMHP presented on several programs, including the Self Care by AbleTo app for emotional wellness, BabyScripts for maternity wellness and education, and CirrusMD for on-demand virtual doctor visits. RMHP emphasized the value of CirrusMD for rural members, as all providers are credentialed through Colorado Medicaid. RMHP clarified that it is not a billed service, but encounter notes and visit summaries are captured.

Other programs discussed included SimpliFed for lactation support and baby feeding education, Wellhop for virtual group prenatal classes, and Scene for medication support, targeting high-risk CHP+ members. RMHP explained that Scene involves pharmacist outreach, comprehensive medication reviews, and observed therapy to improve medication adherence, particularly for asthma management.

RMHP shared two success stories. One involved a high-risk pregnancy member who, with care coordinator support and access to SimpliFed, overcame breastfeeding challenges. The other involved a mother of a CHP+ member needing a psychological evaluation for a potential ASD diagnosis. The care coordinator connected the mother with CYMHTA, facilitating a smooth transition, expedited testing, and access to applied behavior analysis therapy.

HSAG inquired about communication between the various apps and RMHP, asking how RMHP tracks member participation. RMHP confirmed that it receives reports from all the apps, though the data vary.

For example, RMHP can track sign-ups and incentive redemptions through BabyScripts. While CirrusMD data may be limited to encounter notes, RMHP anticipates more comprehensive data from Scene over time, potentially showing improvements in quality measures related to asthma and other conditions. HSAG noted the value of the Wellhop app for connecting expectant mothers to peers during a potentially vulnerable time and expressed enthusiasm for the potential of all the apps.

Health Equity

Regarding RMHP's commitment to equity, it highlighted its NCQA accreditation in this area. RMHP mentioned its multilingual care coordinators and its ongoing efforts to reach rural and frontier communities. RMHP emphasized the importance of understanding members' backgrounds and focusing on health education and critical care coordination for these underserved populations.

HSAG identified the following strengths related to care coordination:

- RMHP leveraged technology like Essette for real-time notifications and care coordination, facilitating timely interventions and communication with hospitals. RMHP also used a variety of apps (Self Care by AbleTo, BabyScripts, CirrusMD, SimpliFed, Wellhop, Scene) to provide members with accessible resources for physical and mental health, maternity support, and medication management.
- RMHP maintained positive relationships and open communication with all 26 hospitals in its network, which is crucial for effective care transitions and coordination.
- RMHP demonstrated a commitment to serving diverse populations, including those with high-risk pregnancies, individuals transitioning from correctional facilities, rural/frontier members, and those with SUD needs. RMHP tailored its care coordination and resources to meet the specific needs of these groups.
- RMHP offered comprehensive maternity support, including prenatal, high-risk, and postpartum care. RMHP also provided resources and addressed social needs related to pregnancy and newborn care.

HSAG identified the following opportunities related to care coordination:

- Develop a system to share app usage data with primary care providers (PCPs) to ensure comprehensive care coordination and integration with member records. This will help PCPs stay informed about members' health needs and facilitate more coordinated care. Also, consider exploring strategies to engage with members who have used these apps but have not had an annual check-up or recent health screening.
- Develop a system to track the long-term outcomes of members who participate in the fourth trimester care model. This will help assess the effectiveness of the program and identify areas for improvement.
- Continue to invest in initiatives to address health disparities and improve access to care for rural and frontier communities.