Colorado Children's Health Insurance Program
Child Health Plan *Plus* (CHP+)

FY 2014–2015 Site Review Report

for

Rocky Mountain Health Plans

June 2016

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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Acknowledgments and Copyrights

Introduction

Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the FY 2015–2016 site review activities for the review period of January 1, 2015, through December 31, 2015. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the four standard areas reviewed this year. Section 2 contains graphical representation of results for all 10 standards across the three-year cycle, as well as trending of required actions. Section 3 describes the background and methodology used for the 2015–2016 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2014–2015 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the grievance and appeal record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2015–2016 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

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

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

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	12	12	12	0	0	0	100%
IV Member Rights and Protections	5	5	4	1	0	0	80%
VIII Credentialing and Recredentialing	48	46	46	0	0	2	100%
X Quality Assessment and Performance Improvement	15	15	15	0	0	0	100%
Totals	**80**	**78**	**77**	**1**	**0**	**2**	**99%**

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

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	90	83	83	0	7	100%
Recredentialing	90	90	90	0	0	100%
Totals	**180**	**173**	**173**	**0**	**7**	**100%**

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

RMHP had policies and procedures that addressed care coordination, assessments, care planning, and continuity of care. In addition, **RMHP** developed several flow charts that clearly described the components of the care coordination process.

RMHP's Medicaid and CHP+ Care Coordination policy and procedure described a comprehensive, client- and family-centered, integrated care coordination program that promoted service accessibility, attention to individual needs, continuity of care, and maintenance of health and independent living for its members. **RMHP**'s procedure began with either direct referrals into the care coordination program or use of a threshold criterion that identified members who might need care coordination. **RMHP** developed a script that was used for determining whether members had a primary care physician (PCP) and identifying current medical needs and any care coordination issues. This script, a best practice, served as a mechanism for referral to the care coordination program.

As mentioned, **RMHP** used threshold criteria that examined emergency department (ED) visits, hospital admissions, special health care needs (SHCNs), total cost of care, use of oncology services, evidence of polypharmacy, and high risk scores for multiple morbidities. The criteria made sure that members were immediately identified and entered into the care coordination program.

RMHP used Essette—an electronic care management record—to assist with care coordination. This tool included both assessment and care planning functions. **RMHP**'s process was extensive and included an assessment of the member's health, behavior risks, and medical and nonmedical needs. The system also allowed for inclusion of linguistic and cultural needs, as well as a thorough assessment of members with SHCNs. The care planning function guided staff through an integrated care planning process.

RMHP used a variety of approaches to ensure its members received essential information. For example, **RMHP**'s staff used a formal, structured script to inform new members with SHCNs who were involved in an ongoing course of treatment that they could continue to receive covered services from their current provider for 60 calendar days from enrollment, and covered services from ancillary or non-network providers for 75 calendar days. The script included information for new members in their second or third trimester of pregnancy about continuing with their current provider until the completion of postpartum care. To ensure access to providers, **RMHP**'s policies and procedures stated (and staff members confirmed) that **RMHP** would make arrangements to access providers outside the network if primary or specialty care could not be provided within the plan and that members with SHCNs could maintain their specialist as their PCP. **RMHP** also incorporated the information included in the script into its member handbook and provider manual as well as into its Medicaid and CHP+ policies and procedures that address care coordination, people with SHCN, continuity of care, and preauthorization; ensuring all staff gave members the same information.

Finally, during the on-site review, **RMHP**'s staff presented several case studies that demonstrated the level of coordination and integration that was provided for members whose needs may be difficult to address, as well as **RMHP**'s commitment to improving quality of care provided to those members.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG required no corrective actions for this standard.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

HSAG found more than ample evidence that member rights are at the core of **RMHP**'s mission and values. **RMHP**'s policies and procedures regarding member rights were comprehensive and well written. During the on-site interview, staff members described the various mechanisms used to provide members, providers, and employees with ongoing education regarding member rights. In addition to the policies and procedures, **RMHP** used newsletters to remind providers, members, and staff that the full list of member rights was available in the provider manual and member handbook, and on its website. **RMHP** also required staff members to participate in annual training that touched on member rights. The template letters used by **RMHP**'s grievance and appeals department included written reminders that **RMHP** members are free to exercise their rights without fear of being treated differently.

RMHP's Equal Opportunity policy required its staff, providers, and vendors to strictly adhere to all federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. **RMHP**'s policy is included in its employee handbook, member handbook, and provider manual and is also attached to all non-provider contracts. **RMHP** also mails letters to all vendors and agency staffing firms annually to remind them of **RMHP**'s commitment to equal opportunity.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

RMHP's Medicaid Prime and CHP+ Member Rights and Responsibilities policy and procedure stated that members had the right "to get family planning services from any Medicaid Prime or CHP+ provider, with no referral required." The document must be revised to allow members to receive family planning services from any duly licensed provider, in or out of **RMHP**'s network.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

RMHP's written policies and procedures described a robust and comprehensive credentialing and recredentialing process for evaluating and selecting licensed providers that was consistent with the National Committee for Quality Assurance (NCQA) standards. The policies described the process used to collect and verify information within the required time frames, criteria required for acceptance, the role of the credentialing committees and medical director, and a well-defined appeal process.

On-site review of both credentialing and recredentialing records demonstrated that applications included all NCQA-required content, that staff verified information using sources identified in the policies within the required time frames, and that **RMHP**'s credentialing committees reviewed the files for providers who failed to meet the criteria delineated in the policies.

RMHP's five Medical Practice Review Committees (MPRCs) functioned as credentialing committees. MPRCs were distributed throughout the region with membership composed of participating physicians from **RMHP**'s provider panel who live and work in the area. Because **RMHP**'s region includes very diverse geographic areas, **RMHP** felt this structure allowed providers to be evaluated by peers with experience and knowledge of the geographic area, further ensuring a fair assessment. HSAG reviewed monthly MPRC meeting minutes that confirmed the committees performed as described in the policies and procedures.

RMHP provided evidence that it monitored both State and federal websites monthly for sanctions, complaints, and adverse events and that its MPRCs followed up on information collected, as appropriate and as described in the policies. **RMHP** delineated the appeal process available to providers in its provider manual and reminded providers of the process used in correspondence to address specific instances that required further review and/or discipline.

RMHP's policies also described the way **RMHP** ensures organizational providers are in good standing with State and federal regulatory bodies prior to contracting with these providers, and again at least every three years. This process includes confirming that the organization was reviewed and approved by an accrediting body. The policy required that organizations not accredited be subject to a CMS or State quality review within the previous three years. HSAG reviewed credentialing files for both accredited and unaccredited organizations which demonstrated that staff implemented the policies as written, and HSAG also found evidence that **RMHP** assessed contracted behavioral and physical health care providers.

RMHP had fully-executed delegation agreements with five organizations for the provision of credentialing activities. **RMHP** provided documentation that demonstrated ongoing (quarterly reporting) and formal (annual audit) oversight of each organization and that it followed up on identified opportunities for improvement.

Summary of Findings Resulting in Opportunities for Improvement

RMHP's policies and procedures stated that **RMHP** allowed use of a CMS or State quality review of non-accredited organizations in lieu of conducting a site visit, providing the CMS or State was conducted within the last three years. The policy did not provide for instances in which the review was conducted more than three years ago. **RMHP** staff members recalled no instance when a non-accredited organization undergoing credentialed or recredentialed had a CMS or State review that fell outside this three-year requirement. HSAG suggested that **RMHP** update its policies to describe the site review process it would use to evaluate a non-accredited organization if the CMS or State quality review was conducted more than three years ago.

Summary of Required Actions

HSAG required no corrective actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

RMHP's Quality Improvement (QI) Program Description 2015–2016 (QI Program Description) addressed HEDIS, CAHPS, performance improvement project (PIP) topics, provider satisfaction surveys, member call center metrics, medical record review, measures that detected over- and underutilization, programs for members with SHCNs, and clinical practice guidelines. **RMHP**'s QI Program Description and related documentation (e.g., policies, procedures, and committee meeting minutes) as well as the QI program overview provided during the on-site review demonstrated **RMHP**'s commitment to improving quality of care provided to its members.

During the onsite interview, HSAG found that the quality assessment and program improvement (QAPI) program was well defined and included all of the requirements of this standard, including a comprehensive annual review. It was clear from the interview that **RMHP** valued quality improvement and used a data-driven system to improve services for its members. **RMHP** focused on activities related to care quality, patient safety, physician access and availability, member and provider satisfaction, continuity and coordination of care, care management, pharmacy management, and member rights and responsibilities. During the site review's opening session, the associate vice president of community integration described how **RMHP** used the data it collected to improve the lives of its members. HSAG was able to connect the presentation to actual improvement efforts discussed in the QAPI interview.

RMHP provided the required clinical practice guidelines. The guidelines cited the relevant literature on which the guidelines were based, and the Clinical Practice Guidelines policy stated that all requested changes to the guidelines are submitted to the Quality Improvement Committee (QIC) for approval. QIC meeting minutes reflected clinical practice guideline review. Policies described how **RMHP** consulted with healthcare providers with specialties specific to the respective guidelines and that the guidelines reflected the specific needs of the membership. The clinical practice guidelines were posted on the **RMHP** websites for providers and members to access at no cost. The provider newsletter was used to inform the provider community of changes in practice guidelines and included a reminder of how to obtain the guidelines if needed. During the on-site interview, HSAG informed **RMHP** that the clinical practice guidelines were difficult to locate on the website and suggested a more prominent location. **RMHP** stated that it was planning to improve the website and that the suggestion would be incorporated into the improvement efforts.

RMHP used an extensive monitoring system to ensure it delivered quality services to its members. **RMHP** used member surveys, anecdotal information, grievances and appeals, and enrollment and disenrollment information to measure members' perception of accessibility and adequacy of services. **RMHP** incorporated monitoring activities into its Corporate Quality Work Plan, which included 12 primary activities—each with multiple measurements for improvement. Each primary activity included a scope of the activity, objectives, monitoring information, and evaluation, and identified a responsible person. All of these activities were reported to the QIC quarterly. Structurally, all committees—including the Medical Advisory and Member Experience Advisory Councils—reported to the QIC.

RMHP CHP+ developed a CHP+ Supplemental Survey that was mailed to members and measured satisfaction levels with **RMHP**, PCPs, and specialists. This survey was in addition to the annual Patient Satisfaction Survey sent to all members. **RMHP**'s CHP+ Program consistently scored higher on the 2015 survey than on the 2014 survey. The survey included many member comments, which provided **RMHP** with anecdotal information. In addition, **RMHP** used a tool called the "Voice of the Customer" to "bring the actual words and language of our customers to every person in **RMHP.**" This high-level summary of member concerns was derived from a number of sources including appeals, social media, customer calls, focus groups, providers, and QI surveys. Feedback from sources was compiled into a Microsoft PowerPoint presentation and shared with each **RMHP** employee. **RMHP** suggested ways for its employees to use the information. The presentation concluded with the following statement: "The Voice of the Customer report aims to highlight the areas that our customers are telling us are the most frustrating and difficult for them. We should listen."

RMHP used a robust information management system that collected, analyzed, and reported data. It is important to note that **RMHP** used the Essette system to integrate data from the member assessment and care plan, and shared the system with community teams to ensure coordination of care. Use of the shared system also allowed **RMHP** to collect data from the community teams to measure their performance.

During the onsite review, **RMHP** CHP+ staff provided evidence of its compliance with the requirement for monthly submittals of immunization information for all covered members to the Colorado Immunization Information System. In fact, **RMHP** CHP+ provided this information weekly.

Summary of Findings Resulting in Opportunities for Improvement

Although **RMHP** met the requirement that the QAPI program include mechanisms for the detection of both under- and overutilization, HSAG suggested that **RMHP** document the mechanism more clearly in its QI Program Description 2016–2017.

HSAG also suggested that the clinical practice guidelines be posted in a more prominent location on the website. **RMHP** was planning improvements to its website and stated the suggestion would be incorporated into the improvement efforts.

Summary of Required Actions

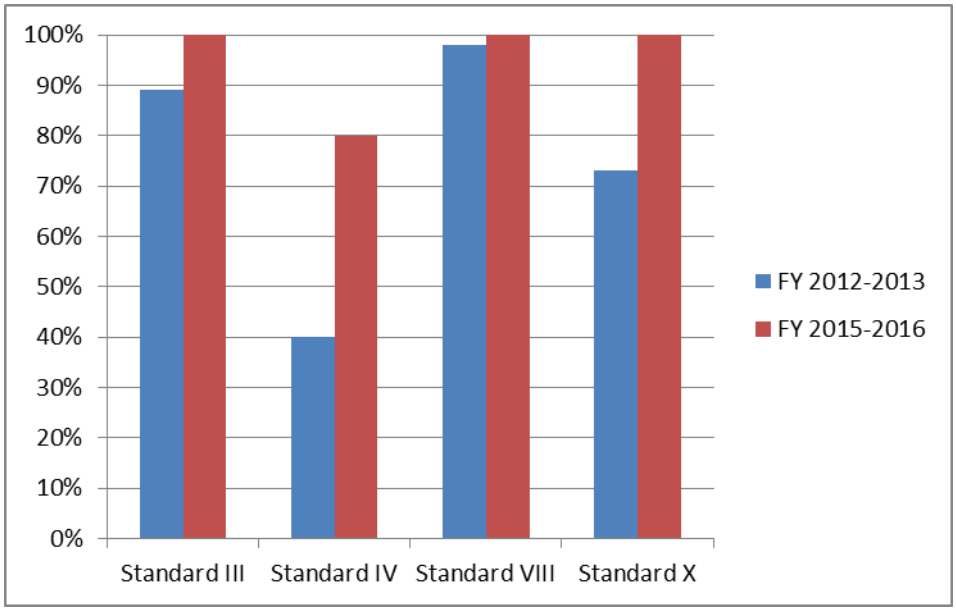
HSAG required no corrective actions for this standard.

Comparison of Results

Comparison of FY 2012–2013 Results to FY 2015–2016 Results

Figure 2-1 shows the scores from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **RMHP**'s contract with the State may have changed and may have contributed to performance changes.

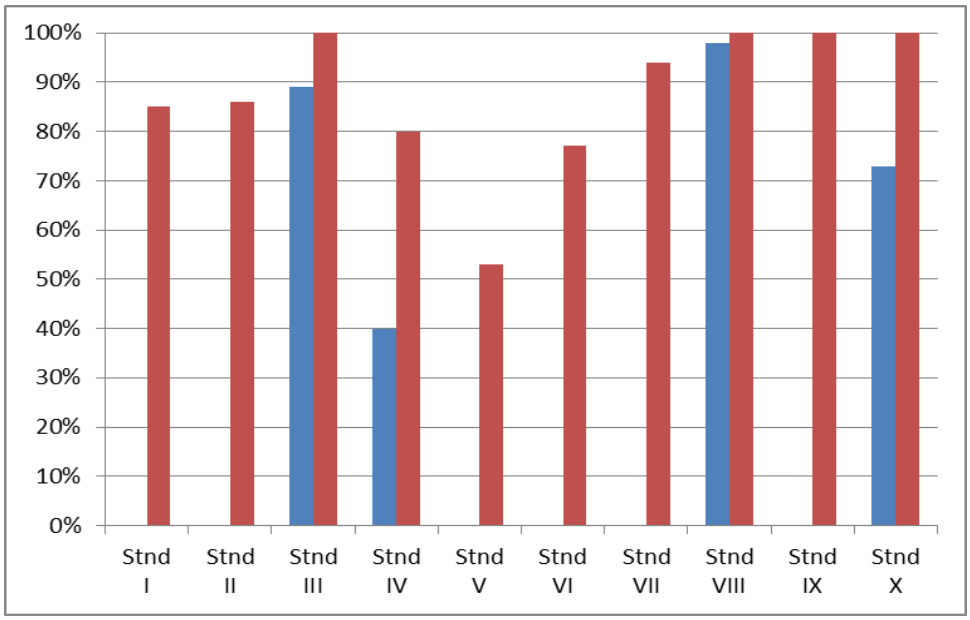
Figure 2-1—Comparison of FY 2012–2013 Results to FY 2015–2016 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the past four years of compliance monitoring. The figure compares the score for each standard across two review periods, as applicable, and may be an indicator of overall improvement.

Figure 2-2—RMHP's Compliance Scores for All Standards



Note: Results shown in blue are from FY 2012–2013. Results shown in red are from FY 2013–2014, FY 2014–2015, and FY 2015–2016.

Table 2-1 presents the list of standards by review year.

Table 2-1—List of Standards by Review Year

Standard	2012–13	2013–14	2014–15	2015–16
I—Coverage and Authorization of Services		X		
II—Access and Availability		X		
III—Coordination and Continuity of Care	X			X
IV—Member Rights and Protections	X			X
V—Member Information			X	
VI—Grievance System			X	
VII—Provider Participation and Program Integrity			X	
VIII—Credentialing and Recredentialing	X			X
IX—Subcontracts and Delegation			X	
X—Quality Assessment and Performance Improvement	X			X

Trending the Number of Required Actions

Figure 2-3 shows the number of requirements with required actions from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared to the results from this year's review. Although the federal requirements did not change for the standards, **RMHP**'s contract with the State may have changed and may have contributed to performance changes.

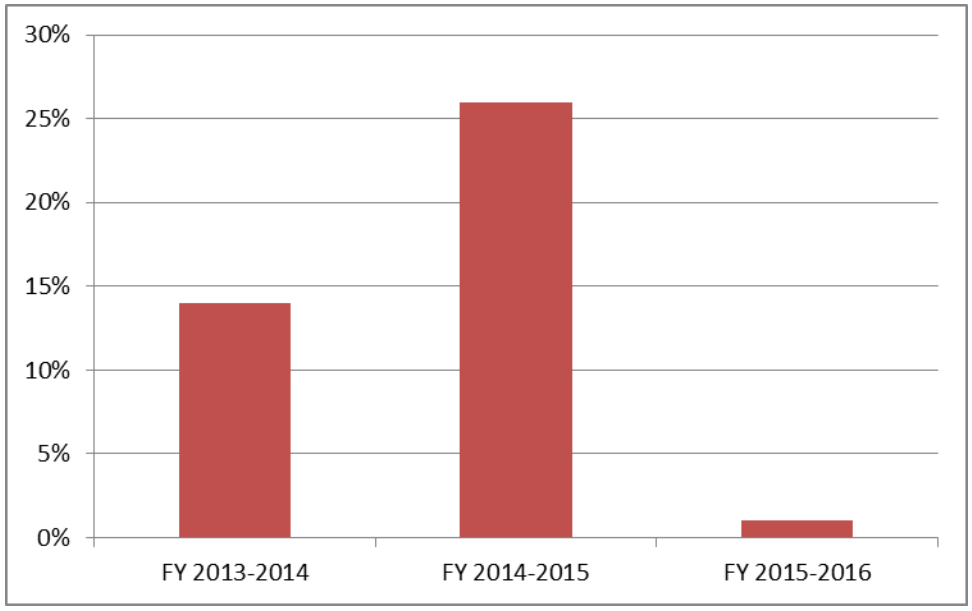
Figure 2-3—Number of FY 2012–2013 and FY 2015–2016 Required Actions per Standard

Note: **RMHP** had no required actions for Coordination and Continuity of Care, Credentialing and Recredentialing, or Quality Assessment and Performance Improvement resulting from the FY 2015–2016 site review.

Trending the Percentage of Required Actions

Figure 2-4 shows the percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards, as indicated in Table 2-1.

Figure 2-4—Percentage of Required Actions—All Standards Reviewed



Overview of FY 2015–2016 Compliance Monitoring Activities

For the fiscal year (FY) 2015–2016 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ credentialing and recredentialing. HSAG documented detailed findings in the Compliance Monitoring tool for any requirement receiving a score *Partially Met* or *Not Met*.

A sample of the health plan's administrative records related to CHP+ credentialing and recredentialing were also reviewed to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements, effective July 2015. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all CHP+ credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG reviewed a sample of 10 credentialing records and 10 recredentialing records, to the extent possible. For the record review, the health plan received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for

the FY 2015–2016 site reviews represent a portion of the CHP+ managed care requirements. These standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

Objective of the Site Review

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

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

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

for **Rocky Mountain Health Plans**

FY 2014–2015 Corrective Action Methodology

As a follow-up to the FY 2014–2015 site review, each health plan that received one or more *Partially Met* or *Not Met* score was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP** until it completed each of the required actions from the FY 2014–2015 compliance monitoring site review.

Summary of 2014–2015 Required Actions

As a result of the 2014–2015 CHP+ site review, **RMHP** was required to implement 11 corrective actions related to Member Information, six corrective actions related to Grievance System, and one corrective action related to Provider Participation and Program Integrity. For Member Information, **RMHP** was required to revise its member handbook to lower the reading level. Other corrective actions were related to enhancing information regarding advance directives and the utilization management program, and clarifying definitions of "emergency medical care" and "poststabilization services." For the Grievance System, **RMHP** was required to expand its definition of an "action" and revise member information to ensure accurate and consistent time frames.

Summary of Corrective Action/Document Review

RMHP submitted its proposed corrective action plan to HSAG and the Department in July 2015. HSAG and the Department worked with **RMHP** to ensure that planned interventions would fully address the required actions. HSAG reviewed documents in October 2015 and again in January 2016, when HSAG and the Department determined that **RMHP** had completed all required actions.

Summary of Continued Required Actions

No required actions were continued from the 2014–2015 site review activities.

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

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by Health Plan	Score
1. The Contractor has written policies and procedures to address the coordination and provision of covered services in conjunction with other medical and behavioral health plans and to promote: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care. ◆ Maintenance of health. ◆ Independent living. *42CFR438.208(b)(2)* Contract: Exhibit A4—2.7.4.1	*III_CM_Medicaid and CHP+ Care Coordination Policy and Process* This is the comprehensive policy and procedure that describes RMHP's formal system of care coordination for its members. RMHP provides comprehensive client and family centered, integrated care coordination. This includes but is not limited to promoting and assuring service accessibility, attention to individual needs, continuity of care, and maintenance of health and independent living. RMHP provides consistent and timely identification of Members who require care coordination. *III_CM_RMHP Care Coordination Workflow-Sage and Cinnamon* This document illustrates RMHP's Care Coordination Workflow, including needs identification, assessment and care planning, oversight, and advanced practice workflow. *III_CM_Continuity of Care 2016* This documents the policy and process to ensure continuity of care when new members are enrolled, and when the member's provider changes during the course of care. *III_CM_People w SHCN Policy* This policy describes the policies RMHP uses to ensure service accessibility, attention to individual needs, continuity of care, maintenance of health, and independent living for individuals with special health care needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor's procedures are designed to address those members who require complex coordination of benefits and services and may require services from multiple providers, facilities and agencies, ancillary or nonmedical services, including social services and other community resources.	*III_CM_People w SHCN Policy* RMHP has a 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. Section VI on page 4 describes RMHP's process for coordinating services for children with special healthcare needs with other agencies, and for	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
Procedures also address: ◆ Coordinating services for children with special healthcare needs with other agencies or entities such as those dealing with mental health and substance abuse, public health, home and community-based care, developmental disabilities, local school districts, child welfare, IDEA programs, Title V, families, caregivers, and advocates. ◆ Criteria for making referrals and coordinating care by specialists, subspecialists, and community-based organizations. Contract: Exhibit A4—2.7.4.3.2; 2.7.4.3.3; 2.7.4.3.5; 2.7.5.5	linking these members with community based services. *III_CM_Medicaid and CHP+ Care Coordination Policy and Process* Section I.C.1.f., pages 4-5 includes criteria for referring children with special healthcare needs for specialty and ancillary services, and to community agencies or entities. *III_CM_Essette Case Management Acuity Levels* This document shows the classification of members based on acuity, which helps define the level of contact during the course of care coordination.	
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. ◆ Upon enrollment, the Contractor makes at least one attempt to contact the member with information on options for selecting a PCP. ◆ If the member does not select a PCP within 10 days, the Contractor assigns the member to a PCP and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number. ◆ The Contractor notifies the PCP of newly assigned members in a timely manner. ◆ The Contractor grants a member's request to change his/her PCP, as reasonable and practical. *42CFR438.208(b)(1)* Contract: Exhibit A4—2.5.8.2	*III_CS_CHP+ Welcome Call Script* All CHP+ Members receive a welcome call attempt. Generally, these calls are made within two weeks of the effective date of enrollment. The Member/parent is encouraged to choose and/or change a PCP during this call. If they do not select a PCP, their record is set to a Not Yet Established (NYE) status. Three times per week, these Members are run through the PCP Auto-assignment process to search for a previous relationship with a PCP. If none is found, then they are randomly assigned to a PCP in their geographic area who is accepting new patients. *III_IT__TechSpecs_PCP_Autoassignment* See page 1 of the TechSpecs for the PCP Auto assignment process summary. Technical details follow on pages 2-6. This process is run by Information Technology (IT) every Monday, Wednesday and Friday, and occurs as soon as an enrollment transaction is received. Auto assignment is delayed until after the member's effective date of enrollment. Since this process runs every Monday, Wednesday and Friday, auto assignment occurs within 10 days for any member who did not select a PCP during the Welcome Call process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	III_CI_CHP+ 2016 ID Card Sample If a member is entered in RMHP's Facets system with a valid PCP, or if the PCP is changed to a different valid PCP, an ID Card is generated in the next Monday/Wednesday/Friday ID Card batch file. The ID Card identifies the PCP and PCP office telephone number. *III_CS_PCP Change SOP* This SOP indicates that Customer Service (CS) receives PCP change requests from multiple sources. It also explains how PCP change requests are handled and documented in the RMHP system. *III_CM_Medicaid and CHP+ Care Coordination Policy and Process* Section III., D-E on pages 12-13 describe that RMHP care coordinators work with providers who are primarily responsible for the member's covered services to develop a plan for regular communication. RMHP will ensure to the extent possible that each member has an ongoing source of primary care appropriate to his or her needs. *RMHP CHP+ Benefits Booklet-0316* Page 6 and page 12 encourage members to pick a primary care provider and to establish a relationship with a PCP by making an appointment. *III_CI_PCP Practice Monthly Report_PHI Removed* RMHP uses an attribution methodology to identify a patient's active medical home relationship with a primary care provider. Each month RMHP identifies all RMHP members who have an active relationship with a primary care provider. RMHP then sends monthly reports to advanced practice primary care providers including information about their current attributed patients. This includes providers who are participating in the Comprehensive Primary Care initiative or in other RMHP practice	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	transformation initiatives. In addition to information about their attributed RMHP patients, this report includes a tab that lists a practice's RMHP assigned patients who are not yet attributed to a provider (ABNA – assigned but not attributed). Providers are encouraged to use this ABNA tab to identify and prioritize patients for outreach and to encourage the establishment of a medical home with the practice.	
4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special healthcare needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate healthcare professionals. ◆ The Contractor will assess members with special healthcare needs within 30 days in order to identify ongoing conditions that require a course of treatment or regular care monitoring. *42CFR438.208(c)(2)* Contract: Exhibit A4—2.7.4.3.1.1; 2.7.5.3	*III_CS_CHP+ Welcome Call Script* RMHP attempts to reach every new CHP+ member with a "welcome call." Sections 4-6 on pages 3-4 describe the initial special healthcare needs screening that is done with resulting referrals to Care Management nurses when health or other problems are identified. *III_CS_CHP+ Welcome Letter_English_Spanish* This letter is sent to new members who cannot be reached by phone. This letter urges members to contact RMHP if they have any special health care needs or concerns so that the member can be connected with nurses who can assess their condition and manage their health and other concerns. *III_CM_People w SHCN Policy* *Assessment and Needs Identification* on pages 2-3 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. *III_CM_Essettev3.5_ New Medicaid Assessment* *III_CM_Essettev3.5_New Medicaid Assessment Diagnosis Guide* *III CM \Essettev3.5_New Complex Assessment V3* *III_CM_Essette_Pregnancy_High Risk-CM* These documents illustrate how RMHP assesses the various health and health behavior risks and medical and nonmedical needs of our members. The Medicaid assessment is also used with CHP+ members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
5. The Contractor shares with other healthcare organizations serving the member with special healthcare needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A4—2.7.5.2	*III_CM_People w SHCN Policy* Section VI.C. on page 4 explains that once the member's treatment needs are determined, RMHP Care Management initiates its protocols for care coordination, which includes sharing the results of its identification and assessment of needs with other providers serving the member with special healthcare needs in order to prevent duplication of those activities. *III_CM_ Medicaid and CHP+ Care Coordination Policy and Process* Section III. D-F on pages 12 -13 describes the RMHP process for assessing current care coordination services the member receives from other providers, helping the member establish an ongoing source for primary care and accessing records from the member's other sources for care. Section IV.N.5., page 16 describes the processes for ensuring providers communicate with each other to ensure that all needed help and communication occurs to support the care plan and interventions established. *III_PT_RMHP Medical Neighborhood Initiative Summary 2016* This document describes RMHP's work at developing a medical neighborhood, including work to improve communication and coordination between providers and care team members. *III_PT_Care Compact Presentation 2016* This document is referenced as an exhibit in the Initiative Summary. This is a copy of a presentation to providers about Care Compacts, which supports better communication between providers. *III_PT_Speciality-PCP Care Coordination Agreement* RMHP worked with providers to develop this document to help define communication between providers for better coordination of care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
6. The Contractor implements procedures to develop an individual treatment plan based on the needs assessment. The treatment plan addresses treatment objectives, treatment follow-up, monitoring of outcomes, and is revised as necessary. *42CFR438.208(c)(3)* Contract: Exhibit A4—2.7.4.3.1.2; 2.7.4.3.1.3	*III_CM_ Medicaid and CHP+ Care Coordination Policy and Process* Section IV, pages 13-18, *Care Plan Development & Care Planning*, describes in detail RMHP's comprehensive care planning process which results in an individualized treatment plan, including establishment of both short term and long term goals, self-management goals, follow-up, monitoring of outcomes and revisions as needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor's procedures for individual needs assessment and treatment planning are designed to: ◆ Accommodate the specific cultural and linguistic needs of the members. ◆ Allow members with special healthcare needs direct access to a specialist as appropriate to the member's conditions and needs. *42CFR438.208(c)(3)(iii)* Contract: Exhibit A4—2.7.4.3.1.4	*III_CM_ Medicaid and CHP+ Care Coordination Policy and Process* Section IV.N.6.g.-h., page 17 shows that RMHP creates care plans that are linguistically appropriate to the member and are consistent with the member's cultural beliefs and values. Section I.C.1.f. xiii., page 6 indicates that the Care Coordinator will make reasonable accommodation for Members with special health care needs or barriers related to non-English speaking or literacy. *III_CM_ Medicaid and CHP+ Care Coordination Policy and Process* Section I.C.1.f.v., page 5 states RMHP care coordinators will inform Persons with Special Health Care Needs who use specialists frequently for their health care to maintain these types of specialists as PCMPs or be allowed direct access or a standing referral to specialists for the needed care. Section I.C.1.f.viii., page 5 states that the Care Coordinator will make arrangements for the member to access providers outside the network, if needed services are not provided by an in-network provider. *III_CM_People w SHCN Policy* Section V, page 4 describes that RMHP allows persons with special healthcare needs who use specialists frequently for their healthcare to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	maintain access to these types of specialists by allowing direct access or a standing referral to specialists for the needed care. *III_CM_Culturally Sensitive Services* This policy and procedure describes how Care Management staff address individual needs arising from cultural, language or other unique aspects of the individual throughout the care coordination process.	
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 (HIPAA), to the extent that they are applicable. In all other operations as well, 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. *42CFR438.208(b)(4)* *42CFR438.224* Contract: Exhibit A4—2.7.4.1, 3.1.4.3	*III_CM_HIPAA Consent Form 0316* 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. *III_CM_Confidentiality and Retention of Member Records Policy* Section I, page 1 states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our members. All information obtained in an official capacity is confidential and will comply with HIPAA Privacy Regulations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment. Contract: Exhibit A4—2.7.4.3.4	*III_CM_ Medicaid and CHP+ Care Coordination Policy and Process* Section IV.C., page 15 indicates that the care plan includes prioritized goals, that takes into account the member's and/or caregiver's goals, preferences and level of involvement of the Care Coordinator, as well as the member's desired health outcomes. Section IV.E-G., pages 13-14 describes that goals are established for medical and behavioral health care in collaboration with the member, and gives examples of member self-management goals and supports.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
10. The Contractor's procedures provide for continuity of care for newly enrolled members to prevent disruption in the provision of medically necessary services. ◆ The Contractor informs new members with special healthcare needs involved in an ongoing course of treatment that he/she: ▪ May continue to receive covered services for 60 calendar days from his/her current provider. ▪ May continue to receive covered services from ancillary or non-network providers for a period of 75 calendar days. ◆ The Contractor informs a new member who is in her second or third trimester of pregnancy that she may continue to see her current provider until the completion of postpartum care. Contract: Exhibit A4—2.7.4.3.6; 2.7.5.1.1; 2.7.5.1.2; 2.7.5.1.3	*RMHP CHP+ Benefits Booklet-0316* Page 12 informs members with special health care needs of the length of time that they can continue to receive covered services from their previous provider(s) after becoming enrolled with RMHP, and that they can continue to see their previous primary care provider if they are in their fourth through ninth month of pregnancy until completion of postpartum care. *III_CS_CHP+ Welcome Call Script* *III_CS_CHP+ Welcome Letter_English_Spanish* In the *Welcome Call Letter* and on page 2 of the *Welcome Call Script*, Members are advised of the length of time that they can continue to receive covered services from their current provider(s) after becoming enrolled with RMHP. In the *Welcome Call Letter*, and on page 4 of the *Welcome Call Script*, Members are advised "If you are in your second or third trimester (from 3 to 9 months) of pregnancy you may stay with your doctor for the delivery of your baby and the care you need after your baby is born." *III_CM_ Medicaid and CHP+ Care Coordination Policy and Process* Section I.C.1.f.iv., page 5 indicates that to preserve continuity of care, RMHP allows a member with special healthcare needs to continue to see their previous provider for up to 60 days from date of enrollment, and for a period of 75 days for covered services provided by an ancillary provider for a prescribed course of care. Additionally, members do not need a referral if they are seeing a specialist in-network. Section I.C.1.G.iii., page 6 indicates that the RMHP care coordinator will inform a new Member who is in her second or third trimester of pregnancy, that she may continue to see her current Provider until the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	completion of post-partum care directly related to the delivery. *III_CM_People w SHCN Policy* The Section *Integrated Patient-Centered Care Coordination*, Section V., page 4 describes that to preserve continuity of care, RMHP allows a member with special healthcare needs to continue to see their previous provider for up to 60 days from date of enrollment, and for a period of 75 days for covered services provided by an ancillary provider for a prescribed course of care. Additionally, members do not need a referral if they are seeing a specialist in-network. *III_CM_Continuity of Care 2016* In the *Medicaid and CHP+ Members* section on page 4 of this policy it is explained that RMHP informs a new member who is a person with special healthcare needs that may continue to receive medically necessary covered services from his or her practitioner for 60 calendar days from the date of enrollment if the member is in an ongoing course of treatment with the previous practitioner. They are also informed that they can receive medically necessary covered services from ancillary practitioners at the level of care received prior to enrollment for a period of 75 calendar days. New members who are in their 2nd or 3rd trimester of pregnancy may continue to see their provider until the completion of postpartum care.	
11. If necessary primary or specialty care cannot be provided to members with special healthcare needs within the Contractor's plan, the Contractor makes arrangements for members to access these providers outside the network. Contract: Exhibit A4—2.7.5.2	*III_CM_Continuity of Care 2016* This policy indicates that RMHP Care Managers are able to help members access out-of-network providers during defined circumstances. *III_CM_ Medicaid and CHP+ Care Coordination Policy and Process* Section I.C.1.f.viii., page 5 states that the Care Coordinator will make arrangements for the member to access providers outside the network, if needed services are not provided by an in-network provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	III_CM_Medicaid CHP+ Preauthorization Policy & Procedure 2016 Section 17, page 4 describes the process RMHP uses to review out-of-network requests for services that may be approved if the request is a result of continuity of care or for other medically necessary reasons.	
12. The Contractor allows members with special healthcare needs direct access to a specialist (for example, through a standing referral), as appropriate for the member's condition, and/or to maintain these types of specialists as PCPs. *42CFR438.208(c)(4)* Contract: Exhibit A4—2.7.5.4	*III_CM_ Medicaid and CHP+ Care Coordination Policy and Process* Section I.C.1.f.v., page 5 states RMHP care coordinators will inform Persons with Special Health Care Needs who use specialists frequently for their health care to maintain these types of specialists as PCMPs or be allowed direct access or a standing referral to specialists for the needed care. Section I.C.1.f.viii., page 5 states that the Care Coordinator will make arrangements for the member to access providers outside the network, if needed services are not provided by an in-network provider. *III_CM_People w SHCN Policy* Section V, page 4 describes that RMHP allows persons with special healthcare needs who use specialists frequently for their healthcare to maintain access to these types of specialists by allowing direct access or a standing referral to specialists for the needed care. *III_CM_ Medicaid and CHP+ Care Coordination Policy and Process* Section I.C.1.f.viii., page 5 states that the Care Coordinator will make arrangements for the member to access providers outside the network, if needed services are not provided by an in-network provider. *RMHP CHP+ Benefits Booklet-0316* Page 13, *Specialists*, informs members that "you do not need a referral to see a specialist that works with RMHP."	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	12

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A4—3.1.1.1	*IV_CS_Prime and CHP+ Rights and Responsibilities _PP* Pages 1-2 of this Policy and Procedure lists Medicaid member rights as specified in state and federal regulation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor ensures that its staff and affiliated and network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A4—3.1.1.1.1	*2016 Provider Manual* Page 96 of the Provider Manual describes member rights to network providers. *IV_PNM_LawExhibit to Provider Agreements* Page 7, Section 5 for Medicaid Recipient Rights. *IV_Corp_Mission and Values* This is core to RMHP's values. RMHP's value statement includes: "We honor the rights of physicians and patients in medical decision-making."	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or	*IV_CS_Prime and CHP+ Rights and Responsibilities_PP* Pages 1-2 of this Policy and Procedure lists member rights as specified in state and federal regulation. *2016 Provider Manual* Page 96 of the Provider Manual describes the specified member rights to network providers.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality. *42CFR438.100(b)(2) and (3)* Contract: Exhibit A4—3.1.1.1.2–3.1.1.1.6; 3.1.1.3.2		
Findings: Medicaid Prime and CHP+ Member Rights and Responsibilities policy and procedure listed all of the rights, as required; however, the document stated that members have the right to obtain family planning services from "any Medicaid Prime or CHP+ provider, with no referral required." The document should specify that CHP+ members have the right to obtain family planning services from any duly licensed provider, in or out of the network, without a referral.		
Required Actions: RMHP must update its Member Rights and Responsibilities policy and procedure to clarify that CHP+ members have the right to obtain family planning services from any duly licensed provider, in or out of the network, without a referral.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: Exhibit A4—3.1.1.1.7	*IV_CS_Prime and CHP+ Rights and Responsibilities_PP* See page 2, bullet #8, which indicates that the member is able to exercise their rights without being treated differently. *2016 Provider Manual* See page 96 of the Provider Manual, which indicates that the member is able to exercise their rights without being treated differently. *RMHP CHP+ Benefits Booklet-0316* See page 17, bullet #8 that indicates to members that they are able to exercise their rights without being treated differently. *IV_PNM_LawExhibit to Provider Agreements* Page 7, Section 5, *Medicaid Recipient Rights*, which states that	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	"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)."	
5. The Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: 21.A	*IV_HR_2015 Equal Opportunity Policy_11-12-15* This policy states that all federally funded benefits and services are provided in accordance with Title VI of the Civil Rights Act, as amended, Section 504 of the Rehabilitation Act, as amended, the Age Discrimination Act of 1975, as amended, the Americans with Disabilities Act of 1990, as amended, as well as other related laws. It further states that all subcontractors are notified of their responsibility to comply with these laws. This policy is distributed widely—to members (in Member Handbook), employees (in Employee Handbook), vendors/contractors (in contact) and providers (in Provider Manual). It is also posted in prominent locations in our offices and on our website. *IV_HR_ Law Exhibit_Non-Prov_Ind Contractor_0815* This Law Exhibit is attached to all non-provider contracts that are executed with RMHP. See page 3, #11 for a list of statutes and regulations that RMHP requires the Contractor and any subcontractor to comply. *IV_HR_Reaffirm Letter Template* This letter reaffirms RMHP's commitment to equal opportunity, and is sent to all RMHMC vendors and agency staffing firms on an annual basis. *IV_PNM_LawExhibit to Provider Agreements* Law Exhibit, page 1, Section I.1. and I.2. presents the *Non-Discrimination* and *Equal Opportunity* language found in provider contracts. Page 7 references other federal and state laws that pertain to member rights.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard IV—Member Rights and Protections							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	5	**Total Score**		=	4

Total Score ÷ Total Applicable	=	80%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence 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's credentialing program shall comply with the standards of the National Committee for Quality Assurance (NCQA) for initial credentialing and recredentialing of participating providers. NCQA CR1 CHP+ Contract: Exhibit A4—3.2.1.1; 3.2.1.3	*VIII_QI_Credentialing Process* *VIII_QI_Recredentialing Process* These two documents define RMHP's credentialing and recredentialing processes for evaluating and selecting licensed independent practitioners to provide care to our members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include MDs, DOs, podiatrists, nurse practitioners, and each type of behavior health provider.) *42CFR438.214(a)* NCQA CR1—Element A1	*VIII_QI_Credentialing Process* Section I. B. *VIII_QI_Recredentialing Process* Section I. C. The tables on pages 4-6 outline the types of practitioners that RMHP credentials and recredentials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.B. The verification sources used. NCQA CR1—Element A2	*VIII_QI_Credentialing Process* Section II. B., pages 8-9 *VIII_QI_Recredentialing Process* Section II. C., pages 9-10 This section (Source Verification) outlines the sources used to verify practitioner credentials (approved credentialing verification sources).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	*VIII_QI_Credentialing Process* Section I. A-B, pages 2-7 *VIII_QI_Recredentialing Process* Section I. A-C, pages 2-7 This section outlines the criteria used for credentialing and recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	*VIII_QI_Credentialing Process* Section II. C-D., pages 10-12 *VIII_QI_Recredentialing Process* Section II. D-E., pages 10-12 *VIII_QI_Credentialing and Recredentialing Approval Workflow 2016* These sections (Review and Determination, Final Decision and Notifications) and the Approval Workflow describe RMHP's process for making credentialing and recredentialing decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	*VIII_QI_Credentialing Process* Section II.C., pages 10-11 *VIII_QI_Recredentialing Process* Section II. D., pages 10-11 This section describes the process for managing credentialing and recredentialing files according to RMHP's criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	*VIII_QI_Delegated Credentialing & Recredentialing* This document outlines the process for delegation of credentialing and recredentialing activities, and establishes uniform guidelines regarding delegated activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.G. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which	*VIII_QI_Nondiscriminatory Credentialing* This policy establishes the steps that RMHP takes during credentialing processes to monitor and prevent discriminatory practices. *VIII_QI_Provider Discrimination Review for 2015 – Final* This document provides results of the Provider Discrimination Review for calendar year 2015. The Conclusion on page 15 indicates that Internal	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
the practitioner specializes; and that it takes proactive steps to prevent and monitor discriminatory practices). NCQA CR1—Element A7	Audit (IA) did not find any evidence that RMHP is engaging in discriminatory practices in the management of its provider network.	
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	*VIII_QI_Credentialing Process* Section II. B., page 8, paragraph 3 *VIII_QI_Recredentialing Process* Section II. C., page 9, paragraph 3 This section provides the process that RMHP follows for notifying practitioners if information obtained from sources varies substantially from that provided on the application	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. NCQA CR1—Element A9	*VIII_QI_Credentialing Process* Section II. D., page 12 *VIII_QI_Recredentialing Process* Section II. E., page 12 This section indicates that when a determination has been made by Medical Direction or the MPRC, the practitioner will be notified via letter from the Professional Relations Representative within 60 days. *VIII_PR_Provider and Group Notification of Initial Credentialing Complete* See *Guideline* on page 1 of this policy. This indicates that notification is sent to providers and groups within 60 days of credentialing approval.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	*VIII_QI_Credentialing Process* Section I., page 1 *VIII_QI_Recredentialing Process* Section I., page 1	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
	Section I. indicates that the RMHMO Board of Directors (BOD) has delegated the responsibility for the credentialing function, review and approval authority for the credentialing policies and procedures and determination as to panel acceptance to the RMHP Chief Medical Officer, and that any Associate Medical Directors may cover for the RMHP Chief Medical Officer for credentialing purposes.	
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process. NCQA CR1—Element A11	*VIII_QI_Credentialing Process* Section II. F., page 12-13 *VIII_QI_Recredentialing Process* Section II. G., page 13 This section delineates the RMHP process for ensuring the confidentiality of information obtained in the credentialing and recredentialing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	*VIII_QI_Practitioner Specialties* The process for ensuring that listings in practitioner directories are accurate is described on page 13, Section F. *VIII_PR_Directory Validation Process* This policy outlines how RMHP validates physician and hospital information for updates to the printed and web-based directories.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.M. The Contractor notifies practitioners about their rights: ◆ The right to review information submitted to support their credentialing or recredentialing application. NCQA CR1—Element B1	*VIII_QI_Credentialing Process* Section II., page 7 *VIII_QI_Recredentialing Process* Section II., page 7 RMHP utilizes the Colorado Health Care Professional Credentialing Application. Through the use of this state application, the applicant is informed of their right to review information submitted to support their credentialing/recredentialing application. *VIII_QI_CHCP_Credential_App*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
	Page 23, item 12 explains the right to review information submitted in support of the application. *VIII_QI_Join RMHP_Providers* See screen print of a page on the rmhp.org website that explains practitioners' rights related to the provider application process.	
2.N. The right to correct erroneous information. NCQA CR1—Element B2	*VIII_QI_Credentialing Process* *VIII_QI_Recredentialing Process* Section II., page 7 of these documents explains that RMHP utilizes the Colorado Health Care Professional Credentialing Application. Through the use of this state application, the applicant is informed of their right to correct erroneous information obtained during the credentialing/recredentialing process. *VIII_QI_CHCP_Credential_App* Page 23, item 12 explains the right to correct erroneous information. *VIII_QI_Join RMHP_Providers* See screen print of a page on the rmhp.org website that explains practitioner rights related to the provider application process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.O. The right to receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	*VIII_QI_Credentialing Process* *VIII_QI_Recredentialing Process* Section II., page 7 RMHP utilizes the Colorado Health Care Professional Credentialing Application. Through the use of this state application, the applicant is informed of their right to receive the status of their application upon request. *VIII_QI_CHCP_Credential_App* Page 23, item 12 explains the right to right to be informed of the status of the application upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
	VIII_QI_Join RMHP_Providers See screen print of a page on the rmhp.org website that explains practitioners' rights related to the provider application process.	
2.P. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles 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 identified instances of poor quality related to the above. NCQA CR6—Element A	*VIII_QI_Midcycle Credentialing* Section II. A. & D., pages 2-3 explains the RMHP process for reviewing provider status updates related to sanctions or limitations on licensure, adverse events and instances of poor quality. *VIII_QI_National Practitioner Databank* This Policy/Procedure explains the RMHP process to query the NPDB as part of the application process. The NPDB report will serve as primary source verification of sanctions against or limitations on licensure, sanction activity by Medicare and Medicaid, and malpractice history. *VIII_QI_Ongoing monitoring sample reports Oct 2015* A sample of a monthly report collected and reviewed for sanctions will be available at the site review. *VIII_QI_Complaints Log* The log of complaints that were collected and reviewed will be available at the site review. There were no office site complaints during this review period. *VIII_QI_QA CASE REVIEW DIAGRAM* This diagram illustrates the RMHP quality case review process. *VIII_QI_MPRC Minutes* These Medical Practice Review Committee (MPRC) minutes illustrate examples of interventions when instances of poor quality are identified.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
2.Q. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR7—Element A1	*VIII_QI_Reduction, Suspension or Termination* Section 1, page 2 describes the range of actions available to RMHP, including mentoring, increased oversight or other proposed professional review action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.R. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR7—Elements A2 and B	*VIII_QI_Reduction, Suspension or Termination* Section 4, page 6 indicates that the RMHP Chief Medical Officer shall report any sanction, suspension or termination of a health care provider due to quality of care issues to the state licensing agency, Colorado Board of Medical Examiners (CBME) and NPDB/HIPDB, as applicable.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.S. A well-defined appeal process for instances in which the Contractor has taken action against a practitioner for quality reasons, which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision.	*VIII_QI_Reduction, Suspension or Termination* Section 1.a., pages 2-3 provides information regarding the Review Committee Recommendation, Notice and Hearing. *VIII_QI_Credentialing Process* Section II. D., page 12 *VIII_QI_Recredentialing Process* Section II. E., page 12 This section provides information regarding the final decision and notification process. *VII_QI_Hearing Panel Notice Template* This notice of MPRC Hearing provides details of the Hearing and lists the Hearing panel members. *VIII_QI_Initial Denial Letter template* *VIII_QI_Recredential Denial* These denial letters provide written notification that a professional review	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
NCQA CR7—Elements A3and C	action has been brought against a practitioner, provides reason for the action, and includes appeal process and timeframe for requesting a hearing. When a letter is drafted, Medical Direction and/or Regulatory Affairs staff include specific reason(s) for each case decision as appropriate.	
2.T. Making the appeal process known to practitioners. NCQA CR7—Elements A4 and C	*VIII_QI_Reduction, Suspension or Termination* Section 1.c., page 4 indicates that RMHP issues a written notice to the practitioner that includes the health care provider's right to appeal the MPRC's recommendation and the process for doing so. *VIII_QI_Credentialing Process* Section II. D., page 12 *VIII_QI_Recredentialing Process* Section II. E., page 12 This section indicates that the practitioner will be notified of a recommended denial of a provider application, and if the recommended denial is a potential professional review action, the practitioner will be notified of the appeal process in the letter.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A1	*VIII_QI_Credentialing Committee* This policy describes the Credentialing committee structure and function. *VIII_QI_MPRC Member List* This MPRC listing shows the range of specialties participating in each regional credentialing committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
4. The credentialing committee: ◆ Reviews credentials for practitioners who do not meet established thresholds. ◆ Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Elements A2 and A3	*VIII_QI_Credentialing Process* Section II. C., pages 10-11 *VIII_QI_Recredentialing Process* Section II. D., pages 10-12 This section, *Review and Determination*, describes the various levels of review/response by the Medical Director or credentialing committee based on the status of the applicant's file. *VIII_QI_MPRC Minutes* This is a sample of the credentialing committee meeting minutes where practitioners who do not meet established thresholds were reviewed. *VIII_QI_Medical Director Review of Clean Files* This message demonstrates that a Medical Director reviews and approves files that meet established criteria.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit is 180 calendar days). ◆ A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification—board certification time limit is 180 calendar days).	*VIII_QI_Credentialing Process* Section II. B., pages 8-9 *VIII_QI_Recredentialing Process* Section II.C., pages 9-10 This Section, *Source Verification*, indicates that RMHP verifies all required credentials within 180 days prior to Medical Direction or credentialing committee review. *VIII_QI_State Licensing Verification Letters* This is a sample of the primary source license verification process for a specific specialty.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
◆ Work history (verification time limit is 365 calendar days; nonprimary verification is most recent five years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit is 180 calendar days). NCQA CR3—Element A		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ 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/professional liability insurance coverage (minimums= physician—0.5mil/1.5mil; facility—0.5mil/3mil). ◆ The correctness and completeness of the application. NCQA CR3—Element C CHP+ Contract: Exhibit A4—3.2.2.1.1; 3.2.2.1.2	*VIII_QI_Credentialing Process* Section II., page 7 *VIII_QI_Recredentialing Process* Section II, page 7 This section indicates that RMHP utilizes the Department of Public Health & Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentialing Application. *VIII_QI_CHCP_Credential_App* ◆ Page 26: ability to perform essential functions of the position ◆ Page 25: attestation regarding illegal use of drugs ◆ Pages 19-20: attestations regarding adverse licensure history or felony convictions ◆ Page 19: attestations regarding loss or limitation of privileges or history of disciplinary actions ◆ Page 17: Current malpractice/professional liability insurance coverage ◆ Page 21: attestation regarding the correctness and completeness of the application RMHP utilizes the Department of Public Health & Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional (CHCP) Credentialing Application, or the Council for Affordable Quality Healthcare (CAQH) Universal Provider Datasource (which utilizes CHCP).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure, or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR3—Element B	*VIII_QI_Credentialing Process* Section II. B., page 9 *VIII_QI_Recredentialing Process* Section II. C., page 10 This section outlines the *Source Verification* process for initial credentialing and recredentialing, including license sanction status (State Board of Medical Examiners, NPDB, HIPDB) and Medicare/Medicaid sanction status (Office of Inspector General Debarment Report). *VIII_QI_National Practitioner Databank* This policy establishes the written guidelines for accessing the NPDB for all new applicants and all currently contracted practitioners as part of the recredentialing process. *VIII_PR_Process to Initiate Credentialing* This policy describes the process that Provider Relations (PR) Representatives follow to initiate credentialing for prospective providers. If a provider is found in any of the databases of excluded or sanctioned providers, credentialing is not initiated.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR5—Element A	*VIII_QI_Standards for Practitioner Site Evaluations* Section I., pages 1-3 lists RMHP office site standards, including physical space and medical records handling and security. *VIII_QI_Office Site Evaluation Form* This Office Site Evaluation Form is completed for each site visit. Completed forms are submitted to the Credentialing Department where the results are reviewed and entered into the Site Visit Data Base, Office Site Complaint Log (if applicable) and a copy of the evaluation form is maintained on file.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR5—Element B	*VIII_QI_Office Site Quality – Credentialing* Section I., page 1 indicates that office site evaluations are conducted when member complaints are received about the quality of a practitioner's office. Follow-up reviews are scheduled in offices where deficiencies are noted. Page 2 describes how member complaints regarding office deficiencies are received and monitored. Section II., pages 2-3 outlines when an office site evaluation should be performed and the requirements by which they will be conducted, monitored, repeated and documented. Practice sites not meeting RMHP criteria will continue to be monitored until deficiencies are corrected. All follow-up and follow-through will be documented and monitored by the Credentialing Department. No site evaluations were performed during this review period because RMHP did not receive any member complaints about the quality of a practitioner's office during this period. *VIII_QI_Office Site Evaluation Form* This Office Site Evaluation Form is completed for each site visit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor formally recredentials its practitioners at least every 36 months. NCQA CR4	*VIII_QI_Recredentialing Process* Section I., page. 2 states that recredentialing will occur at least every three years.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms—initially and at least every three years—that the provider is in good standing with state and federal regulatory bodies. NCQA CR8—Element A1	*VIII_QI_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Section I. F., page 4 states that each organizational provider with which RMHP contracts will be assessed by the credentialing staff for continued compliance with the Standards for Participation every three years for the duration of the contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
11.B. The Contractor confirms—initially and at least every three years— that the provider has been reviewed and approved by an accrediting body. NCQA CR8—Element A2	*VIII_QI_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Section I. B., page 2 states that RMHP will verify that current accreditation is in good standing with an acceptable accrediting body if applicable. The accrediting bodies recognized by RMHP are listed in Section I.C., page 3.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.C. The Contractor conducts—initially and at least every three years—an on-site quality assessment if there is no accreditation status. NCQA CR8—Element A3	*VIII_QI_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Section I. D., pages 3-4 describes the process that RMHP follows in the case of non-accredited facilities. RMHP accepts a State Survey report or CMS Survey report in lieu of accreditation, providing the report is less than three years old at time of verification. State/CMS Surveys do not serve as accreditation of a provider, however, these surveys are considered an acceptable substitute for accreditation since significant oversight is provided by these regulatory bodies. *VIII_QI_Mechanism for Reviewing State Operations Manual* This document describes how RMHP will accept the standards set forth in the Colorado State Operations Manual for RMHP credentialed facilities in lieu of performing site visits internally.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.D. The Contractor's policies specify the sources used to confirm: ◆ That providers are in good standing with state and federal requirements. ◆ The provider's accreditation status. (Includes applicable state or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider.) NCQA CR8—Element A, Factors 1 and 2	*VIII_QI_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. Section I. B., page 2 lists the documentation that must be submitted by all organizational providers to demonstrate that they are in good standing with regulatory or accrediting bodies. The accrediting bodies recognized by RMHP are listed in Section I.C., page 3. Section I.D., page 4 indicates that a non-accredited organization must provide a copy of the State/CMS Survey report, including the cover letter and correction of deficiencies statement or a letter from CMS or the applicable state agency which shows the organization was reviewed and indicates that it passed inspection.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that that the provider credentials its practitioners. NCQA CR8—Element A, Factor 3	*VIII_QI_Health Delivery Organization* Section I. D., pages 3-4 describes the process that RMHP follows in the case of non-accredited facilities. RMHP accepts a State Survey report or CMS Survey report in lieu of accreditation, providing the report is less than three years old at time of verification. State/CMS Surveys do not serve as accreditation of a provider, however, these surveys are considered an acceptable substitute for accreditation since significant oversight is provided by these regulatory bodies. Section D., page 4 indicates that non-accredited organizational providers must also provide confirmation such as policies and procedures regarding credentialing and/or hiring practices, or a written description of such practices attesting that staff are both legally and professionally qualified for the positions they hold. *VIII_QI_Mechanism for Reviewing State Operations Manual* This document describes how RMHP will accept the standards set forth in the Colorado State Operations Manual for RMHP credentialed facilities. Page 2 indicates that the RMHP Credentialing Lead and Manager verify that the survey process evaluates the facility's procedure for the credentialing of medical staff providing services to members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards. NCQA CR8—Element A, Factor 3	*VIII_QI_Health Delivery Organizations* This policy describes the initial credentialing and recredentialing criteria for organizational providers. See section I. D., pages 3-4 for information regarding RMHP's acceptance of recent State Survey report or CMS Survey report in lieu of accreditation, provided that the report is less than three years old at time of verification. RMHP obtains a copy of the State/CMS Survey report or a letter from the applicable agency, which shows that the facility was reviewed and passed inspection. *VIII_QI_Mechanism for Reviewing State Operations Manual* This document describes how RMHP will accept the standards set forth in the Colorado State Operations Manual for RMHP credentialed facilities in lieu of performing site visits internally.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers: ◆ Hospitals. ◆ Home health agencies. ◆ Skilled nursing facilities. ◆ Free-standing surgical centers. NCQA CR8—Element B	*VIII_QI_Health Delivery Organizations* Section I., page. 1 lists the organizational providers defined for the purposes of this policy, including hospitals, home health agencies, skilled nursing facilities, free-standing surgical centers and others.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor's organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: ◆ Inpatient. ◆ Residential. ◆ Ambulatory. NCQA CR8—Element C	*VIII_QI_Health Delivery Organizations* Section I., page 1 lists the organizational providers defined for the purposes of this policy, including behavioral health facilities providing mental health or substance abuse services in inpatient, residential, or ambulatory settings.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. The Contractor has documentation that it has assessed contracted medical healthcare (organizational) providers. NCQA CR8—Element D	*VIII_QI_HDO Medical Universe* This file represents RMHP contracted organizational providers (Health Delivery Organization) and their credentialing status, including initial credentialing date, last credentialing date, next credentialing date, etc. *VIII_QI_SAMPLE - Accred Medical HDO* This is a sample credentialing record of an accredited organizational provider (Health Delivery Organization) credentialed by RMHP. *VIII_QI_SAMPLE - Non-Accred Medical HDO* This is a sample credentialing record of a non-accredited organizational provider (Health Delivery Organization) credentialed by RMHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
16. The Contractor has documentation that it has assessed contracted behavioral healthcare (organizational) providers. NCQA CR8—Element E	*VIII_QI_HDO Behavioral Health Universe* This file represents RMHP contracted behavioral health organizational providers (Health Delivery Organization) and their credentialing status, including initial credentialing date, last credentialing date, next credentialing date, etc. *VIII_QI_SAMPLE - Accred Behavioral Health HDO* This is a sample credentialing record of an accredited behavioral health organizational provider (Health Delivery Organization) credentialed by RMHP. *VIII_QI_SAMPLE - Non-Accred Behavioral Health HDO* This is a sample credentialing record of a non-accredited behavioral health organizational provider (Health Delivery Organization) credentialed by RMHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR9	*VIII_QI_Delegated Credentialing Audit Activities* Section II. B., page 2 of this policy describes RMHP's oversight of delegated activities. Each delegated credentialing entity is audited on at least an annual basis by RMHP for compliance with RMHP standards. *VII_QI_2015 P&P Audit Tool SWH* *VII_QI_2015 P&P Audit Tool - UPI* These completed audit tools provide evidence of RMHP oversight of delegated credentialing activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. 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	*VIII_QI_Delegated Credentialing & Recredentialing* Section I., page 1states that each delegated entity and RMHP enter into a mutually agreed upon Delegated Credentialing Agreement prior to the entity performing any portion of the credentialing process on behalf of RMHP. Sections II. D., page 5 indicates that the specific elements delegated to each entity are outlined in the Delegated Credentialing Addendum attached to each contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the delegation agreement) if the delegate does not fulfill its obligations. NCQA CR 9—Element A	*VIII_QI_Delegated Cred Agmt template* For each bullet in Column 1, see notes on pages 1, 2, 3, 5, 7. *VIII_QI_Delegated Cred Agreement_Southwest HealthNet* *VIII_QI_Delegated Cred Agreement_UPI* *VIII_QI_Delegated Cred Agreement_Vail Clinic* *VIII_QI_Delegated Cred Agreement_Montrose Community HP* *VIII_QI_Delegated Cred Agreement_Physiotherapy Corp* *VIII_QI_Delegated Credentialing Agreement Termination* This policy establishes a procedure for transitioning the credentialing activities back to RMHP when either party terminates a delegated agreement.	
19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR9—Element B	Member specific PHI is not shared or included in any of RMHP's delegated arrangements.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
Findings: RMHP's credentialing delegation arrangements include no use of protected health information.		
20. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR9—Element C	*VIII_QI_Delegated Credentialing & Recredentialing* Section I., page 1 of this policy states that RMHP retains the right to approve, deny, suspend, or terminate each practitioner and practitioner site of care. *VIII_QI_Delegated Cred Agmt template* Section 2. I., page 3 states that RME reserves the right to approve, suspend, terminate or restrict the right of any Participating Provider to treat Covered Persons.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR9—Element D	*VIII_QI_Delegated Credentialing & Recredentialing* Section II. B. 2., pages 3-4 states that each prospective delegated entity will complete the Pre-contractual Delegation Evaluation Form. The form will be evaluated by RMHMC credentialing staff. *VIII_QI_Delegated Credentialing Audit Activities* Section II. A., page 1 states that each prospective delegated credentialing entity will be evaluated for delegation capacity prior to extension of a Delegated Credentialing Agreement. The evaluation will consist of a Pre-contractual Delegation Evaluation Form, file audit and a review of the entity's Credentialing Policy and Procedures. RMHP does not have any delegated agreement(s) in effect for less than 12 months in the Medicaid/CHP+ service area.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: RMHP's policies described the process for evaluating a potential delegate's capacity before signing a delegation agreement; however, RMHP had no delegation agreements in effect for less than 12 months.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the Health Plan**	**Score**
22. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR9—Element E1	*VIII_QI_Delegate Annual Oversight Tracking Tool* This tracking tool illustrates current RMHP activity to audit delegated credentialing files. *VIII_QI_Delegate Oversight File Review 2015 - Southwest HealthNet* *VIII_QI_Delegate Oversight File Review 2015 - UPI* Samples of RMHP annual delegated file reviews against NCQA standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR9—Element E2	*VIII_QI_Delegate Annual Oversight Tracking Tool* This tracking tool illustrates current RMHP activity to audit delegated activities against NCQA standards. *VII_QI_2015 P&P Audit Tool - SWH* *VII_QI_2015 P&P Audit Tool - UPI* Samples of annual evaluation of delegation activities against NCQA standards and organization expectations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR9—Element E3	*VIII_QI_Delegate Semi-Annual Report Tracking Tool* Demonstrates RMHP activity to evaluate credentialing reports from Delegates semiannually. *VIII_QI_1SA15 report SWHN.pdf* *VIII_QI_2SA15 report SWHN.pdf* *VIII_QI_1SA15 report UPI.pdf* *VIII_QI_2SA15 report UPI.pdf* Samples of semi-annual reports.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor identified and followed up on opportunities for improvement (at least once in each of the past two years), if applicable. NCQA CR9—Element F	*VIII_QI_Delegate Annual Oversight Tracking Tool* RMHP identified and followed up on 3 issues noted in the *Annual Oversight Tracking Tool.* *VIII_QI_2SA15 report SWHN* *VIII_QI_2SA15 report UPI* Examples of two delegates, Southwest HealthNet, and University Physicians, Inc. self-identifying and reporting improvement activities on the Semi-Annual Credentialing Submission Form.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	46	X	1.00	=	46
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	2	X	NA	=	0
Total Applicable		=	46	**Total Score**		=	46

Total Score ÷ Total Applicable	=	100%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240*(a) Contract: Exhibit A4—2.9.1	*X_QI_Corporate QI Program Description 2015_2016* *X_QI_Corporate Quality WorkPlan_2015 Final* *X_QI_Corporate Quality Program Annual Report 2014 Final* *X_QI_Intervention Work Plan 2015*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A4—2.9.4.4.1	*X_QI_Corporate Quality WorkPlan_2015 Final* Page 7, Section H.1.d. Demonstrate improvement in ER utilization in the target population. Page 10, Section 1.b.3.b. Behavioral Health Integration: development of Community Health Team to focus on behavior change in inappropriate ER utilization populations. *X_QI_Corporate Quality Program Annual Report 2014 Final* Page 50, Section H., 1.d. Practice Transformation Community Health Worker Pilot Pages 67-68, Section K., 1.b.3. b. Pay for Performance Behavioral Health Integration and development of Community Health Team. *X_QI_Intervention Work Plan 2015* Includes interventions to address under-utilization, for example, page 5, targeted prenatal calls.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care for persons with special healthcare needs.	*X_QI_Corporate Quality WorkPlan_2015 Final* Page 2, 1h Complex Health Needs Assessment Page 4, Section 7: Complex Case Management	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
42CFR438.240(b)(4) Medicaid Contract: Exhibit A—2.7.2.4.4 CHP+ Contract: Exhibit A4—None	Page 5, Section C: Continuity and Coordination of Medical Care and Between Medical and Behavioral Healthcare *X_QI_Corporate QI Program Description 2015_2016* Page 11, A.1.c. Complex Health Needs, and Page 11, A.1d. Collaboration on Continuity and Coordination of Care Page 12, A.1.f. Complex Case Management Program	
4. The Contractor adopts practice guidelines for the following: ◆ Perinatal, prenatal, and postpartum care for women. ◆ Conditions related to persons with a disability or special healthcare needs. ◆ Well child care. Contract: Exhibit A4—2.9.2.1.1	*X_QI_AAP_Bright Futures Periodicity Schedule_2015* Recommendations for Preventive Pediatric Health Care. *X_QI_Clinical Practice Guidelines* Outlines RMHP's process for reviewing, approving, and distributing clinical guidelines. RMHP adopts both Medical and Behavioral Health Guidelines, to support quality and clinical activities at RMHP. *X_QI_Perinatal Care Guideline* Guidelines adopted and approved by RMHP Medical Advisory Committee September 23, 2014. *X_QI_Special Health Care Needs_Children 0514* *X_QI_Adults with Special Health Care Needs 2014 _Final* These documents represent RMHP's Clinical Practice Guidelines for Children and Adults with Special Health Care Needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor ensures that practice guidelines comply with the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field.	*X_QI_Clinical Practice Guidelines* Page 1, Section 1.c. Guidelines will be reviewed and adopted directly from a recognized source (an organization that develops evidence based clinical practice guidelines, such as Health TeamWorks or specialty societies).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare professionals. ◆ Are reviewed and updated annually. *42CFR438.236(b)* Contract: Exhibit A4—2.9.2.1.2	Page 2, Section 1.e. Includes an analysis of the relevancy of the guideline to the RMHP population. Page 1, Section 1.a. Annually and when new scientific evidence and/or national standards warrant a review, guidelines are reviewed for updates or changes to current clinical practice initially by the Quality Improvement Department with consultation by other internal clinical staff as necessary (i.e. Medical Directors and pharmacists). *X_CM_UM 2 Criteria for UM Decisions* The intent of this policy is to ensure that RMHP applies written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services; that appropriate licensed practitioners are involved in the development, adoption, and review of clinical guidelines; that all healthcare professionals apply the guidelines accurately and consistently; that RMHP identifies opportunities to improve and acts on them. Section I, pages 1-2 describes the processes used for guideline application and review, lists the approved guidelines and Section VI**,** the order in which they are applied. Sections II, III, and IV, pages 2-3 describe the clinical information used in making a decision as well as consideration of Member needs and characteristics of the local delivery system. Section I.B.5, page 2 indicates that practitioners with professional knowledge or clinical expertise in the relevant area have an opportunity to give advice or comment on development, review, and adoption of UM criteria and on instructions for applying criteria.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	X_CM_UM 2 Criteria Development Workflow *X_CM_Template for Practitioner Review Letter* *X_CM_Template_Present Physician Reviews* The workflow describes the process and participants in the development and approval of criteria used in UM decision making. Practitioner input is solicited through written contact with contracted specialties with expertise in the relevant area (see *Template for Practitioner Review Letter*). Their responses are reviewed by the responsible Associate Medical Director and presented to the NTAG Committee during annual review of the guidelines or during development of new guidelines (see *Template_Present Physician Reviews).* *X_CM_UM 2 Criteria for UM Decisions* *X_CM_Annual Guideline Review* Section VII, page 4 of *Criteria for UM Decisions* indicates that guidelines are reviewed at least annually through the New Technology and Guidelines Physician Advisory Committee (NTAG). *Annual Guideline Review* includes the review dates for guidelines. Pages 4-5 include the *Minutes from the Medical Advisory Council* (MAC) where guidelines were approved. See the New Technology and Guidelines Physician Advisory Committee (NTAG) section on page 5.	
6. The Contractor disseminates the guidelines to all affected providers, and upon request to members, the Department, other nonmembers, and the public, at no cost. *42CFR438.236(c)* Contract: Exhibit A4—2.9.2.1.3	*X_CM_UM 2 Criteria for UM Decisions* Section VIII, page 4 indicates that guidelines used in UM decision-making are available at no cost upon request. Practitioners and Members are notified in writing that they are available. *X_CM_Preauthorization_All LOB Web Page* Website information at http://www.rmhp.org/members/prior-authorization informs members about the preauthorization process. See page 3 for criteria used to make decisions, and informs members of the availability	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	of these criteria at no cost to the Member or doctor. *X_RMHP Fall 2015 Medicaid_CHP+ Newsletter* *See page 3.* Members are informed in this member newsletter that information regarding preauthorizations is available at rmhp.org or by calling Customer Service. *X_CM_Denial Letter_Commercial_Medicaid_CHP+* When requests for preauthorization are denied, providers and Members are informed in writing that they can request free copies of any information or criteria used in making the decision. *X_CM_Provider Web Page* See pages 2- 3. This web page is publically accessible at http://www.rmhp.org/providers/prior-authorization. The section titled *Criteria* informs providers that criteria are available and how to make a request for copies. *2016 Provider Manual* See page 72. Criteria used to make decisions are available, free of charge, to Physicians, Practitioners, facilities, and Members upon request to RMHP. The process is explained.	
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: Exhibit A4—2.9.2.1.4	*Standard X_CM_UM 2 Criteria for UM Decisions* Section I, pages 1-2 describe preauthorization, concurrent review, and medical claims retrospective review processes and lists the approved criteria. Sections II – IV, pages 2-5 address application of criteria based on pertinent information, the Member's needs, and local delivery systems. Section V, page 3 provides an alternative when no criteria are available. Section VI, pages 5-6 lists the order in which criteria are selected. Section VII, page 6 describes annual review of established criteria and the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	addition of new criteria. Section VIII, page 4 states that criteria are available to practitioners and Members at no cost. Section IX, pages 4-5 addresses consistency in application of criteria. Section X, page 5 informs that delegated entities have processes that comply with the RMHP policy. *X_CM_Denial Letter_Commercial_Medicaid_CHP+* Any time an adverse decision is made for a preauthorization request, the Member and provider(s) are informed in writing. The letter includes the decision, lists what information and criteria were used, and explains which criteria were not met. It includes contact information so that the provider can contact the Medical Director, informs how to obtain a copy of the criteria used, and includes appeal rights and process. *2016 Provider Manual* The Care Management section starting on page 66 of the Provider Manual addresses many aspects of the Care Management Program. It describes the organizational structure that is in place to support correct and consistent development and application of guidelines.	
8. The Contractor calculates and submits specified HEDIS measures determined by collaboration between the Department and the Contractors quality improvement committee. The Contractor: ◆ Analyzes and responds to results indicated in the HEDIS measures. ◆ Calculates additional mandatory federal performance measures when they are required by CMS. Contract: Exhibit A4—2.9.4.1.1; 2.9.4.1.2; 2.9.4.2.1	*X_QI_Annual Population Assessment_2014* The Annual Population Assessment analyzes and responds to results indicated in the HEDIS measures. *X_QI_Corporate Quality Program Annual Report 2014 Final* Page 13. Clinical Monitoring—HEDIS Collection, and Recording Page 14. Review of HEDIS & other clinical quality data results Page 28. HEDIS summary CHP+ Pages 67-69. Pay for Performance (Medicaid & CHP+)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
9. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member Surveys (CAHPS). ◆ Anecdotal information. ◆ Grievance and appeals data. ◆ Enrollment and disenrollment information. Contract: Exhibit A4—2.9.4.3.2	*X_QI_Corporate Quality Program Annual Report 2014 Final* Page 55-59. Delineates various member satisfaction survey tools, results and analysis Page 61. CHP+ CAHPS analysis Page 57, 62-63. Complaints & Appeals Annual Review: An annual analysis is performed on Member complaints and appeals with a correlation to the annual CAHPS surveys. Opportunities for improvement were identified and discussed with the Member Experience Advisory Committee (MEAC). Results are found on pages 62-63. *RMHP CHP MCO Combined Report SFY 2015-16* This report which tracks grievances and appeals will be made available onsite.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor investigates any alleged quality of care concerns. ◆ Upon request, the Contractor shall submit a letter (within 10 business days) to the Department that includes a brief but clear description of the issue, the efforts that the Contractor took to investigate the issue, the outcome of the review, and what action the Contractor intends to take with the providers involved. Contract: Exhibit A4—2.9.4.5.1; 2.9.4.5.2	*X_QI_Qmi-I.2014.Retro Review* Section G, page 5 indicates that upon request, a letter will be submitted to HCPF (within 10 business days) that includes a brief description of the quality of care issue, the efforts taken to investigate the issue, the outcome of the review, and any action RMHP intends to take with the providers involved.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. ◆ The Contractor has a Quality Improvement Committee to assess and implement measures of quality, access, and customer satisfaction. ◆ The annual QAPI report includes:	*X_QI_Corporate Quality Program Annual Report 2014 Final* Page 3 indicates that program activities are structured around an ongoing process of quality monitoring, reporting, and evaluation. A detailed evaluation of the Quality Improvement Program and its activities is conducted annually. This report is a formal summary of the annual evaluation of the quality improvement activities. Page 3. The Quality Improvement Committee (QIC) provides oversight of	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
▪ Specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period. ▪ Status and results of each performance improvement project (PIP) started, continuing, or completed during the prior 12-month period. ▪ Results of member satisfaction surveys completed during the prior 12-month period. ▪ Detailed description of the findings of the program impact analysis. ▪ Techniques used by the Contractor to improve performance. ▪ Overall impact and effectiveness of the QAPI Program during the prior 12-month period. ◆ Upon request, this information shall be made available to providers and members at no cost. *42CFR438.240(e)(2)* Contract: Exhibit A4—2.9.4.7; 2.9.4.6.1	the Quality Improvement Program and continually reviews the performance of the Quality Improvement Program to identify and monitor areas for improvement. Page 4. The QI Program evaluation and report is prepared annually and is reviewed and discussed by the QIC. Page 34. See Wellness and Prevention section. Page 31. See Benchmark Focus for wellness and prevention activities. Page 65-66. See information about CHP+ performance improvement project (PIP). Page 55-63. CAHPS and other survey results, analysis and planning. Pages 50-53. Examples of techniques used by RMHP to improve performance in the area of Practice Transformation. More techniques are found in the entire report. Page 73-74. Summarizes the overall effectiveness of the Quality Program and delineates the major areas requiring improvement. *2016 Provider Manual* RMHP's *Quality Improvement Program Description 2015-2016* is included in its entirety in the RMHP *2016 Provider Manual* (pdf pages 122-143). *RMHP CHP+ Benefits Booklet-0316* Page 71 informs members about RMHP's Quality Improvement Plan and advises that they can request a copy of this plan at no cost.	
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data, including, but not limited to, information on utilization, grievances and appeals, encounters, and disenrollment. *42CFR438.242(a)* Contract: Exhibit A4—2.9.4.10.1	*X_RMHP Health Information Systems_v0.4* This flowchart illustrates the various Health information systems used by RMHP to collect, analyze, integrate and report data. *X_Claims_Steps to Process a Medical Claim* Describes the steps the RMHP takes to process electronic and paper	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	claims from providers—includes the processing steps, role of examiners, systems utilized, workflows and queues. *RMHP CHP MCO Combined Report SFY 2015-16* This report which tracks grievances and appeals will be made available onsite.	
13. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: Exhibit A4—2.9.4.10.2	*X_CI_PCP Practice Monthly Report_PHI Removed* This PCP Practice monthly report demonstrates how RMHP collects and uses data on member and provider characteristics regarding services furnished to members. The various worksheets provide practice summaries, patient summary, patient detail, members who are assigned but unattributed, and enrollment and claims data.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* CHP+ Contract: None	*X_Claims_Steps to Process a Medical Claim* Describes the steps the RMHP takes to process electronic and paper claims from providers—includes the processing steps, role of examiners, systems utilized, workflows and queues. • Verify accuracy and timeliness examples Page 3: checking of line items Page 4: claims sorted and worked by age Page 4: errors researched and cleared Page 4: duplicates are checked by the system automatically • Completeness, logic and consistency examples Page 2: claim with lack of information or eligibility is rejected Page 3: checking of line items Page 4: claims that do not meet criteria are pended • Service information in standardized formats examples Page 1: claims can be received electronically	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	X_IA_2016 Annual Audit Plan These documents describe RMHP audit activities to verify accuracy and timeliness of reported data; screening data for completeness, logic and consistency; and collecting information in standardized formats. See page 4: • Claims Financial and Transaction Accuracy Audit. Additional information in *X_Claims Auditing Manual* below. • Hospital Bill and Chart Review Audits. CAS audit software review, which is an electronic review to identify claims and claim combinations that were possibly paid incorrectly or should not have been paid, depending on set criteria. • Provider Correct Coding Audit. Additional information in *X_FAAD P&P Correct Coding* below. • DME Invoices and Rentals. Audit to review a sample of claims for DME products and services for transactional accuracy and medical necessity. The review includes medical records request to support billed charges. • Percent Billed Contracts. Audit to review a sample of claims paid on percent billed contracts for transactional accuracy to contracted terms. The review includes medical records request to support billed charges. See page 6: • APR-DRG Accuracy. Reviews claims paid with APR-DRG codes for transactional accuracy. The review includes medical records request to support billed charges. *X_IA_Claims Auditing Manual updated 090815* RMHP performs Claims Financial and Transaction Accuracy audits monthly. This document describes the claims accuracy reviews.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by Health Plan**	**Score**
	X_IA_FAAD P&P Correct Coding RMHP conducts post-payment reviews of E&M coding practices to monitor potential upcoding of claims and to improve the accuracy of and consistency of codes submitted by participating providers.	
15. The Contractor submits immunization information for all covered members to the Colorado Immunization Information System (CIIS) monthly. Contract: Exhibit A4—2.9.4.10.6	*X_QI_CIIS Agreement 080414* This agreement with the State of Colorado Immunization Information System illustrates that RMHP has agreed to send immunization and demographic data electronically to CIIS. *X_QI_CIIS Process Documentation* This document describes RMHP's process for sending immunization data to the State of Colorado on a weekly basis. (CIIS has requested that RMHP submit this data weekly).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard X—Quality Assessment and Performance Improvement						
Total	Met	=	15	X	1.00	= 15
	Partially Met	=	0	X	.00	= 0
	Not Met	=	0	X	.00	= 0
	N/A	=	0	X	NA	= 0
Total Applicable		=	15	**Total Score**		= 15

Total Score ÷ Total Applicable	= 100%

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Rocky Mountain Health Plans

Review Period:	January 1, 2013, through December 31, 2015
Date of Review:	April 19–21, 2016
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Judy Narenkivicius and Kelsy Hurley

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (MD, PhD, NP, PA, MSW)	LPC	NP	LCSW	PT	PT	LCSW	PsyD	MD	MD	PsyD
Application/Attestation Date	5/27/14	8/16/13	4/4/14	1/4/15	2/20/14	4/9/14	6/26/14	4/11/13	2/26/14	6/19/14
Credentialing Date (Committee/Medical Director Approval Date)	7/30/14	9/3/13	6/11/14	4/15/15	3/3/14	6/18/14	9/3/14	7/29/13	3/26/14	6/25/14
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	8	9	8	8	8	8	8	9	9	8
# Compliant elements	8	9	8	8	8	8	8	9	9	8
Percentage compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Total Record Review Score					**Total Applicable: 83**		**Total Compliant: 83**		**Total Percentage: 100%**	

Comments:

Review Period:	January 1, 2013, through December 31, 2015
Date of Review:	April 19, 2016
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Judy Narenkivicius and Kelsy Hurley

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (MD, PhD, NP, PA, MSW)	MD	MD	MD	OD	MD	MD	MD	MD	MD	MD
Application/Attestation Date	10/22/13	10/21/14	5/12/15	6/2/15	10/30/15	9/9/15	10/15/13	9/24/15	5/14/15	10/24/14
Last Credentialing/Recredentialing Date	1/31/11	2/21/12	5/29/12	10/1/12	12/17/12	11/19/12	12/20/10	10/29/12	7/9/12	12/20/11
Recredentialing Date (Committee/Medical Director Approval Date)	11/11/13	12/24/14	5/27/15	9/9/15	12/23/15	10/14/15	11/4/13	10/7/15	7/1/15	10/29/14
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☒ N☐ NA☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	9	9	9	9	9	9	9	9	9	9
# Compliant elements	9	9	9	9	9	9	9	9	9	9
Percentage compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Total Record Review Score					**Total Applicable: 90**	**Total Point Score: 90**	**Total Percentage: 100%**

Comments:

Appendix C. Site Review Participants
for Rocky Mountain Health Plans

Table C-1 lists the participants in the FY 2015–2016 site review of **RMHP**.

Table C-1—HSAG Reviewers and Health Plan Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager, State & Corporate Services
Mary Wiley, BSW, RN, MEd	Project Director, State & Corporate Services
Rachel Henrichs	EQR Compliance Auditor, State & Corporate Services
Barbara McConnell, MBA, OTR (telephonic participant in opening session)	Executive Director, State & Corporate Services
Rodd J. Mas (telephonic participant in opening session)	Vice President, State & Corporate Services
RMHP Participants	**Title**
Angela Engle	Quality Improvement Compliance Specialist
Carol Ann Hendrikse	Project Manager, Care Management, and RCCO Clinical Manager
Curtis Fleming	Staff Attorney
Dale Renzi	Director of Provider Network Management
Daniel Grossman	Manager, Internal Audit
David Klemm	Member Experience Manager
Eve Presler	RCCO Colorado Opportunity Project Liaison
Greg Coren	Western Slope Provider Relations Manager and Provider Network Manager
Jackie Hudson	Director of Quality Improvement
Judy Narenkivicius	Credentialing Compliance Coordinator
Kelli Steinkirchner	PNM Project Coordinator
Kelsy Hurley	Credentialing Coordinator Team Lead
Kendra Peters	RCCO Marketing and Communications Coordinator
Kevin Fitzgerald	Chief Medical Officer
Kila Watkins	Complex Case Management/Disease Management Manager
Lesley Reeder	Consultant, Steadman Group
Lori Stephenson	Director of Clinical Program Development and Evaluation
Marci O'Gara	Director of Customer Service
Mike Huotari	Vice President of Legal and Government Affairs
Nancy Steinke	Clinical Policy Manager
Nicole Konkoly	Program Development Specialist, Community Integration
Nora Foster	Compliance/Audit Coordinator
Patrick Gordon	Associate Vice President, Community Integration
Pauline Casey	Senior Program Operations Leader

RMHP Participants	Title
Rhonda Hastings	Program Logistics Coordinator
Sandy Dowd	Director of Care Management
Sharon Steadman	Consultant, Steadman Group
Sheila Worth	Human Resources Analyst
Department Observers	**Title**
Teresa Craig (telephonic)	Contract Manager, CHP+
Chavanne Lamb	Contract Manager, Payment Reform Pilot Program
Katie Mortensen	Quality and Health Improvement Unit
Matt Vedal	Policy and Outreach Specialist

Appendix D. Corrective Action Plan Template for FY 2015–2016 *for* Rocky Mountain Health Plans

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

The template for the CAP follows.

Table D-1—FY 2015–2016 Corrective Action Plan *for* RMHP

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality.	Medicaid Prime and CHP+ Member Rights and Responsibilities policy and procedure listed all of the rights, as required; however, the document stated that members have the right to obtain family planning services from "any Medicaid Prime or CHP+ provider, with no referral required." The document should specify that CHP+ members have the right to obtain family planning services from any duly licensed provider, in or out of the network, without a referral.	RMHP must update its Member Rights and Responsibilities policy and procedure to clarify that CHP+ members have the right to obtain family planning services from any duly licensed provider, in or out of the network, without a referral.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

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

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal healthcare regulations and managed care contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted lists of all CHP+ credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site review request. HSAG used a random sampling technique to select records for review during the site visit. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 3:	**Conduct Site Visit**
	◆ During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance.

For this step,	HSAG completed the following activities:
	◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to CHP+ credentialing and recredentialing. ◆ Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2015–2016 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.