COLORADO

Department of Health Care Policy & Financing

Fiscal Year 2024–2025 Compliance Review Report

for

Rocky Mountain Health Plans

Region 1

April 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Summary of Results

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

Rocky Mountain Health Plans (RMHP) demonstrated a strong general understanding of the federal regulations with an overall score of 96 percent. Two standards scored 100 percent, which is the same score compared to the prior review. However, the Standard VIII and Standard XI scores declined compared to the prior review of those standards.

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%~
IV. Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%~
VIII. Credentialing and Recredentialing	33	32	31	1	0	1	97%v
XI. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	7	7	6	1	0	0	86%v
Totals	**56**	**55**	**53**	**2**	**0**	**1**	**96%**

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

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

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

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	74	74	74	0	0	100%~
Recredentialing	55	55	55	0	0	100%~
Totals	**129**	**129**	**129**	**0**	**0**	**100%**

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

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

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

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

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

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

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

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

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

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

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

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

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

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

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

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

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

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

Recommendations and Opportunities for Improvement

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

Required Actions

RMHP posted credentialing policies on its public website, which described RMHP's procedures for the selection of its providers. While RMHP posted its credentialing policies and other credentialing information on its website, RMHP did not post its policies and procedures for the retention of providers on its website. RMHP must post its policies and procedures for the retention of its providers publicly on its website.

Standard XI—EPSDT Services

Evidence of Compliance and Strengths

RMHP established a comprehensive EPSDT program to ensure children and pregnant members eligible for this benefit had access to covered medically necessary services. RMHP's EPSDT procedure addressed outreach efforts, contact strategies, messaging content, identification of members with SHCN, and staff engagement protocols. RMHP supported early identification of developmental delays and utilized the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule to track and notify families of recommended preventive screenings and immunizations. EPSDT benefits covered a range of services, including developmental screens, immunizations, lead screening, vision, dental, hearing care, and diagnostic services. RMHP also assisted members in finding primary care providers (PCPs) and scheduling appointments.

RMHP's data analytics team merged data from various sources to identify EPSDT-eligible members, including those with SHCN and pregnant individuals, enabling targeted outreach campaigns. Outreach was conducted within 60 days of eligibility determination, when well visits were overdue, or after 12 months of service inactivity. Pregnant members received ongoing outreach and connections to resources.

Welcome calls were made to newly eligible members, followed by mailings if contact was unsuccessful. All new members received information about EPSDT benefits and were encouraged to schedule appointments with their PCPs. New members also received welcome materials containing EPSDT information.

RMHP deployed multiple outreach attempts, considering additional opportunities for children involved with child welfare or those transitioning from residential treatment facilities. Gaps in care, identified using AAP guidelines, triggered outreach emails or letters. RMHP had systems in place to protect sensitive information, particularly related to sexual health. Five primary contact methods were used: mailed correspondence (available in Spanish), email, telephone, direct care coordination/provider communication, and text messaging. Member messaging content included welcome kits, call scripts, screeners, "Sorry We Missed You" letters, educational flyers, annual notifications, provider guidebooks, and email blasts.

RMHP monitored utilization and quality, and performed an annual quality audit on a sample of members. RMHP provided referrals for uncovered but needed treatments, collaborating with various agencies and programs. Transportation and appointment scheduling assistance were offered.

Recommendations and Opportunities for Improvement

While RMHP's Member Advisory Committee (MAC) had been tasked with reviewing various member communication documents and mailers, RMHP could not confirm whether the committee consisted of members (or the caretakers of members) who qualified for EPSDT services or whether EPSDT-specific documents had been reviewed. HSAG suggests that RMHP consider the EPSDT population and EPSDT materials when recruiting for the MAC and developing an agenda for upcoming review cycles.

Required Actions

While RMHP provided evidence of provider education, the evidence and process described did not demonstrate how updates on EPSDT were made available to network providers every six months. RMHP must ensure that updates on EPSDT are made available to network providers every six months.

3. Background and Overview

Background

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposal 2017000265, the Department of Health Care Policy & Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service PCPs and capitated behavioral health providers to ensure access to care for Medicaid members. In accordance with Title 42 of the Code of Federal Regulations (42 CFR), RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). The CFR requires PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PIHPs to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), HSAG.

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

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

Overview of FY 2024–2025 Compliance Monitoring Activities

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

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

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

Compliance Monitoring Review Methodology

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

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

Objective of the Compliance Review

The objective of the compliance review was to provide meaningful information to the Department and the RAE regarding:

- The RAE'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 RAE into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality, timeliness, and accessibility of services furnished by the RAE, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the RAE's services related to the standard areas reviewed.

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

FY 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 compliance review, each RAE that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the RAE 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 RAE 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 2023–2024 compliance monitoring review.

Summary of FY 2023–2024 Required Actions

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

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

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

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

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

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

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

Summary of Corrective Action/Document Review

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

Summary of Continued Required Actions

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. The Contractor implements procedures to deliver care to and coordinate services for all members. B. *For all members*, the Contractor's care coordination activities place emphasis on acute, complex, and high-risk members and ensure active management of high-cost and high-need members. The MCE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. • Is documented, for both medical and non-medical activities. *42 CFR 438.208(b)*	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* This policy and procedure describes the Rocky Mountain Health Plans (RMHP) comprehensive, client and family centered integrated care coordination program. Bullet 1: Page 13, section 6.8, Integrated Community Care Teams Bullet 2: Pages 22-24, section 6.8.13, Active Care Plan Maintenance and Follow-up Bullet 3: Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning Bullet 4: Found throughout the P&P Bullet 5: Found throughout the P&P Bullet 6: Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning; Pages 22-24, section 6.8.13, Active Care Plan Maintenance and Follow-up Bullet 7: Page 20, section 6.8.9, Care Coordinator; Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning Bullet 8: Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning Bullet 9:	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 17: Exhibit B—11.3.1, 11.3.7	Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning *III_1_ComprehensiveAssessment* Bullets 1-9 RMHP assesses the Member's health and health behavior risks, medical and nonmedical needs, and social determinants of health needs, including determining if a care plan exists. RMHP uses a comprehensive, client/family centered, integrated approach to assessment of members for care coordination needs. *III_1,6_HNS Workflow* The Health Needs Survey is a voluntary survey completed by Members enrolling in a Medicaid program such as RAE or PRIME. Members indicate when they need help managing their health conditions, are pregnant, would like help with resources or to receive an outreach call from a care coordinator. Survey data is transferred from HCPF to the RAE/MCO and helps prioritize Members who could benefit from care coordination. *III_1_Top 40 Complex Outreach Workflow 10.31.24_FINAL* This workflow describes Outreach to the Top 40 Members from populations stratified as Complex and how they are outreached in a campaign. The documents listed below demonstrate procedures to deliver care to and coordinate services for all members. *III_1_Care Plan Workflow*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_1,10_CM_Essette Documentation Screen Shot Additionally, this Essette Documentation Screen Shot contains a view of a Member's Care Plan in Essette. RMHP care coordination works collaboratively with the Member and caregivers (if applicable) to create an individualized care plan that includes documentation of the Member's desired health outcomes and identifies other providers of that member's care coordination team. **RAE-specific:** See above **Prime-specific:** See above	
2. The Contractor ensures that each behavioral health member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 17: Exhibit B—None	**Both RAE and Prime:** *III_2_SorryWeMissedYou_RAEorPrime_Adult_Eng_3033_Template* *III_2_SorryWeMissedYou_RAEorPRIME_Child-W-EPSDT_Eng_3029_Template* *III_2_SorryWeMissedYou_RAE_PRIME_YA_Preg-EPSDT_Eng_3031_Eng_Templ* This letter is sent to all members who are not reached through the Welcome Call. Members are urged to call Member Services if they need assistance to access appropriate care and/or to connect with the community resources. *III_2, 7_CO_PR21_Welcome_Script.1* *III_2,7_CO_PRYA_Welcome_Script-RAE PrimeYoungAdult-Pregnant.1* *III_2,7_CO_PR17_Welcome_Script-PrimeRAEChild.1* Member Services representatives make outbound Welcome Calls to all new members. These scripts show the initial Member services portion of the	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	welcome call, that then leads into the Welcome Screener Script. Whether the Member call is outgoing or incoming, the initial Member conversation introduces care coordination and screens the Member for social, medical and behavior heath needs. When a Member is reached and a screener is completed the information is housed in Essette. *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 23, section 6.8.13.3.6 shows that RMHP ensures that each member has an ongoing source of care appropriate to his or her needs by providing the Member with ongoing information about choices of settings, providers, treatment option and resources as needed and appropriate. Page 13, section 6.8.2, states that RMHP is exclusively responsible for ensuring that appropriate care coordination is provided for all Medicaid and CHP+ members. Page 20, section 6.8.10.1 indicates the care plan identifies a lead care coordinator who is formally designated as primarily responsible for coordinating covered services furnished to the member. Page 16, section 6.8.8.1.6.3 states that once a member is engaged with their local Care Coordinator the member is provided with the direct contact information for the Care Coordinator	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: see above	
3. The *RAE* no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. The *MCO* receives and processes the Department's attribution and assignment list to ensure accurate member attribution and assignment. Members enrolled in the MCO have 90 days in which to opt out. Any member who does not opt out remains enrolled until the member's next open enrollment period, at which time the member shall receive an open enrollment notice. Subsequent enrollment will be for 12 months, and a member may not disenroll from the limited managed care capitation initiative (except as provided in the disenrollment terms). Contract Amendment 17: Exhibit B—6.8.1	**Both RAE and Prime:** **RAE-specific:** *III_3_RAE PCMP Change Process Note* This document in an example of the process for helping RAE Member's identify and change their Primary Care Medical Provider (PCMP). Care Coordinators (CC) offer a three-way call with Member, the CC and the Department's enrollment broker to assist the Member in choosing a different PCMP. *III_3_CI_Attribution Validation_Final 11.22.24* This document describes attribution validation activity for this review period.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extensive assistance and include appropriate interventions. Contract Amendment 17: Exhibit B—11.3.3	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 5, section 6.4.3.4, states that RMHP care coordinators will provide assistance during care transitions from hospitals or other care institutions, to home or community-based settings, or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. *III_4_CM10_SpcialHlthCareNeeds.2_24* Addresses this requirement for people with special health care needs. Page 2, 4.0 Policy section provides that RMHP coordinates health care services for children with Special Health Care Needs with other agencies or entities. *III_4,5_2024 RMHP Webinars and Events Catalog 11.7.24* This document provides examples of educational offerings to support the organization and facilitation of the delivery of health and social services for Members. **RAE-specific:** see above **Prime-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The Contractor implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. • Including Medicaid-eligible individuals being released from incarceration to ensure they transition successfully to the community. *Note: Contractor shall ensure that care coordination is provided to members who are transitioning between health care settings and to populations who are served by multiple systems, including, but not limited to, children involved with child welfare; Medicaid-eligible individuals transitioning out of the criminal justice system; members receiving long-term services and supports (LTSS); members transitioning out of inpatient, residential, and institutional settings; and members residing in the community who are identified as at-risk for institutionalization.*	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 2, section 4.2 describes that RMHP utilizes a single care management platform, Essette, for all services that allows the many entities that may be providing care/services to a Member to coordinate and share information seamlessly. Page 5, section 6.4.3.4, states that RMHP care coordinators will provide assistance during care transitions from hospitals or other care institutions, to home or community-based settings, or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. Page 18, section 6.8.8.3.61 describes the procedures for coordinating services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. Pages 14-15, section 6.8.7 "Integration with BH and PH Providers" is addressed. Page 18, section 6.8.8.3.1 describes that RMHP works collaboratively with the Member's care team – Member, PCP and other providers, community partners, family/caregiver/representative, as appropriate – to create the care plan. The care plan identifies members of the Member's care team, which at a minimum include the Member or family/responsible party and the PCP. Page 11, section 6.4.5.5 describes the process to coordinate services with individuals being released from incarceration, to ensure a successful transition.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b)(2) Contract Amendment 17: Exhibit B—14.1, 14.3, 11.3.10, 11.3.10.4.2.3, 11.3.20.2.1	Page 12, section 6.4.5.6 describes the process to coordinate services with members in foster care. *III_5_8_Referral Campaign Workflow 11042024 V2* This document shows RMHP's referral workflow process. *III_5_Welcome Call Toolbox - Colorado* This document identifies scripts, resources and information for Member Service Reps to support Members. One phone number per line of business is maintained, staffed, and published for Members to call regarding customer service or care coordination issues. The call center serves Members and providers. *III_5_Provider Insider Plus_ Special Edition _ Feb. 1, 2024* Periodically, RMHP has a need to send a special edition for informational updates to providers. This document is an example of when this occurred in 2024. *III_5_UHC Network News_Dec '24 Monthly Overview* *III_5_PNM_Network News October 2024* Network News is the UHC Provider Newsletter, which includes RMHP information. Network news is available online and accessible for providers via their portal and distribution lists. This document is an example of the December 2024 and October information within Network News (The URL link is included on the 1st page of these documents)	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_5_RAE 1 BH Office Hours PP - Aug 6 2024 This document demonstrates RMHP's communication with BH providers through Meeting Webinars to fully engage them in the work outlined in the contract for RAE and for PRIME. The Webinars are presented quarterly in the format of "RMHP BH Office Hours" where RMHP presents on relevant topics and providers have the opportunity to ask questions and to provide feedback. *III_4,5_2024 RMHP Webinars and Events Catalog 11.7.24* This document provides examples of educational offerings to support the organization and facilitation of the delivery of health and social services for Members. *III_5_QI_8.2024 CQI Newsroom Presentation* *III_5_QI_11.2024 CQI Newsroom Presentation* These documents demonstrate RMHP's communication with providers through Meeting Webinars to fully engage them in the work outlined in the contract for RAE and for PRIME. The Webinars are presented monthly in the format of "Clinical Quality Improvement Newsroom" where RMHP presents on relevant topics and providers have the opportunity to ask questions and to provide feedback. **RAE-specific:** see above	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The MCE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or MCE. *42 CFR 438.208(b)(3)* Contract Amendment 17: Exhibit B—7.5.2–3	**Both RAE and Prime:** *III_6_CM_Health Needs Survey Process_12.18.24* *III_1,6_HNS Workflow* *III_6_HNS_Redacted* The Health Needs Survey is a voluntary survey completed by Members enrolling in a Medicaid program such as RAE or PRIME. Members indicate when they need help managing their health conditions, are pregnant, would like help with resources or to receive an outreach call from a care coordinator. The policy describes how RMHP processes and stratifies the survey. The Workflow illustrates how RMHP receives, processes and reviews the data to inform member outreach and care coordination activities. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The Contractor ensures that it has procedures to ensure: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2–3)* Contract Amendment 17: Exhibit B—14.7.1	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Bullet 1: Page 2, section 4.2 indicates that All members identified by these activities receive outreach to conduct screening, assessment, coordination and care planning as needed. Bullet 2: Pages 18-24, section 6.8.8.3 "CarePlan Development & Care Planning" Bullet 3: Pages 6-12, section 6.4.5 "Special Populations" describes continuity of care activities for Members in transition and involved in multiple systems.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_7_CM-UM 6 *Continuity_Coordination_Care_Transitions 10.24.2024V2* Purpose on page 1 indicates that RMHP facilitates continuity and coordination of medical care across its delivery system. *III_2, 7_CO_PR21_Welcome_Script.1* *III_2,7_CO_PRYA_Welcome_Script-RAE PrimeYoungAdult-Pregnant.1* *III_2,7_CO_PR17_Welcome_Script-PrimeRAEChild.1* Member Services representatives make outbound Welcome Calls to all new members. These scripts show the initial Member services portion of the welcome call, that then leads into the Welcome Screener Script. Whether the Member call is outgoing or incoming, the initial Member conversation introduces care coordination and screens the Member for social, medical and behavior heath needs. When a Member is reached and a screener is completed the information is housed in Essette. **RAE-specific:** see above	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 17: Exhibit B—None	**Both RAE and Prime:** *III_8_9_CM 14 Confidentiality and Retention of Member Records 2024* Page 1, section I, states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our members. All information obtained in an official capacity is confidential and staff will comply with HIPAA Privacy Regulations. *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 2, section 4.2 explains that RMHP utilizes a care management system platform named Essette to achieve distribution of all of the members identified by stratification, ADT alerts, Special Populations and Referrals to RMHP. Screening, assessment, care planning, and follow up are all managed through Essette. The sharing and integration of Essette allows coordination of the many entities that may be providing care/services to a members resulting in better member outcomes and less duplication of care and services. Page 21, section 6.8.11.6. describes the activities that ensure, to the extent possible, that all communications and interventions have been established and describes activities of sharing assessments and identified needs of the Member with other providers serving the member in order to prevent duplication of activities. *III_5_8_Referral Campaign Workflow 11042024 V2*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This document shows RMHP's referral workflow process. **RAE-specific:** see above	
9. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(5) and (6)* Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 21-22, section 6.8.11.8 provides that any communication with a non-Member representative will require the appropriate Appointment of Representative/HIPAA paperwork to be filled out. *III_9_RMHP ROI 2024* *III_9_RMHP Spanish ROI 2024* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR requirements to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *III_8,9_CM14_Confidentiality-Retention_MemberRecords2024* 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 staff will comply with HIPAA Privacy Regulations.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_7,9_PNM_2024 Provider Manual Page 93-94 describes all aspects of Medical Records and Release of Information and Transfer of Records including how each provider needs to make health service records available to the Member and to other participating providers and authorized individuals in accordance with HIPAA and the terms of the RMHP Provider Agreement. Page 93 includes detailed information to PCP's and Page 94 includes detailed information to specialists about what office records should include. Providers are responsible for the maintenance of adequate medical records, which are to be secure, complete, legible, accurate, accessible, organized, and maintained in a format that facilitates retrieval of information and assures confidentiality. Page 96, Ch 12: Member Rights and Responsibilities for RMHP Prime, RAE, and CHP+ Members, states Members have the right, "To expect all communications regarding your care to be kept confidential as required by law" *III_9_PNM_Physician Medical Services Agreement(Primary Care-all inclusive)_RAEPRIME* Page 14-15, Section Q. Records: (4) This section specifies medical records requirements in accordance with professional, state and law requirements, including paragraph (7) which requires physicians to share medical records with other treating providers to	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	facilitate continuity of care consistent with state and federal law. *III_9_PNM_Physician Medical Services Agreement(Not Primary Care)_RAEPRIME* Page 13-14, Section N. Records: (4) This section specifies medical records requirements in accordance with professional, state and law requirements, including paragraph (7) which requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law. *III_9_Professional Services Agreement Example_BH* Page 10-11, Section H. Records: (4) This section specifies medical records requirements in accordance with professional, state and law requirements, including paragraph (7) which requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law. **RAE-specific:** see above	
10. The Contractor possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided.	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 2, section 4.2 explains that RMHP utilizes a care management system platform, Essette, to support communication and coordination among the many entities (members of the provider network and health neighborhood) providing care/services to members.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. The care coordination tool, at a minimum: • Works on mobile devices. • Supports HIPAA and 42 CFR Part 2 compliant data sharing. • Provides role-based access to providers and care coordinators. *Note: The Contractor shall collect and be able to report the information identified in Section 15.2.1.3 for its entire network. Although network providers and subcontracted care coordinators may use their own data collection tools, the Contractor shall require them to collect and report on the same data.* Contract Amendment 17: Exhibit B—15.2.1.1, 15.2.1.2, 15.2.1.3–5	*III_1,10_CM_Essette Documentation Screen Shot* This document illustrates the data that is collected and aggregated in Essette, including the items listed in this element. -Page 1 provides an example of the following fields: Name, Age, Gender, Care Coordinator, Stratification Level [Acuity], Medicaid ID. -Page 2 provides an example of member's lead coordinator and other providers involved their care. -Pages 3-11 provides member assessment information -Page 12 provides a sample care plan for the member -Page 13 provides care coordination notes -Pages 14-15 provides additional information that can aid in the creation and monitoring of the care plan for the member. *III_10_Essette Platform Information* This document shows screenshots of the Essette system that provide information showing Essette is available on mobile devices, supports HIPAA and 42 CFR Part 2 compliance, and provides role-based access to providers and care coordinators. **RAE-specific:** see above	

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

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 17: Exhibit B—7.3.7.1–2	**Both RAE and Prime:** *IV_1,3,4,6_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* This Policy and Procedure documents RMHP's written policy regarding a Prime, RAE, or CHP+ Member's Rights and Responsibilities. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* Contract Amendment 17: Exhibit B—17.10.7.2	**Both RAE and Prime:** *IV_2_CI_CSCO23MD0040511_000_Eng_CO_Medicaid_NonDiscrim_ShortForm-PRNC* *IV_2_CI_CSCO24MD0167794_001_Eng_CO_Medicaid_NonDiscrim_LongForm-PRNC* *IV_2_CI_CSCO24MD0167795_001_SP_CO_Medicaid_NonDiscrim_LongForm-PRNC* *IV_2_CI_CSCO24MD0167796_001_EngSP_CO_Medicaid_NonDiscrim_LongForm-PRNC* The CRN/MLIS documents listed above (4 versions) demonstrate that RMHP complies with applicable federal and state laws that pertain to member rights. *IV-2,4,6_PNM_2024 Provider Manual* Page 96-97 of the Provider Manual describes Prime, RAE and CHP+ Member rights to network providers. Page 85 informs providers of the values and tenens of the RMHP Compliance Plan/Code of conduct which demonstrate compliance with Federal and State laws that pertain to Member rights.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IV_2_4_ PNM_Law Exhibit to Services Agreements_RAE_PRIME See Page 8-9, numbers 19 & 20 : Medicaid/CHP+ Recipient Rights and Medicaid and CHP+ Contracts Statutes and Regulations lists the federal and State laws with which RMHP, providers and subcontractors shall comply with. *IV_2_PNM_Law Exhibit-NonProv_RAE_PRIME.pdf* This Law Exhibit is attached to all non-provider contracts that are executed with RMHP. It includes requirements for compliance with all applicable federal and state law that pertain to member rights. *IV_2,5_CM14_Confidentiality-Retention_MemberRecords2024* Page 1, Purpose statement identifies that RMHP complies will all federal and state regulations that pertain to member activity and confidentiality. *IV_2_5_RMHP English ROI 2024* *IV_2_5_RMHP Spanish ROI 2024* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information **RAE-specific:** see above	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 17: Exhibit B—7.3.7.2.1–6	**Both RAE and Prime:** *IV_1_3_4_6_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* Page 2, Section 6 describes Member rights as specified in state and federal regulation **RAE-specific:** *IV_3_CO-RMHP-RAE-Getting-Started-Guide-EN* Members are directed how to find information online to learn more about their Member rights and responsibilities in these Getting Started Guides that are sent to all new members *IV_3_Member Annual Notice CM89-RAE only-2024* These Member Annual Notices advise Members how to find information online to learn more about their Member rights and responsibilities.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the RAE, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* Contract Amendment 17: Exhibit B—7.3.7.2.7	**Both RAE and Prime:** *IV_1,3,4,6_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* Page 2, bullet #9 indicates that the member is able to exercise their rights without being treated differently. *IV_2,4,6_PNM_ 2024 Provider Manual* Page 96 includes the Members right to freely exercise their rights without being treated differently. *IV_2_4_PNM_Law Exhibit to Services Agreements_RAE_PRIME* Page 8, Number 19: Medicaid Recipient Rights, paragraph C states that "Contractor shall ensure that Medicaid Recipients have the rights set forth in 42 C.F.R. section 438.100(b)(2), including but not limited to the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, consistent with 42 C.F.R., section 438.100.(b)(2)(v) **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information that identify a particular member, the MCE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224*	**Both RAE and Prime:** *IV_2,5_CM14_Confidentiality-Retention_MemberRecords2024* Page 1-2, Purpose statement identifies that RMHP complies will all federal and state regulations that pertain to member activity and confidentiality. *IV_2_5_RMHP English ROI 2024* *IV_2_5_RMHP Spanish ROI 2024*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contract Amendment 17: Exhibit B—11.3.7.10.6, 15.1.1.5	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. **RAE-specific:** see above	
6. The Contractor maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the MCE. Advance directives policies and procedures include: • Notice that members have the right to request and obtain information about advance directives at least once per year. • A clear statement of limitation if the MCE cannot implement an advance directive as a matter of conscience. – The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection. – Description of the range of medical conditions or procedures affected by the conscientious objection.	**Both RAE and Prime:** *IV_2,4,6_PNM_2024 Provider Manual* Pages 80-81 provides written information to providers about advance directives. It also explains practitioner responsibilities around advance directives, including the policies they must have in place to provide information to Members about their rights under state law to create an advance directive, and the policies of their organization to respect implementation of those rights (including any limitations because of conscientious objections). *IV_1_3_4_6_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* Page 3, last bullet indicates that Members have a responsibility to choose a PCP and to inform that PCP of any advance direction for the Member's care. **Bullet 1:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 1, Section 4.1.1, demonstrates that members can request information regarding advance directives at least once per year.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions: – For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. – For providing advance directive information to the incapacitated member once he or she is no longer incapacitated. – To document in a prominent part of the member's medical record whether the member has executed an advance directive. – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. – To ensure compliance with State laws regarding advance directives. – To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment. – To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law.	**Bullet 2:** RMHP does not impose any limitations with respect to implementing advance directives as a matter of conscience, therefore no statement to this effect is included in written information to individuals. **Bullet 2, 1st, 2nd and 3rd dashes:** *IV_6_PNM-007 Advance Directives* Page 1, 2.0 Purpose indicates this policy provides guidelines in the event a practitioner is unable to implement a patient's advance directive based on conscience. Page 2, 5.1 bullet 4, describes that the practitioners described in the previous bullet, are required to maintain written policies about advance directives and provide written information as specified in 42 CFR 489.102 to Members regarding the policy of the provider or organization to provide a clear and precise statement of limitation if they cannot implement an advance directive based on conscience. *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 3, section 6.3-6.3.1 and Page 2, section 4.1.2-4.1.3 indicates the provider's obligations in relations to Members with advance directions. **3rd bullet, 1st dash:** *IV_6_PNM-007 Advance Directives* Page 2, 5.1 last bullet states, practitioners must provide advance directive information to incapacitated Members once they are no longer incapacitated.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– To educate staff concerning its policies and procedures on advance directives. – The components for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. *Note: The MCE must be able to document its community education efforts.* *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 17: Exhibit B—7.3.11.2, 7.3.11.3.3	*IV_6_PNM-007 Advance Directives* Page 2, 5.1 first bullet states a practitioner is required to include a Member's advance directive in the medical record. *IV_2,4,6_PNM_2024 Provider Manual* Page 81, first paragraph provides that a practitioner must include a Member's advance directive in the medical record. *IV_6_PNM-007 Advance Directives* On page 2, Section 5.1 3rd bullet of the policy, providers are prohibited from discriminating against Members based on whether the Member has executed an advance directive. *V_2,4,6_PNM_2024 Provider Manual* Page 81 provides that a practitioner may not condition the provision of health or medical care based on whether or not the Member has signed an advance directive. *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 2, sections 4.1.1.3 - 4.1.1.4 provide that Members rights include that advance directive information is given to the Member's family if he or she is incapacitated at the time of enrollment. Once the Member is no longer incapacitated, the information is given to the individual directly. **3rd bullet, 3rd dash:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024*	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 3, section 6.2.2. and 6.3.2 sets forth the Member's right to have an advance directive recorded in the medical record. Page 3, section 6.4 provides that when chart audits occur they will include a review for the presence or absence of advance directives in the medical record. **3rd bullet, 7th dash:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 3, section 6.5.1 provides that Members will be informed of changes in state law concerning advance directives no later than 90 days following the change in law. **3rd bullet, 8th dash:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 3, item 6.5.3 provides that RMHP will train staff on policies and procedures on advance directives. **3rd bullet, 9th dash:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 3, section 6.5.4 provides that RMHP will provide community education on advance directives. *IV-6_Website Education Advance Directives* This documents demonstrates that RMHP provides community education regarding advance directives in several places on the Colorado RMHP landing pages. **RAE-specific:** see above	

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 Contract Amendment 17: Exhibit B—9.3.5.2.1	**Both RAE and Prime:** The following documents demonstrate RMHP has a well defined credentialing and recredentialing process for evaluating and selecting licensed practitioners: *VIII_1-14,16-19_Credentialing Plan_BH* Page 7, Section 3.1 National Quality Improvement Committee, A. *VIII_1,2_CO Addendum_CredPolicies_BH* Page 1, Policy Statement and Purpose **RAE-specific:** see above **Prime-specific:** Note: UHC currently holds a National CR Accreditation from NCQA through January 2026. *VIII_1_NCQA_United_Healthcare_Services__Inc_Cred Accred Cert 2023-2026* *VIII_1-12,14,16-19_2024 CRM Program_PH* This Document defines a consistent credentialing and recredentialing process for Physical Health practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for credentialing of its providers. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 7, section 4.1 Page 10, section 5.2 These sections describes a process for evaluating and selecting licensed independent practitioners to provide care to its members, using NCQA standards and guidelines.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's level psychologists, master's level clinical social workers, master's level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.* *42 CFR 438.214(a)–(b)(1)* NCQA CR1—Element A1 Contract Amendment 17: Exhibit B—9.1.6	**Both RAE and Prime:** *VIII_2, 2A._P&Ps for selection-retention on websites* This document demonstrates where P&Ps for selection-retention of providers can be found on the various RMHP-UHC website locations. *VIII_1-14,16-19_Credentialing Plan_BH* PDF Pages 10-12, section 4.2 - Administrative Review This section outlines the types of BH practitioners **RAE-specific:** see above **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* PDF page 6 "Licensed Independent Practitioner or Provider (LIP)" describes the type of PH practitioners that the contractor credentials and recredentials. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 3, section 2.0 - Definitions - Licensed Independent Practitioner (LIP) This defines the types of health care professionals who can be credentialed or re-credentialed. Page 7, section 4.1 This section describes the written policies and procedures for the selection and retention of the types of practitioners, it credentials and recredentials.	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: RMHP posted credentialing policies on its public website, which described RMHP's procedures for the selection of its providers. While RMHP posted its credentialing policies and other credentialing information on its website, RMHP did not post its policies and procedures for the retention of providers on its website.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: RMHP must post its policies and procedures for the retention of its providers publicly on its website.		
2.B. The verification sources it uses. NCQA CR1—Element A2	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF pages 11-13, section 4.2, B - Verification of Credentials PDF pages 15-16, section 6.1 - Criteria for Credentialing Organizational Provider These sections describe the verification sources used. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF pages 8-13, section 4.0 Initial Credentialing of licensed Clinicians PDF pages 13-15, section 5.0 Recredentialing of Participating Clinicians These sections describe the criteria used for these activities. *VIII_1,2_CO Addendum_CredPolicies_BH* This policy supplements the Credentialing Plan to describe criteria used. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 13, section 4.3 - Credentialing Committee Review PDF Page 14, section 5.2, A- "UBH Review Criteria" last paragraph and section 5.2, B - "Credentialing Committee Action," These describe the process for making credentialing and recredentialing decisions. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 13, section 4.3 Credentialing Committee Review, "A Credentialing Committee Action 1," PDF pages 14-15, section 5.2 Recredentialing Criteria of Participating Clinicians, "A UBH Review Criteria" - last paragraph These describe the process for managing cred/recred files. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.*	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 4, section 1.1 - Purpose, 2nd paragraph PDF page 18, section 7.1 - Confidentiality of Applicant and Participating Clinician and Participating Organizational Provider Information These describe UBH's credentialing and recredentialing are conducted in a non-discriminatory manner.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.214(c) NCQA CR1—Element A6	**RAE-specific:** see above	
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 18, section 7.2 "Applicant Rights" paragraph B-(b) describes the process for notifying applicant if information obtained varies substantially from the information provided by the applicant. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	**Both RAE and Prime:** *VIII_1,2_CO Addendum_CredPolicies_BH* Page 2, section 5 A, demonstrates the process for notifying practitioner of the credentialing decision. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 7, section 3.2 Credentialing Committee describes the responsibility and participation in the credentialing committee of the medical director or other designated physician. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF pages 18-19, section 7.0 - Confidentiality and Applicant Rights, Section describes the process for securing the confidentiality of all information obtained during the credentialing process, except as otherwise provided by law. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	**Both RAE and Prime:** The following documents describe the various processes used to ensure provider information in provider directories are consistent with credentialing data. *VIII_2K_NCC P-P 110 Initial Cred Proc for LIP* Describes the process of collecting applicant information such as education, training, board certification and this information is electronically sent to NDB and completed profile shall be posted and attached to the Credentialing Cycle (CC) in Salesforce so inclusion in the provider directories occurs. See page 3, 5.5. *VIII_2K_E2E Non Del Contract-NDM Process flow chart* This chart demonstrates the End to End process for inputting provider data into PhyCon, which feeds the data to the provider directories. *VIII_2K_PhyCon Contract_Amendmnt_Execution SOP* This document describes the process of execution of a contract/amendment for a provider which includes ensuring demographic information such as education, training, specialties, etc. so that it is populated in the directory.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_2K_PDA Attestation Process SOP This SOP document describes the process to complete attestation review of provider directory accuracy to ensure credentialing/recredentialing information is included in the directory. **RAE-specific:** see above	
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 18, section 7.2 - Applicant Rights describes how providers have the right to review information submitted to support their cred or recred application as well as indicating that UBH is not required to allow the applicant to review personal or professional references, internal UHB documents, or any other information that is peer review protected or restricted by law. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.B. To correct erroneous information. NCQA CR1—Element B2	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 18, section 7.2 - Applicant Rights, Paragraph B (b) describes how the provider will notified if the information that varies substantially from the information provided by applicant. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 15, section 7.2, "Applicant Rights", paragraph B.a describes application status information. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 1, section 1.1, "Purpose" -1st and 2nd paragraphs describes the designated credentialing committee and peer review **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A1–3	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 4, Sections 3.2 Credentialing Committee Page 10, Section 4.3, A, Credentialing Committee Review & Committee Action Pages 11-12, Section 5.2, A& B, Recredentialing Criteria of Participating Clinicians, UBH Review Criteria and B Credentialing Committee Action Page 14, section 6.3, Credentialing Committee Responsibilities These sections in this document describe the responsibilities of the credentialing committee **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit is 180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit is prior to the credentialing decision). • Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing decision; if board certification, time limit is 180 calendar days). • Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days).	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 8-9, sections 4.2 Administrative Review B Verification of Credentials; Page 11, section 5.2 Recredentialing Criteria of Participating Clinicians A UBH Review Criteria **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless the organization communicates board certification of those types of providers to members.* NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. *42 CFR 438.214(d)(1)* NCQA CR3—Element B	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 9-12, section 4.2, Administrative Review, section B - Verification of Credentials, Items 5-6 describe verification processes **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions.	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 5-6, section 4.1 Clinician Application Criteria B Application Form 1-10, describes the information included in the application **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• History of loss or limitation of privileges or disciplinary actions. • Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C		
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**Both RAE and Prime:** VIII_1-14,16-19_Credentialing Plan_BH Page 14, Section 5.1 Recredentialing Participating Clinicians, A indicates a 36 month review **RAE-specific:**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure. • Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events.	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 16-17, section 8.0 ON-GOING MONITORING AND REPORTING describes processes for ongoing monitoring **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Implementing appropriate interventions when it identifies instances of poor quality related to the above. *42 CFR 438.214(d)(1)* NCQA CR5—Element A		
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 18-19, section 9.0 QUALITY IMPROVEMENT OF LICENSED PARTICIPATING CLINICIANS AND PARTICIPATING ORGANIZATIONAL PROVIDERS describes processes for taking action against practitioner when applicable. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies.	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 12-14, section 6.0 Credentialing and Recredentialing of Organizational Providers Pages 16-17, section 8.0 On-going Monitoring and Reporting These describe processes to ensuring ongoing assessments every 36 months **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable. *42 CFR 438.214(d)(1)* NCQA CR7—Element A1		
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 12, section 6.1 Criteria for Credentialing Organizational Providers, A, details organizational provider must be in good standing with state and federal regulatory bodies. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following*	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 13-14, sections 6.2 Organizational Providers that are Not Accredited or Certified describes how the contractor conducts a site review if the organizational provider is not accredited. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.) NCQA CR7—Element A3		
13. The Contractor's organizational provider assessment policies and processes includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory NCQA MBHO CR7—Elements B and C NCQA MBHO CR7—Element B	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 3, "Organizational Providers" provides the definition of provider types. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses providers every 36 months. NCQA MBHO CR7—Elements D and E NCQA MBHO CR7—Element C	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 11, section 5.1 General A Page 14, section 6.4 Recredentialing of Participating Organizational Provider, A These describe that the contractor assess providers every 36 months. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The MCE shall submit a monthly Credentialing and Contracting Report to the Department with information about Provider contracting timelines, using a format determined by the Department. Contract Amendment 17: B-13—9.1.6.5.5	**Both RAE and Prime:** *VIII_15_R1_RM_CredConRpt_10-24* This deliverable report is completed monthly by RMHP for both RAE and PRIME credentialing and contracting statistics. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners, providers, and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 24, section 13.2 Delegation Agreement describes requirements for delegation agreements **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *The requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 25-26, section 13.4 Pre-Assessment Responsibilities of UBH describes the contractor evaluates the delegates capacity to meet NCQA requirements ***Note:*** No delegation agreements have been in effect less than 12 months. **RAE-specific:** see above	**RAE:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
18. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. • At least annually, monitors the delegate's credentialing system security controls to ensure the delegate monitors its compliance with the delegation agreement or with the delegates policies and procedures. • At least annually, acts on all findings from above monitoring for each delegate and implements a quarterly monitoring process until each delegate	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 26, sections 13.5 Annual Evaluation and 13.6 Review of Oversight and Monitoring Reports describe processes for annual evaluations of delegates **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
demonstrates improvement for one finding over three consecutive quarters. NCQA CR8—Element C		
19. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 26, section 13.7 Required Follow-Up describes activities to review and develop improvement plans as applicable. **RAE-specific:**	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	31
Total Score ÷ Total Applicable						=	97%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCE onboards and informs members and their families regarding the services provided by EPSDT. This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the MCE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation and scheduling assistance. Contract Amendment 17: Exhibit B—7.3.12.1, 7.6.2	**Both RAE and Prime:** *XI_1,2_QI_EPSDT Flyer_ENG 7.25.24 FINAL.pdf* *XI_1,2_QI_EPSDT Flyer_SPA 7.25.24 FINAL.pdf* This 2024 flyer was included in communications to caregivers and Members 0-20 to inform about the EPSDT program, including the services available to them without cost. *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* This document describes RMHP's annual process for notifying eligible members and their caregivers, in clear and nontechnical language, of EPSDT benefits. Pages 5-7 of the P&P describes outreach and methods of contact, including the process for informing Members within 60 days, gap analysis, outreach, and preventative care. These following letters were sent in 2024 to caregivers and Members 0-20 to inform about the EPSDT program, including the services available to them without cost. *XI_1,2_QI_EPSDT Quarterly_ENG 18+_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18+_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 0-17_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 0-17_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 18+_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18+_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_October 2024.pdf*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_1,2_QI_EPSDT Quarterly_SP 0-17_October 2024.pdf *XI_1,2_QI_EPSDT Quarterly_ENG 18-20_October 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18-20_October 2024.pdf* *XI_1,2_QI_Pfizer_CO_Postcard_MissedDose -Postcard and IVR* *XI_1,2_QI_Pfizer_CO_Postcard_WellVisit -Postcard and IVR* *XI_1,2_QI_UHC_CO_Postcard_16_17YO -Postcard* *XI_1,2_QI_UHC_CO_Postcard_15monthWellVisit* These materials were used in an outreach campaign in 2024. The campaign included monthly postcard mailings to the target population of children who missed an immunization between six months and 18 months of age, children identified as due for a 12-month well child visit, and adolescents who missed an immunization between 16-18 years of age. *XI_1_WelcomeCallToolbox-Colorado_Toolbox for rep resources* This document identifies scripts, resources and information for Member Service Reps to support Members. One phone number per line of business is maintained, staffed, and published for Members to call regarding customer service or care coordination issues. The call center serves Members and providers. *XI_1_CO_PR17_Welcome_Script-PrimeRAEChild.1* *XI_1_CO_PRYA_Welcome_Script-RAE PrimeYoungAdult-Pregnant.1*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These scripts show the initial Member Services portion of the welcome call, that then leads into the Welcome Screener Script. Within the Welcome Screener, Member's are notified of the availability of EPSDT services and benefits. **RAE-specific:** *XI_1_CO-RMHP-RAE-Getting-Started-Guide-EN* Page 5 section- Getting Care, explains how members can receive EPSDT benefits through their PCP	
2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT-eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: • Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls • Video conferencing • Email, text/SMS messages Contract Amendment 17: Exhibit B—7.6.6	**Both RAE and Prime:** *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* This document describes RMHP's annual process for notifying eligible members and their caregivers, in clear and nontechnical language, of EPSDT benefits. Pages 5-7 of the P&P describes outreach and methods of contact, including the process for informing Members within 60 days, gap analysis, outreach, and preventative care. These following letters were sent in 2024 to caregivers and Members 0-20 to inform about the EPSDT program, including the services available to them without cost. *XI_1,2_QI_EPSDT Quarterly_ENG 18+_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18+_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 0-17_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 0-17_June 2024.pdf*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_1,2_QI_EPSDT Quarterly_ENG 18+_June 2024.pdf *XI_1,2_QI_EPSDT Quarterly_SP 18+_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_October 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 0-17_October 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 18-20_October 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18-20_October 2024.pdf* *XI_1,2_QI_Pfizer_CO_Postcard_MissedDose -Postcard and IVR* *XI_1,2_QI_Pfizer_CO_Postcard_WellVisit -Postcard and IVR* *XI_1,2_QI_UHC_CO_Postcard_16_17YO -Postcard* *XI_1,2_QI_UHC_CO_Postcard_15monthWellVisit* These materials were used in an outreach campaign in 2024. The campaign included monthly postcard mailings to the target population of children who missed an immunization between six months and 18 months of age, children identified as due for a 12-month well child visit, and adolescents who missed an immunization between 16-18 years of age. **RAE-specific:** see above	
3. The MCE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT.	**Both RAE and Prime:** *XI_3_CI_Screenshot_EPSDT Prov Trainings* This section of the website provides links to the training webinars on key EPSDT topics requested by providers. *XI_3_CI_EPSDT Provider Guidebook_Final_12.10.24* This annual publication is shared with providers to make them aware of the Colorado Medicaid EPSDT program	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensuring that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 17: Exhibit B—12.9.2.1, 12.9.3	*XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* Page 11, "Provider Engagement," Describes provider engagement activities and trainings related to the benefits of EPSDT *XI_3,4,5_PNM_2024 Provider Manual* Pages 51-53 describe the Colorado Medicaid EPSDT program and includes references to the Health First Colorado website and how to access EPSDT materials. The manual provides indication to outreach to RMHP for any questions or supports related to EPSDT services. The manual also provides information on public health programs such as the Vaccines for Children Program (page 53). The following documents are examples of notifications, training materials and roster of providers who were invited and/or attended webinars regarding EPSDT benefits in 2024 *XI_3_EPSDT_DecCQINewsroom_ Email Edition_12.18.24* *XI_3_EPSDT Provider Guidebook follow up email_12.18.24* *XI_3_CI_EPSDT Provider Guidebook_Final_12.10.24* *XI_3_CI_Screenshot_EPSDT Prov Trainings* *XI_3_EPSDT Rocky Presentation-Prov Trn_3.6.24* March Provider Training for EPSDT was communicated to providers in the February and March CQI Newrooms. There were 35 attendees in this training and a recording is available and distributed to providers via the CQI Newsroom. Providers also have the on-demand training available on the website	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: see above	
Findings: While RMHP provided evidence of provider education, the evidence and process described did not demonstrate how updates on EPSDT were made available to network providers every six months.		
Required Actions: RMHP must ensure that updates on EPSDT are made available to network providers every six months.		
4. For children under the age of 21, the MCE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). The MCE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed, and the date ordered.	**Both RAE and Prime:** *XI_4_QI_EPSDT 2024 Analysis Report* RMHP conducts an annual audit of a small sample of provider medical records in QHN to verify EPSDT screenings and examinations are documented in the medical record. This report summarizes the results of this longitudinal audit of QHN records. *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* This written Policy and Procedure describes RMHP's process for providing EPSDT services to members ages 20 and under. This policy describes the methods RMHP employs to assure that appropriate preventive care and screening, to include mental/behavioral health developmental screenings, are provided to members. Page 11, section 6.18 Staff Training and page 8, section 6.12.4 This states that RMHP provides care coordination that is committed to promoting culturally competent care that is delivered in a linguistically sensitive manner. Page 8-9; section 6.12 - Children with special needs and their families	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 17: Exhibit B—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	This provides that RMHP Care Management will arrange or refer members to access diagnostic and treatment services for all physical or mental illnesses or conditions discovered by any screening or diagnostic procedure – even if the service is not covered by the health plan. *XI_3,4,5_PNM_2024 Provider Manual* Page 53, first paragraph states that: - Providers qualified to furnish primary medical and/or mental health services should perform screenings. - Instructs providers that screenings should be performed in a culturally and linguistically sensitive manner. - Instructs providers to record the results of screenings and examinations in the child's medical record. - Diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure are covered. Page 88-89 Cultural Competence section communicates to providers RMHP's expectation that services are provided in a culturally competent manner. RMHP advocates for continued education and diversity training. **RAE-specific:** see above	
5. The Contractor: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis.	**Both RAE and Prime:** *XI_5_CI_EPSDT Screenshot of Member Info* On the RMHP (CO) landing page, a tile is available for members and the general public to provide information describing what EPSDT is and high level description of services. This section refers the member to the handbook and the Bright Futures scheduled for more information. The plan specific pages (links in evidence document) provide	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provides assistance with transportation and scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61–62* Contract Amendment 17: Exhibit B—14.5.3 10 CCR 2505-10 8.280.4.C	the link to additional information on the Health First Colorado website along with the links to the handbooks, and contact information to RMHP Member Services and Care Coordination for any questions or supports needed. *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* Pages 10 & 11, "Treatment," Describes how RMHP provides referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. This section also demonstrates that RMHP care coordination offers assistance with transportation and scheduling appointments. *XI_3,4,5_PNM_2024 Provider Manual* Page 53, Third paragraph states that medically necessary treatments for conditions discovered by any screening or diagnostic procedure — even if they are not covered by First Health Colorado — may be covered by RMHP under the EPSDT program. The manual goes on to explain how a request for an EPSDT exception may be submitted. Contact information for the RMHP Care Management department is also provided on page 7 of the manual. **RAE-specific:** see above	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Assists the member to achieve or maintain maximum functional capacity. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider nor primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. Contract Amendment 17: Exhibit B—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	**Both RAE and Prime:** *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* Pages 1, "Definitions," Describes RMHP's definition of medical necessity for EPSDT services, which comports with the definition set forth in regulation and in the contract. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor provides or arranges for the following for children/youth from ages 0 to 21: intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (except for respite and vocational rehabilitation).* Contract Amendment 17: Exhibit B—14.5.7.1	**Both RAE and Prime:** *XI_7_CI_1915(b)(3) Services by CSNPs_Final_12.15.24* CSNPs within RAE Region 1 provide or arrange 1915(b)(3) services for children from ages 0 to 21. This document includes these 1915(b)(3) services. The CSNPs in RAE Region 1 are Axis Health System, Eagle Valley Behavioral Health, SummitStone Health Partners and Mind Springs Health. **RAE-specific:** see above	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard XI—EPSDT Services							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	86%

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Rocky Mountain Health Plans RAE 1

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

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	****	****	****	****	****	****	****	****	****	****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LCSW	NP	LPC	LAC, LPC	LPC	LPC	LPC	DO	LPC	LCSW
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Social Worker	Nurse Practitioner	Masters Level Counselor	Masters Level Counselor	Masters Level Counselor	Professional Counselor	Masters Level Counselor	Physician Psych	Masters Level Counselor	Social Worker
Date of Completed Application [MM/DD/YYYY]	1/24/2024	2/12/2024	3/26/2024	4/18/2024	5/3/2024	6/11/2024	08/10/2024	9/10/2024	10/08/2024	10/21/2024
Date of Initial Credentialing [MM/DD/YYYY]	1/25/2024	2/22/2024	3/27/2024	4/23/2024	5/10/2024	6/17/2024	08/16/2024	9/19/2024	10/09/2024	10/25/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	Yes	NA	NA	NA	NA	NA	Yes	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	Met	NA	NA	NA	NA	NA	Met	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	Yes	NA	NA	NA	NA	NA	Yes	NA	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	Met	NA	NA	NA	NA	NA	Met	NA	NA
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

Comments:
N/A

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Initial Credentialing Record Review
for Rocky Mountain Health Plans RAE 1

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Applicable Elements	7	9	7	7	7	7	7	9	7	7
Compliant (Met) Elements	7	9	7	7	7	7	7	9	7	7
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	74									
Total Compliant Elements	74									
Total Percent Compliant	100%									

Notes:

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

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

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

365 Calendar Days
- Signed application/attestation
- Work history

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Rocky Mountain Health Plans RAE 1

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

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1
Provider ID #	****	****	REMOVED	****	****	****	****	****	****	****	****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LPC/LAC	LPC		LPC	LPC	LCSW/LAC	LCSW/LAC	APN/RN	LPC	LPC	LPC
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Masters Level Counselor	Professional Counselor		Masters Level Counselor	Masters Level Counselor	Social Worker	Social Worker	Nurse with RX	Masters Level Counselor	Masters Level Counselor	Masters Level Counselor
Date of Last Credentialing [MM/DD/YYYY]	12/7/2021	3/16/2021		4/15/2022	5/26/2022	6/20/2022	7/12/2022	7/8/2022	7/15/2022	9/6/2022	11/24/2021
Date of Recredentialing [MM/DD/YYYY]	1/31/2024	2/27/2024		5/13/2024	6/12/2024	7/15/2024	8/14/2024	9/11/2024	9/19/2024	10/10/2024	2/2/2024
Months From Initial Credentialing to Recredentialing	25	35		24	24	24	25	26	26	25	26
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)	Met	Met		Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met		Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	NA		NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	NA		NA	NA	NA	NA	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	NA		NA	NA	NA	NA	Yes	NA	NA	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	NA		NA	NA	NA	NA	Met	NA	NA	NA
Evidence of Malpractice History Yes, No, NA	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met		Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]	Met	Met		Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes		Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]	Met	Met		Met	Met	Met	Met	Met	Met	Met	Met

Comments:
File 3 was removed from the sample and replaced with File OS1, as RMHP reported File 3 was out of scope for this audit.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2024–2025 External Quality Review
Recredentialing Record Review
for Rocky Mountain Health Plans RAE 1

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10	File OS1
Total Applicable Elements	5	5		5	5	5	5	6	5	5	5
Total Compliant (Met) Elements	5	5		5	5	5	5	6	5	5	5
Total Percent Compliant	100%	100%		100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**55**										
Total Compliant Elements	**55**										
Total Percent Compliant	**100%**										

Notes:

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

   Prior to Credentialing Decision
   - DEA or CDS certificate

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

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

Appendix C. Compliance Review Participants

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

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

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

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

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

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

Table D-1—CAP Process

Step	Action
Step 1	**CAPs are submitted**
If applicable, the MCE will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The MCE must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training, monitoring and follow-up activities, and final evidence to be submitted following the completion of the planned interventions.	
Step 2	**Prior approval for timelines exceeding 30 days**
If the MCE is unable to submit the CAP proposal (i.e., the outline of the plan to come into compliance) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.	
Step 3	**Department approval**
Following review of the CAP, the Department and HSAG will: • Review and approve the planned interventions and instruct the MCE to proceed with implementation, or • Instruct the MCE to revise specific planned interventions, training, monitoring and follow-up activities, and/or documents to be submitted as evidence of completion and to proceed with resubmission.	
Step 4	**CAPs are closed**
Once the MCE has received Department approval of the CAP, the MCE will be instructed that it may proceed with the planned interventions and the CAP will be closed. RAE Accountable Care Collaborative 2.0 contracts end June 30, 2025. RAEs that continue to contract with the Department are encouraged to follow through on completion of their CAP(s) to ensure compliance with their new contract.	

The CAP template follows on the next page.

Table D-2—FY 2024–2025 CAP for RMHP RAE 1 and Prime

Standard VIII—Credentialing and Recredentialing
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's level psychologists, master's level clinical social workers, master's level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.* *42 CFR 438.214(a)–(b)(1)* NCQA CR1—Element A1 Contract Amendment 17: Exhibit B—9.1.6 RMHP Prime Contract Amendment 19: Exhibit M-18—9.1.7
Findings
RMHP (RAE 1 and Prime) posted credentialing policies on its public website, which described RMHP's procedures for the selection of its providers. While RMHP posted its credentialing policies and other credentialing information on its website, RMHP did not post its policies and procedures for the retention of providers on its website.
Required Actions
RMHP (RAE 1 and Prime) must post its policies and procedures for the retention of its providers publicly on its website.

Standard VIII—Credentialing and Recredentialing
Planned Interventions
Person(s)/Committee(s) Responsible
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
3. The MCE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. Contract Amendment 17: Exhibit B—12.9.2.1, 12.9.3 RMHP Prime Contract Amendment 19: Exhibit M-18—12.8.3.4, 12.9.2.5
Findings
While RMHP (RAE 1 and Prime) provided evidence of provider education, the evidence and process described did not demonstrate how updates on EPSDT were made available to network providers every six months.
Required Actions
RMHP (RAE 1 and Prime) must ensure that updates on EPSDT are made available to network providers every six months.
Planned Interventions
Person(s)/Committee(s) Responsible

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
Training Required
Monitoring and Follow-Up Activities Planned
Documents to Be Submitted as Evidence of Completion
HSAG Initial Review:
Documents Included in Final Submission: ***(Please indicate where required updates have been made by including the page number, highlighting documents, etc.)***
Date of Final Evidence:

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

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

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

COLORADO

Department of Health Care Policy & Financing

Appendix F:

Fiscal Year 2024–2025 Compliance Review Report

for

Rocky Mountain Health Plans Medicaid Prime

April 2025

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

HSAG HEALTH SERVICES ADVISORY GROUP

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Summary of Results

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

Rocky Mountain Health Plans Medicaid Prime (RMHP Prime) showed a strong general understanding of the federal regulations with an overall score of 96 percent. Two standards scored 100 percent, which is the same score compared to the prior review. However, the Standard VIII and Standard XI scores declined compared to the prior review of those standards.

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

Table 1-1—Summary of Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
III. Coordination and Continuity of Care	10	10	10	0	0	0	100%~
IV. Member Rights, Protections, and Confidentiality	6	6	6	0	0	0	100%~
VIII. Credentialing and Recredentialing	33	32	31	1	0	1	97%v
XI. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	7	7	6	1	0	0	86%v
Totals	**56**	**55**	**53**	**2**	**0**	**1**	**96%**

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

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

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

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

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

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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Credentialing	80	80	80	0	0	100%~
Recredentialing	68	68	68	0	0	100%~
Totals	**148**	**148**	**148**	**0**	**0**	**100%**

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

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

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

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

Standard III—Coordination and Continuity of Care

Evidence of Compliance and Strengths

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

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

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

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard IV—Member Rights, Protections, and Confidentiality

Evidence of Compliance and Strengths

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

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

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

Recommendations and Opportunities for Improvement

HSAG identified no opportunities for improvement.

Required Actions

HSAG identified no required actions.

Standard VIII—Credentialing and Recredentialing

Evidence of Compliance and Strengths

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

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

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

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

excluded between credentialing cycles. RMHP Prime further described how adverse events and quality of care (QOC) concerns were integrated into the credentialing committee review and decision process.

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

Recommendations and Opportunities for Improvement

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

Required Actions

RMHP Prime posted credentialing policies on its public website, which described RMHP Prime's procedures for the selection of its providers. While RMHP Prime posted its credentialing policies and other credentialing information on its website, RMHP Prime did not post its policies and procedures for the retention of providers on its website. RMHP Prime must post its policies and procedures for the retention of its providers publicly on its website.

Standard XI—EPSDT Services

Evidence of Compliance and Strengths

RMHP Prime established a comprehensive EPSDT program to ensure children and pregnant members eligible for this benefit had access to covered medically necessary services. RMHP Prime's EPSDT procedure addressed outreach efforts, contact strategies, messaging content, identification of members with SHCN, and staff engagement protocols. RMHP Prime supported early identification of developmental delays and utilized the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule to track and notify families of recommended preventive screenings and immunizations. EPSDT benefits covered a range of services, including developmental screens, immunizations, lead screening, vision, dental, hearing care, and diagnostic services. RMHP Prime also assisted members in finding primary care providers (PCPs) and scheduling appointments.

RMHP Prime's data analytics team merged data from various sources to identify EPSDT-eligible members, including those with SHCN and pregnant individuals, enabling targeted outreach campaigns.

Outreach was conducted within 60 days of eligibility determination, when well visits were overdue, or after 12 months of service inactivity. Pregnant members received ongoing outreach and connections to resources. Welcome calls were made to newly eligible members, followed by mailings if contact was unsuccessful. All new members received information about EPSDT benefits and were encouraged to schedule appointments with their PCPs. New members also received welcome materials containing EPSDT information.

RMHP Prime deployed multiple outreach attempts, considering additional opportunities for children involved with child welfare or those transitioning from residential treatment facilities. Gaps in care, identified using AAP guidelines, triggered outreach emails or letters. RMHP Prime had systems in place to protect sensitive information, particularly related to sexual health. Five primary contact methods were used: mailed correspondence (available in Spanish), email, telephone, direct care coordination/provider communication, and text messaging. Member messaging content included welcome kits, call scripts, screeners, "Sorry We Missed You" letters, educational flyers, annual notifications, provider guidebooks, and email blasts.

RMHP Prime monitored utilization and quality, and performed an annual quality audit on a sample of members. RMHP Prime provided referrals for uncovered but needed treatments, collaborating with various agencies and programs. Transportation and appointment scheduling assistance were offered.

Recommendations and Opportunities for Improvement

While RMHP Prime's Member Advisory Committee (MAC) had been tasked with reviewing various member communication documents and mailers, RMHP Prime could not confirm whether the committee consisted of members (or the caretakers of members) who qualified for EPSDT services or whether EPSDT-specific documents had been reviewed. HSAG suggests that RMHP Prime consider the EPSDT population and EPSDT materials when recruiting for the MAC and developing an agenda for upcoming review cycles.

Required Actions

While RMHP Prime provided evidence of provider education, the evidence and process described did not demonstrate how updates on EPSDT were made available to network providers every six months. RMHP Prime must ensure that updates on EPSDT are made available to network providers every six months.

3. Background and Overview

Background

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposal 2017000265, the Department of Health Care Policy & Financing (the Department) executed contracts with the Regional Accountable Entities (RAEs) for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The RAEs are responsible for integrating the administration of physical and behavioral healthcare and managing networks of fee-for-service PCPs and capitated behavioral health providers to ensure access to care for Medicaid members. In accordance with Title 42 of the Code of Federal Regulations (42 CFR), RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). In addition, the RMHP Region 1 RAE contract incorporates into the RAE a limited managed care initiative for capitated physical health (PH) services (managed care organization [MCO]), applicable to a designated service area within the region. The CFR requires PIHPs to comply with specified provisions of 42 CFR §438—managed care regulations—and requires that states conduct a periodic evaluation of their managed care entities (MCEs), including PIHPs and MCOs, to determine compliance with Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. The Department has elected to complete this requirement by contracting with an external quality review organization (EQRO), HSAG.

To evaluate RMHP Prime's compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2024–2025 was calendar year (CY) 2024. This report documents results of the FY 2024–2025 compliance review activities for the Region 1 limited managed care initiative—RMHP Prime. Section 1 includes the summary of scores for each of the standards reviewed this year. Section 2 contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 3 describes the background and methodology used for the FY 2024–2025 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2023–2024 compliance review activities. Appendix F-A contains the compliance monitoring tool for the review of the standards. Appendix F-B contains details of the findings for the credentialing and recredentialing record reviews.

Overview of FY 2024–2025 Compliance Monitoring Activities

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

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

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

Compliance Monitoring Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the MCO's contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. Additional revisions were released in December 2020, February 2023, and May 2024. HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* The Department determined that the review period was CY 2024. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key MCO personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials. While the RAE and MCO managed care requirements were reviewed simultaneously, HSAG delineated results for each product line into individual separate reports. However, required corrective actions for the MCO are the responsibility of the RAE and are incorporated into Appendix D of the RAE Region 1 report.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix E of the RAE Region 1 report contains a detailed description of HSAG's compliance review activities consistent with those outlined in the CMS EQR protocol. The four standards chosen for the FY 2024–2025 compliance reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services; Standard II—Adequate Capacity and Availability of Services; Standard V—Member Information Requirements; Standard VI—Grievance and Appeal Systems; Standard VII—Provider Selection and Program Integrity; Standard IX—Subcontractual Relationships and Delegation; Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

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

- The MCO'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 MCO into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality, timeliness, and accessibility of services furnished by the MCO, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the MCO's services related to the standard areas reviewed.

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

FY 2023–2024 Corrective Action Methodology

As a follow-up to the FY 2023–2024 compliance review, each MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with RMHP Prime until it completed each of the required actions from the FY 2023–2024 compliance monitoring review.

Summary of FY 2023–2024 Required Actions

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

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

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

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

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

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

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

Summary of Corrective Action/Document Review

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

Summary of Continued Required Actions

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. The Contractor implements procedures to deliver care to and coordinate services for all members. B. *For all members*, the Contractor's care coordination activities place emphasis on acute, complex, and high-risk members and ensure active management of high-cost and high-need members. The MCE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. • Is documented, for both medical and non-medical activities. *42 CFR 438.208(b)*	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* This policy and procedure describes the Rocky Mountain Health Plans (RMHP) comprehensive, client and family centered integrated care coordination program. Bullet 1: Page 13, section 6.8, Integrated Community Care Teams Bullet 2: Pages 22-24, section 6.8.13, Active Care Plan Maintenance and Follow-up Bullet 3: Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning Bullet 4: Found throughout the P&P Bullet 5: Found throughout the P&P Bullet 6: Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning; Pages 22-24, section 6.8.13, Active Care Plan Maintenance and Follow-up Bullet 7: Page 20, section 6.8.9, Care Coordinator; Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning Bullet 8: Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning Bullet 9:	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RMHP Prime Contract Amendment 19: Exhibit M-18—11.3.3, 11.3.7	Pages 18-19, section 6.8.8.3, Care Plan Development & Care Planning *III_1_ComprehensiveAssessment* Bullets 1-9 RMHP assesses the Member's health and health behavior risks, medical and nonmedical needs, and social determinants of health needs, including determining if a care plan exists. RMHP uses a comprehensive, client/family centered, integrated approach to assessment of members for care coordination needs. *III_1,6_HNS Workflow* The Health Needs Survey is a voluntary survey completed by Members enrolling in a Medicaid program such as RAE or PRIME. Members indicate when they need help managing their health conditions, are pregnant, would like help with resources or to receive an outreach call from a care coordinator. Survey data is transferred from HCPF to the RAE/MCO and helps prioritize Members who could benefit from care coordination. *III_1_Top 40 Complex Outreach Workflow 10.31.24_FINAL* This workflow describes Outreach to the Top 40 Members from populations stratified as Complex and how they are outreached in a campaign. The documents listed below demonstrate procedures to deliver care to and coordinate services for all members. *III_1_Care Plan Workflow*	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_1,10_CM_Essette Documentation Screen Shot Additionally, this Essette Documentation Screen Shot contains a view of a Member's Care Plan in Essette. RMHP care coordination works collaboratively with the Member and caregivers (if applicable) to create an individualized care plan that includes documentation of the Member's desired health outcomes and identifies other providers of that member's care coordination team. **Prime-specific:** See above	
2. The Contractor ensures that each behavioral health member has an ongoing source of care appropriate to the member's needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact the designated person or entity. *42 CFR 438.208(b)(1)* RMHP Prime Contract Amendment 19: Exhibit M-18—None	**Both RAE and Prime:** *III_2_SorryWeMissedYou_RAEorPrime_Adult_Eng_3033_Template* *III_2_SorryWeMissedYou_RAEorPRIME_Child-W-EPSDT_Eng_3029_Template* *III_2_SorryWeMissedYou_RAE_PRIME_YA_Preg-EPSDT_Eng_3031_Eng_Templ* This letter is sent to all members who are not reached through the Welcome Call. Members are urged to call Member Services if they need assistance to access appropriate care and/or to connect with the community resources. *III_2, 7_CO_PR21_Welcome_Script.1* *III_2,7_CO_PRYA_Welcome_Script-RAE PrimeYoungAdult-Pregnant.1* *III_2,7_CO_PR17_Welcome_Script-PrimeRAEChild.1* Member Services representatives make outbound Welcome Calls to all new members. These scripts show the initial Member services portion of the welcome call, that then leads into the Welcome	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Screener Script. Whether the Member call is outgoing or incoming, the initial Member conversation introduces care coordination and screens the Member for social, medical and behavior heath needs. When a Member is reached and a screener is completed the information is housed in Essette. *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 23, section 6.8.13.3.6 shows that RMHP ensures that each member has an ongoing source of care appropriate to his or her needs by providing the Member with ongoing information about choices of settings, providers, treatment option and resources as needed and appropriate. Page 13, section 6.8.2, states that RMHP is exclusively responsible for ensuring that appropriate care coordination is provided for all Medicaid and CHP+ members. Page 20, section 6.8.10.1 indicates the care plan identifies a lead care coordinator who is formally designated as primarily responsible for coordinating covered services furnished to the member. Page 16, section 6.8.8.1.6.3 states that once a member is engaged with their local Care Coordinator the member is provided with the direct contact information for the Care Coordinator	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: *III_2,3_CO-RMHP-PRIME-Handbook-EN* Pages 24-25 explain How to Contact an RMHP Care Coordinator.	
3. The *RAE* no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. The *MCO* receives and processes the Department's attribution and assignment list to ensure accurate member attribution and assignment. Members enrolled in the MCO have 90 days in which to opt out. Any member who does not opt out remains enrolled until the member's next open enrollment period, at which time the member shall receive an open enrollment notice. Subsequent enrollment will be for 12 months, and a member may not disenroll from the limited managed care capitation initiative (except as provided in the disenrollment terms). RMHP Prime Contract Amendment 19: Exhibit M-18—6.7	**Both RAE and Prime:** **Prime-specific:** III_2,3_CO-RMHP-PRIME-Handbook-EN On pages 24, Members are advised of the circumstances and timeframe for leaving RMHP. They must call the number for Health First Colorado Enrollment to request disenrollment or to change plans. Note regarding MCO opt out activity: all MCO enrollment/disenrollment activity is performed by First Health Colorado Enrollment (the enrollment broker).	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor's care coordination activities will comprise: • A range of deliberate activities to organize and facilitate the appropriate delivery of health and social services that support member health and well-being. • Activities targeted to specific members who require more intense and extensive assistance and include appropriate interventions. RMHP Prime Contract Amendment 19: Exhibit M-18—11.3.3	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 5, section 6.4.3.4, states that RMHP care coordinators will provide assistance during care transitions from hospitals or other care institutions, to home or community-based settings, or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. *III_4_CM10_SpcialHlthCareNeeds.2_24* Addresses this requirement for people with special health care needs. Page 2, 4.0 Policy section provides that RMHP coordinates health care services for children with Special Health Care Needs with other agencies or entities. *III_4,5_2024 RMHP Webinars and Events Catalog 11.7.24* This document provides examples of educational offerings to support the organization and facilitation of the delivery of health and social services for Members. **Prime-specific:** see above	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. The Contractor is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. The Contractor implements procedures to coordinate services furnished to the member:	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 2, section 4.2 describes that RMHP utilizes a single care management platform, Essette, for all services that allows the many entities that may be	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. • Including Medicaid-eligible individuals being released from incarceration to ensure they transition successfully to the community. *Note: Contractor shall ensure that care coordination is provided to members who are transitioning between health care settings and to populations who are served by multiple systems, including, but not limited to, children involved with child welfare; Medicaid-eligible individuals transitioning out of the criminal justice system; members receiving long-term services and supports (LTSS); members transitioning out of inpatient, residential, and institutional settings; and members residing in the community who are identified as at-risk for institutionalization.* *42 CFR 438.208(b)(2)* RMHP Prime Contract Amendment 19: Exhibit M-18—10.3.2, 10.3.4, 11.3.5, 11.3.7.7, 11.3.10, 11.3.10.4.2.3	providing care/services to a Member to coordinate and share information seamlessly. Page 5, section 6.4.3.4, states that RMHP care coordinators will provide assistance during care transitions from hospitals or other care institutions, to home or community-based settings, or during other transitions, such as the transition from children's health services to adult health services or from hospital or home care to care in a nursing facility. Page 18, section 6.8.8.3.61 describes the procedures for coordinating services between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. Pages 14-15, section 6.8.7 "Integration with BH and PH Providers" is addressed. Page 18, section 6.8.8.3.1 describes that RMHP works collaboratively with the Member's care team – Member, PCP and other providers, community partners, family/caregiver/representative, as appropriate – to create the care plan. The care plan identifies members of the Member's care team, which at a minimum include the Member or family/responsible party and the PCP. Page 11, section 6.4.5.5 describes the process to coordinate services with individuals being released from incarceration, to ensure a successful transition. Page 12, section 6.4.5.6 describes the process to coordinate services with members in foster care. *III_5_8_Referral Campaign Workflow 11042024 V2* This document shows RMHP's referral workflow process.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_5_Welcome Call Toolbox - Colorado This document identifies scripts, resources and information for Member Service Reps to support Members. One phone number per line of business is maintained, staffed, and published for Members to call regarding customer service or care coordination issues. The call center serves Members and providers. *III_5_Provider Insider Plus_ Special Edition _ Feb. 1, 2024* Periodically, RMHP has a need to send a special edition for informational updates to providers. This document is an example of when this occurred in 2024. *III_5_UHC Network News_Dec '24 Monthly Overview* *III_5_PNM_Network News October 2024* Network News is the UHC Provider Newsletter, which includes RMHP information. Network news is available online and accessible for providers via their portal and distribution lists. This document is an example of the December 2024 and October information within Network News (The URL link is included on the 1st page of these documents) *III_5_RAE 1 BH Office Hours PP - Aug 6 2024* This document demonstrates RMHP's communication with BH providers through Meeting Webinars to fully engage them in the work outlined in the contract for RAE and for PRIME. The Webinars are presented quarterly in the format of "RMHP BH Office Hours" where RMHP presents on relevant topics and providers	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	have the opportunity to ask questions and to provide feedback. *III_4,5_2024 RMHP Webinars and Events Catalog 11.7.24* This document provides examples of educational offerings to support the organization and facilitation of the delivery of health and social services for Members. *III_5_QI_8.2024 CQI Newsroom Presentation* *III_5_QI_11.2024 CQI Newsroom Presentation* These documents demonstrate RMHP's communication with providers through Meeting Webinars to fully engage them in the work outlined in the contract for RAE and for PRIME. The Webinars are presented monthly in the format of "Clinical Quality Improvement Newsroom" where RMHP presents on relevant topics and providers have the opportunity to ask questions and to provide feedback. **Prime-specific:** see above	
6. The Contractor uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The MCE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP and/or MCE.	**Both RAE and Prime:** *III_6_CM_Health Needs Survey Process_12.18.24* *III_1,6_HNS Workflow* *III_6_HNS_Redacted* The Health Needs Survey is a voluntary survey completed by Members enrolling in a Medicaid program such as RAE or PRIME. Members indicate when they need help managing their health conditions, are pregnant, would like help with resources or to receive an outreach call from a care coordinator. The policy describes how RMHP processes and stratifies	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b)(3) RMHP Prime Contract Amendment 19: Exhibit M-18—7.5.2–3	the survey. The Workflow illustrates how RMHP receives, processes and reviews the data to inform member outreach and care coordination activities. **Prime-specific:** see above	
7. The Contractor ensures that it has procedures to ensure: • Each member receives an individual intake and assessment appropriate for the level of care needed. • It uses the information gathered in the member's intake and assessment to build a service plan. • It provides continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2–3)* RMHP Prime Contract Amendment 19: Exhibit M-18—14.5.1	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Bullet 1: Page 2, section 4.2 indicates that All members identified by these activities receive outreach to conduct screening, assessment, coordination and care planning as needed. Bullet 2: Pages 18-24, section 6.8.8.3 "CarePlan Development & Care Planning" Bullet 3: Pages 6-12, section 6.4.5 "Special Populations" describes continuity of care activities for Members in transition and involved in multiple systems. III_7_CM-UM 6 *Continuity_Coordination_Care_Transitions 10.24.2024V2* Purpose on page 1 indicates that RMHP facilitates continuity and coordination of medical care across its delivery system. *III_2, 7_CO_PR21_Welcome_Script.1* *III_2,7_CO_PRYA_Welcome_Script-RAE PrimeYoungAdult-Pregnant.1* *III_2,7_CO_PR17_Welcome_Script-PrimeRAEChild.1*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member Services representatives make outbound Welcome Calls to all new members. These scripts show the initial Member services portion of the welcome call, that then leads into the Welcome Screener Script. Whether the Member call is outgoing or incoming, the initial Member conversation introduces care coordination and screens the Member for social, medical and behavior heath needs. When a Member is reached and a screener is completed the information is housed in Essette. **Prime-specific:** see above	
8. The Contractor shares with other entities serving the member the results of its identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* RMHP Prime Contract Amendment 19: Exhibit M-18—None	**Both RAE and Prime:** *III_8_9_CM 14 Confidentiality and Retention of Member Records 2024* Page 1, section I, states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our members. All information obtained in an official capacity is confidential and staff will comply with HIPAA Privacy Regulations. *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 2, section 4.2 explains that RMHP utilizes a care management system platform named Essette to achieve distribution of all of the members identified by stratification, ADT alerts, Special Populations and Referrals to RMHP. Screening, assessment, care planning, and follow up are all managed through Essette. The sharing and integration of Essette allows coordination of the many entities that may be providing	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	care/services to a members resulting in better member outcomes and less duplication of care and services. Page 21, section 6.8.11.6. describes the activities that ensure, to the extent possible, that all communications and interventions have been established and describes activities of sharing assessments and identified needs of the Member with other providers serving the member in order to prevent duplication of activities. *III_5_8_Referral Campaign Workflow 11042024 V2* This document shows RMHP's referral workflow process. **Prime-specific:** see above	
9. The Contractor ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards and in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(5) and (6)* RMHP Prime Contract Amendment 19: Exhibit M-18—11.3.7.13, 15.1.1.5	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 21-22, section 6.8.11.8 provides that any communication with a non-Member representative will require the appropriate Appointment of Representative/HIPAA paperwork to be filled out. *III_9_RMHP ROI 2024* *III_9_RMHP Spanish ROI 2024* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR requirements to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_8,9_CM14_Confidentiality-Retention_MemberRecords2024 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 staff will comply with HIPAA Privacy Regulations. *III_7,9_PNM_2024 Provider Manual* Page 93-94 describes all aspects of Medical Records and Release of Information and Transfer of Records including how each provider needs to make health service records available to the Member and to other participating providers and authorized individuals in accordance with HIPAA and the terms of the RMHP Provider Agreement. Page 93 includes detailed information to PCP's and Page 94 includes detailed information to specialists about what office records should include. Providers are responsible for the maintenance of adequate medical records, which are to be secure, complete, legible, accurate, accessible, organized, and maintained in a format that facilitates retrieval of information and assures confidentiality. Page 96, Ch 12: Member Rights and Responsibilities for RMHP Prime, RAE, and CHP+ Members, states Members have the right, "To expect all communications regarding your care to be kept confidential as required by law"	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_9_PNM_Physician Medical Services Agreement(Primary Care-all inclusive)_RAEPRIME Page 14-15, Section Q. Records: (4) This section specifies medical records requirements in accordance with professional, state and law requirements, including paragraph (7) which requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law. *III_9_PNM_Physician Medical Services Agreement(Not Primary Care)_RAEPRIME* Page 13-14, Section N. Records: (4) This section specifies medical records requirements in accordance with professional, state and law requirements, including paragraph (7) which requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law. *III_9_Professional Services Agreement Example_BH* Page 10-11, Section H. Records: (4) This section specifies medical records requirements in accordance with professional, state and law requirements, including paragraph (7) which requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law. **Prime-specific:** see above	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. The care coordination tool, at a minimum: • Works on mobile devices. • Supports HIPAA and 42 CFR Part 2 compliant data sharing. • Provides role-based access to providers and care coordinators.	**Both RAE and Prime:** *III_1-2,4-5,7-10_CM 28 Care Coordination Policy and Procedure Updated 2024* Page 2, section 4.2 explains that RMHP utilizes a care management system platform, Essette, to support communication and coordination among the many entities (members of the provider network and health neighborhood) providing care/services to members. *III_1,10_CM_Essette Documentation Screen Shot* This document illustrates the data that is collected and aggregated in Essette, including the items listed in this element. -Page 1 provides an example of the following fields: Name, Age, Gender, Care Coordinator, Stratification Level [Acuity], Medicaid ID. -Page 2 provides an example of member's lead coordinator and other providers involved their care. -Pages 3-11 provides member assessment information -Page 12 provides a sample care plan for the member -Page 13 provides care coordination notes -Pages 14-15 provides additional information that can aid in the creation and monitoring of the care plan for the member. *III_10_Essette Platform Information* This document shows screenshots of the Essette system that provide information showing Essette is available on mobile devices, supports HIPAA and 42 CFR Part 2 compliance, and provides role-based access to providers and care coordinators.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Note: The Contractor shall collect and be able to report the information identified in Section 15.2.1.3 for its entire network. Although network providers and subcontracted care coordinators may use their own data collection tools, the Contractor shall require them to collect and report on the same data. RMHP Prime Contract Amendment 19: Exhibit M-18—15.2.1.1, 15.2.1.3–4	**Prime-specific:** see above	

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

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.7.1	**Both RAE and Prime:** *IV_1,3,4,6_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* This Policy and Procedure documents RMHP's written policy regarding a Prime, RAE, or CHP+ Member's Rights and Responsibilities. **Prime-specific:** see above	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor complies with any applicable federal and State laws that pertain to member rights (e.g., non-discrimination, Americans with Disabilities Act) and ensures that its employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2) and (d)* RMHP Prime Contract Amendment 19: Exhibit M-18—5.2.4	**Both RAE and Prime:** *IV_2_CI_CSCO23MD0040511_000_Eng_CO_Medicaid_NonDiscrim_ShortForm-PRNC* *IV_2_CI_CSCO24MD0167794_001_Eng_CO_Medicaid_NonDiscrim_LongForm-PRNC* *IV_2_CI_CSCO24MD0167795_001_SP_CO_Medicaid_NonDiscrim_LongForm-PRNC* *IV_2_CI_CSCO24MD0167796_001_EngSP_CO_Medicaid_NonDiscrim_LongForm-PRNC* The CRN/MLIS documents listed above (4 versions) demonstrate that RMHP complies with applicable federal and state laws that pertain to member rights. *IV-2,4,6_PNM_2024 Provider Manual* Page 96-97 of the Provider Manual describes Prime, RAE and CHP+ Member rights to network providers. Page 85 informs providers of the values and tenens of the RMHP Compliance Plan/Code of conduct which demonstrate compliance with Federal and State laws that pertain to Member rights. *IV_2_4_ PNM_Law Exhibit to Services Agreements_RAE_PRIME*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	See Page 8-9, numbers 19 & 20 : Medicaid/CHP+ Recipient Rights and Medicaid and CHP+ Contracts Statutes and Regulations lists the federal and State laws with which RMHP, providers and subcontractors shall comply with. *IV_2_PNM_Law Exhibit-NonProv_RAE_PRIME.pdf* This Law Exhibit is attached to all non-provider contracts that are executed with RMHP. It includes requirements for compliance with all applicable federal and state law that pertain to member rights. *IV_2,5_CM14_Confidentiality-Retention_MemberRecords2024* Page 1, Purpose statement identifies that RMHP complies will all federal and state regulations that pertain to member activity and confidentiality. *IV_2_5_RMHP English ROI 2024* *IV_2_5_RMHP Spanish ROI 2024* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information **Prime-specific:** *IV_2,4,6_CO-RMHP-PRIME-Handbook-EN* Page 71 informs Members of the RMHP Equal Opportunity Policy.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for the member's dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding their health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of their medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.7.2	**Both RAE and Prime:** *IV_1_3_4_6_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* Page 2, Section 6 describes Member rights as specified in state and federal regulation **Prime-specific:** *IV_3_CO-PRIME-WelcomeKit-EN* Members are directed how to find information online to learn more about their Member rights and responsibilities in these Welcome Kits that are sent to all new members *IV_3_ Member Annual Notice CM89-PRIME -2024* These Member Annual Notices advise Members how to find information online to learn more about their Member rights and responsibilities.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor ensures that each member is free to exercise their rights and that the exercise of those rights does not adversely affect how the RAE, its network providers, or the Department treat(s) the member. *42 CFR 438.100(c)* RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.7.2.7	**Both RAE and Prime:** *IV_1,3,4,6_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* Page 2, bullet #9 indicates that the member is able to exercise their rights without being treated differently. *IV_2,4,6_PNM_ 2024 Provider Manual* Page 96 includes the Members right to freely exercise their rights without being treated differently. *IV_2_4_PNM_Law Exhibit to Services Agreements_RAE_PRIME* Page 8, Number 19: Medicaid Recipient Rights, paragraph C states that "Contractor shall ensure that Medicaid Recipients have the rights set forth in 42 C.F.R. section 438.100(b)(2), including but not limited to the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, consistent with 42 C.F.R., section 438.100.(b)(2)(v) **Prime-specific:** *IV_2,4,6_CO-RMHP-PRIME-Handbook-EN* Page 61, bullet #8 indicates to Members that they are able to exercise their rights without being treated differently.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
5. For medical records and any other health and enrollment information that identify a particular member, the MCE 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.	**Both RAE and Prime:** *IV_2,5_CM14_Confidentiality-Retention_MemberRecords2024* Page 1-2, Purpose statement identifies that RMHP complies will all federal and state regulations that pertain to member activity and confidentiality. *IV_2_5_RMHP English ROI 2024*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.224 RMHP Prime Contract Amendment 19: Exhibit M-18—11.3.7.13, 15.1.1.5	*IV_2_5_RMHP Spanish ROI 2024* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this Authorization to Use or Disclose Specific Information (Consent Form) for RMHP to use/obtain or disclose specific personal health information. **Prime-specific:** see above	
6. The Contractor maintains written policies and procedures and provides written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the MCE. Advance directives policies and procedures include: • Notice that members have the right to request and obtain information about advance directives at least once per year. • A clear statement of limitation if the MCE cannot implement an advance directive as a matter of conscience. – The difference between institution-wide conscientious objections and those raised by individual physicians. – Identification of the State legal authority permitting such objection. – Description of the range of medical conditions or procedures affected by the conscientious objection.	**Both RAE and Prime:** *IV_2,4,6_PNM_2024 Provider Manual* Pages 80-81 provides written information to providers about advance directives. It also explains practitioner responsibilities around advance directives, including the policies they must have in place to provide information to Members about their rights under state law to create an advance directive, and the policies of their organization to respect implementation of those rights (including any limitations because of conscientious objections). *IV_1_3_4_6_CS_Medicaid_CHP+ Mmbr Rights_Responsibilities 11.19.2024* Page 3, last bullet indicates that Members have a responsibility to choose a PCP and to inform that PCP of any advance direction for the Member's care. **Bullet 1:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 1, Section 4.1.1, demonstrates that members can request information regarding advance directives at least once per year.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions: – For providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. – For providing advance directive information to the incapacitated member once he or she is no longer incapacitated. – To document in a prominent part of the member's medical record whether the member has executed an advance directive. – That care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. – To ensure compliance with State laws regarding advance directives. – To inform individuals that complaints concerning noncompliance with advance directive requirements may be filed with the Colorado Department of Public Health and Environment. – To inform members of changes in State laws regarding advance directives no later than 90 days following the changes in the law.	**Bullet 2:** RMHP does not impose any limitations with respect to implementing advance directives as a matter of conscience, therefore no statement to this effect is included in written information to individuals. **Bullet 2, 1st, 2nd and 3rd dashes:** *IV_6_PNM-007 Advance Directives* Page 1, 2.0 Purpose indicates this policy provides guidelines in the event a practitioner is unable to implement a patient's advance directive based on conscience. Page 2, 5.1 bullet 4, describes that the practitioners described in the previous bullet, are required to maintain written policies about advance directives and provide written information as specified in 42 CFR 489.102 to Members regarding the policy of the provider or organization to provide a clear and precise statement of limitation if they cannot implement an advance directive based on conscience. *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 3, section 6.3-6.3.1 and Page 2, section 4.1.2-4.1.3 indicates the provider's obligations in relations to Members with advance directions. **3rd bullet, 1st dash:** *IV_6_PNM-007 Advance Directives* Page 2, 5.1 last bullet states, practitioners must provide advance directive information to incapacitated Members once they are no longer incapacitated.	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– To educate staff concerning its policies and procedures on advance directives. – The components for community education regarding advance directives that include: ▪ What constitutes an advance directive. ▪ Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. ▪ Description of applicable State law concerning advance directives. *Note: The MCE must be able to document its community education efforts.* *42 CFR 438.3(j)* *42 CFR 422.128* RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.11.3–6	*IV_6_PNM-007 Advance Directives* Page 2, 5.1 first bullet states a practitioner is required to include a Member's advance directive in the medical record. *IV_2,4,6_PNM_2024 Provider Manual* Page 81, first paragraph provides that a practitioner must include a Member's advance directive in the medical record. *IV_6_PNM-007 Advance Directives* On page 2, Section 5.1 3rd bullet of the policy, providers are prohibited from discriminating against Members based on whether the Member has executed an advance directive. *V_2,4,6_PNM_2024 Provider Manual* Page 81 provides that a practitioner may not condition the provision of health or medical care based on whether or not the Member has signed an advance directive. *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 2, sections 4.1.1.3 - 4.1.1.4 provide that Members rights include that advance directive information is given to the Member's family if he or she is incapacitated at the time of enrollment. Once the Member is no longer incapacitated, the information is given to the individual directly. **3rd bullet, 3rd dash:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024*	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 3, section 6.2.2. and 6.3.2 sets forth the Member's right to have an advance directive recorded in the medical record. Page 3, section 6.4 provides that when chart audits occur they will include a review for the presence or absence of advance directives in the medical record. **3rd bullet, 7th dash:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 3, section 6.5.1 provides that Members will be informed of changes in state law concerning advance directives no later than 90 days following the change in law. **3rd bullet, 8th dash:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 3, item 6.5.3 provides that RMHP will train staff on policies and procedures on advance directives. **3rd bullet, 9th dash:** *IV_6_CM 61 Medicaid Medicare Advance Directives 2024* Page 3, section 6.5.4 provides that RMHP will provide community education on advance directives. *IV-6_Website Education Advance Directives* This documents demonstrates that RMHP provides community education regarding advance directives in several places on the Colorado RMHP landing pages. **Prime-specific:** *IV_2,4,6_CO-RMHP-PRIME-Handbook-EN*	

Standard IV—Member Rights, Protections, and Confidentiality		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 73-87 provides written information to Members about advance directives. **3rd bullet, 4th dash:** *IV_2,4,6_CO-RMHP-PRIME-Handbook-EN* Page 74, Know the Law, informs Members that they will not be denied services, treatment or admission to a health care facility if the Member does not sign an advance directive. **3rd bullet, 5th and 6th dash:** *IV_2,4,6_CO-RMHP-PRIME-Handbook-EN* Page 74, "Know the Law" section provides members information regarding State laws and advance directives. Page 75, "How do I complain if my advance directive is not followed?" provides information to Members about how to complain if an advance directive is not followed.	

Results for Standard IV—Member Rights, Protections, and Confidentiality							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. • The Contractor shall use National Committee on Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all applicable providers. *42 CFR 438.214(b)* NCQA CR1 RMHP Prime Contract Amendment 19: Exhibit M-18—9.2.4	**Both RAE and Prime:** The following documents demonstrate RMHP has a well defined credentialing and recredentialing process for evaluating and selecting licensed practitioners: *VIII_1-14,16-19_Credentialing Plan_BH* Page 7, Section 3.1 National Quality Improvement Committee, A. *VIII_1,2_CO Addendum_CredPolicies_BH* Page 1, Policy Statement and Purpose **Prime-specific:** Note: UHC currently holds a National CR Accreditation from NCQA through January 2026. *VIII_1_NCQA_United_Healthcare_Services__Inc_Cred Accred Cert 2023-2026* *VIII_1-12,14,16-19_2024 CRM Program_PH* This Document defines a consistent credentialing and recredentialing process for Physical Health practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for credentialing of its providers. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 7, section 4.1 Page 10, section 5.2 These sections describes a process for evaluating and selecting licensed independent practitioners to provide care to its members, using NCQA standards and guidelines.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners it credentials and recredentials. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. The Contractor shall document and post on its public website policies and procedures for the selection and retention of providers. *Examples of behavioral health practitioners include psychiatrists, physicians, addiction medicine specialists, doctoral or master's level psychologists, master's level clinical social workers, master's level clinical nurse specialists or psychiatric nurse practitioners, and other behavioral health care specialists.* *42 CFR 438.214(a)–(b)(1)* NCQA CR1—Element A1 RMHP Prime Contract Amendment 19: Exhibit M-18—9.1.7	**Both RAE and Prime:** *VIII_2, 2A._P&Ps for selection-retention on websites* This document demonstrates where P&Ps for selection-retention of providers can be found on the various RMHP-UHC website locations. *VIII_1-14,16-19_Credentialing Plan_BH* PDF Pages 10-12, section 4.2 - Administrative Review This section outlines the types of BH practitioners **RAE-specific:** see above **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* PDF page 6 "Licensed Independent Practitioner or Provider (LIP)" describes the type of PH practitioners that the contractor credentials and recredentials. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 3, section 2.0 - Definitions - Licensed Independent Practitioner (LIP) This defines the types of health care professionals who can be credentialed or re-credentialed. Page 7, section 4.1 This section describes the written policies and procedures for the selection and retention of the types of practitioners, it credentials and recredentials.	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: RMHP Prime posted credentialing policies on its public website, which described RMHP Prime's procedures for the selection of its providers. While RMHP Prime posted its credentialing policies and other credentialing information on its website, RMHP Prime did not post its policies and procedures for the retention of providers on its website.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: RMHP Prime must post its policies and procedures for the retention of its providers publicly on its website.		
2.B. The verification sources it uses. NCQA CR1—Element A2	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF pages 11-13, section 4.2, B - Verification of Credentials PDF pages 15-16, section 6.1 - Criteria for Credentialing Organizational Provider These sections describe the verification sources used. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 14, sections 3.4 - Recredentialing Process and 3.5 - Primary Source Verification (PSV) of Credentials These sections describe the verification sources used for credentialing and recredentialing. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 7, section 4.2 Page 10, section 5.2, #1 These describe the verification sources it uses for credentialing and recredentialing.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF pages 8-13, section 4.0 Initial Credentialing of licensed Clinicians PDF pages 13-15, section 5.0 Recredentialing of Participating Clinicians These sections describe the criteria used for these activities. *VIII_1,2_CO Addendum_CredPolicies_BH* This policy supplements the Credentialing Plan to describe criteria used. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Pages 12-14, section 3.2 - Credentialing Criteria of Providers This section outlines the criteria used for credentialing and recredentialing. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 7, section 4.2 Page 10, section 5.2 These sections describe the criteria for credentialing and recredentialing.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 13, section 4.3 - Credentialing Committee Review PDF Page 14, section 5.2, A- "UBH Review Criteria" last paragraph and section 5.2, B - "Credentialing Committee Action," These describe the process for making credentialing and recredentialing decisions.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 16-17, sections 3.8 - Clean Application Process and 3.9 - CRM Clinical Review and 4 - CRMC Review and Decision-Making These describe the process for making credentialing and recredentialing decisions. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 5, section 3.3 describes the process for making credentialing and recredentialing decisions.	
2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 13, section 4.3 Credentialing Committee Review, "A Credentialing Committee Action 1," PDF pages 14-15, section 5.2 Recredentialing Criteria of Participating Clinicians, "A UBH Review Criteria" - last paragraph These describe the process for managing cred/recred files. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Section 3.8 Clean Application Process, Page 16 describes the process for managing credentialing/recredentialing files. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Section 4.2-4.4, pages 7-9 and Section 5, page 10 describes the process for managing credentialing/recredentialing files that meet the Contractor's established criteria	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.F. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. *Examples include nondiscrimination of applicant, a process for preventing and monitoring discriminatory practices, and monitoring the credentialing/recredentialing process for discriminatory practices at least annually.* *42 CFR 438.214(c)* NCQA CR1—Element A6	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 4, section 1.1 - Purpose, 2nd paragraph PDF page 18, section 7.1 - Confidentiality of Applicant and Participating Clinician and Participating Organizational Provider Information These describe UBH's credentialing and recredentialing are conducted in a non-discriminatory manner. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 7, section 2.2 - Statement of Non-Discrimination This describes that RMHP-UHC's cred/recred are conducted in a non-discriminatory manner. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Pages 5-6, section 3.4 describes the process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.G. The process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A7	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 18, section 7.2 "Applicant Rights" paragraph B-(b) describes the process for notifying applicant if information obtained varies substantially from the information provided by the applicant. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH,* Page 8, section 2.3 - Provider Rights in the Credentialing Process paragraph B - "Notice of Erroneous Information" informs that an applicant will be notified if information	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	obtained varies substantially from the information provided by the applicant. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.2 describes the process for notifying practitioners if information obtained during the Contractor's credentialing process varies substantially from the information they provided to the Contractor.	
2.H. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision. NCQA CR1—Element A8	**Both RAE and Prime:** *VIII_1,2_CO Addendum_CredPolicies_BH* Page 2, section 5 A, demonstrates the process for notifying practitioner of the credentialing decision. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 19, section 4.6 Notice of CRMC Decisions, (A,B) Page 36, Colorado, (2) These indicate that initial credentialing will be completed within 60 days and approval for recredentialing will be sent as required by regulatory and accreditation requirements. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.2 describes the process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the Credentialing Committee's decision.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2.I. The medical director or other designated physician's direct responsibility and participation in the credentialing program. NCQA CR1—Element A9	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 7, section 3.2 Credentialing Committee describes the responsibility and participation in the credentialing committee of the medical director or other designated physician. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 8, section 2.5 - Credentialing Risk Management Committee (CRMC) describes responsibilities of the medical director/designee *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 5, section 3.2 describes the direct responsibilities and participation of the medical director or other designated physicians in the credentialing program.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2.J. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. NCQA CR1—Element A10	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF pages 18-19, section 7.0 - Confidentiality and Applicant Rights, Section describes the process for securing the confidentiality of all information obtained during the credentialing process, except as otherwise provided by law. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 7, section 2.1 - Confidentiality describes the process for securing the confidentiality of all information obtained during the credentialing process, except as otherwise provided by law.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025 Page 13, section 8.1 describes the process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	
2.K. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification (including board certification, if applicable) and specialty. NCQA CR1—Element A11	**Both RAE and Prime:** The following documents describe the various processes used to ensure provider information in provider directories are consistent with credentialing data. *VIII_2K_NCC P-P 110 Initial Cred Proc for LIP* Describes the process of collecting applicant information such as education, training, board certification and this information is electronically sent to NDB and completed profile shall be posted and attached to the Credentialing Cycle (CC) in Salesforce so inclusion in the provider directories occurs. See page 3, 5.5. *VIII_2K_E2E Non Del Contract-NDM Process flow chart* This chart demonstrates the End to End process for inputting provider data into PhyCon, which feeds the data to the provider directories. *VIII_2K_PhyCon Contract_Amendmnt_Execution SOP* This document describes the process of execution of a contract/amendment for a provider which includes ensuring demographic information such as education, training, specialties, etc. so that it is populated in the directory. *VIII_2K_PDA Attestation Process SOP* This SOP document describes the process to complete attestation review of provider directory accuracy to ensure credentialing/recredentialing information is included in the directory.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: see above	
3. The Contractor notifies practitioners about their rights: 3.A. To review information submitted to support their credentialing or recredentialing application. *The Contractor is not required to make references, recommendations, or peer-review protected information available.* NCQA CR1—Element B1	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 18, section 7.2 - Applicant Rights describes how providers have the right to review information submitted to support their cred or recred application as well as indicating that UBH is not required to allow the applicant to review personal or professional references, internal UHB documents, or any other information that is peer review protected or restricted by law. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 8, section 2.3 - Provider Rights in the Credentialing Process describes how providers have the right to review information submitted to support their cred or recred application as well as indicating that references, recommendations, or peer-review protected information is not available to the applicant. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.2 describes the process the Contractor notifies practitioners about their rights to review information submitted to support their credentialing or recredentialing application.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3.B. To correct erroneous information. NCQA CR1—Element B2	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* PDF page 18, section 7.2 - Applicant Rights, Paragraph B (b) describes how the provider will notified if the information that varies substantially from the information provided by applicant. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 8, section 2.3 - Provider Rights in the Credentialing Process B describes how the provider will be notified if any erroneous information is found and that the notice does not need to disclose the source of the discrepancy but must include: -the time frame to submit corrections and/or changes -the format for submitting corrections -the person to whom the corrections or explanation must be submitted -documentation of receipt of any corrections *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.2 describes the process the applicant has to correct erroneous information. Page 13, section 8.3 describes the Appeals process from adverse credentialing or sanctions monitoring decision	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
3.C. To receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 15, section 7.2, "Applicant Rights", paragraph B.a describes application status information. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 8, Section 2.3 "Provider Rights in the Credentialing Process", paragraph D "Status in the Credentialing Process" describes application status information. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13, section 8.2 describes the process the applicant to receive the status of their credentialing or recredentialing application, upon request.	
4. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. NCQA CR2	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 1, section 1.1, "Purpose" -1st and 2nd paragraphs describes the designated credentialing committee and peer review **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 8, section 2.4 Quality Improvement Committee (QIC) and Optum Physical Health of California Quality Management & Improvement Committee (QMIC)., 2.5 Credentialing Risk Management Committee (CRMC) describes the credentialing committee and peer-review process. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 14, section 9.2 describes how the Contractor establishes a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Credentialing Committee: • Uses participating practitioners to provide advice and expertise for credentialing decisions. • Reviews credentials for practitioners who do not meet established thresholds. • Ensures that clean files are reviewed and approved by a medical director or designated physician. NCQA CR2—Element A1–3	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 4, Sections 3.2 Credentialing Committee Page 10, Section 4.3, A, Credentialing Committee Review & Committee Action Pages 11-12, Section 5.2, A& B, Recredentialing Criteria of Participating Clinicians, UBH Review Criteria and B Credentialing Committee Action Page 14, section 6.3, Credentialing Committee Responsibilities These sections in this document describe the responsibilities of the credentialing committee **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 10, section 2.9 describes committee membership *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 5, sections 3.2, 3.3, 3.4, describe how the Credentialing Committee reviews files to provide credentialing decisions for clean files and practitioners who do not meet established thresholds.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
6. For credentialing and recredentialing, the Contractor verifies the following within the prescribed time limits.: • A current, valid license to practice (verification time limit is 180 calendar days). • A current, valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (verification time limit is prior to the credentialing decision).	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 8-9, sections 4.2 Administrative Review B Verification of Credentials; Page 11, section 5.2 Recredentialing Criteria of Participating Clinicians A UBH Review Criteria **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Education and training—the highest of the following: graduation from medical/professional school; completion of residency; or board certification (verification time limit is prior to the credentialing decision; if board certification, time limit is 180 calendar days). • Work history—most recent five years; if less, from time of initial licensure—from practitioner's application or CV (verification time limit is 365 calendar days). – If a gap in employment exceeds six months, the practitioner clarifies the gap verbally or in writing and notes clarification in the credentialing file. If the gap in employment exceeds one year, the practitioner clarifies the gap in writing. • History of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner—most recent five years (verification time limit is 180 calendar days). – The organization is not required to obtain this information for practitioners who had a hospital insurance policy during a residency or fellowship. *Note: Education/training and work history are NA for recredentialing. Verification of board certification does not apply to nurse practitioners or other health care professionals unless*	Page 11, section 3.1 - Application, C. and D for Liability; Page 12, section 3.2 - Credentialing Criteria of Providers; Pages 14-15, sections 3.5 - Primary Source Verification (PSV) of Credentials and 3.6 - Verification Time Limit. Pages 60-61, Attachment D, sections 1 and 9 Professional Liability History; Section 6 and 14, Gaps in Employment/Practice History *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 7-8, section 4.2, describes the credentialing criteria and primary source verification requirements for credentialing and recredentialing.	

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
the organization communicates board certification of those types of providers to members. NCQA CR3—Element A		
7. The Contractor verifies the following sanction information for credentialing and recredentialing (verification time limit is 180 days): • State sanctions, restrictions on licensure, or limitations on scope of practice. • Medicare and Medicaid sanctions. *42 CFR 438.214(d)(1)* NCQA CR3—Element B	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 9-12, section 4.2, Administrative Review, section B - Verification of Credentials, Items 5-6 describe verification processes **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 12, section 3.2 describes credentialing criteria to include sanctions and restriction/limitations. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Pages 8-9, section 4.2, describes the primary source verification requirements for state sanctions, restrictions on licensure, or limitations on scope of practice as well as Medicare and Medicaid sanctions for credentialing and recredentialing.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. Applications for credentialing include the following (attestation verification time limit is 365 days): • Reasons for inability to perform the essential functions of the position, with or without accommodation. • Lack of present illegal drug use. • History of loss of license and felony convictions. • History of loss or limitation of privileges or disciplinary actions.	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 5-6, section 4.1 Clinician Application Criteria B Application Form 1-10, describes the information included in the application **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Current malpractice insurance coverage (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate). • Current and signed attestation confirming the correctness and completeness of the application. NCQA CR3—Element C	Page 11, section 3.1 Application; describes the information included in the application *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Pages 7-9, section 4.2 describes the verification requirements for affirmative responses to disclosure questions, maintaining current malpractice insurance coverage, and current and signed attestation.	
9. The Contractor formally recredentials its practitioners within the 36-month time frame. NCQA CR4	**Both RAE and Prime:** VIII_1-14,16-19_Credentialing Plan_BH Page 14, Section 5.1 Recredentialing Participating Clinicians, A indicates a 36 month review **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 14, section 3.4 Recredentialing Process indicates a 36 month review *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 10, section 5.1, describes the process for recredentialing practitioners within a 36 month time frame.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor implements policies and procedures for ongoing monitoring and takes appropriate action, including: • Collecting and reviewing Medicare and Medicaid sanctions. • Collecting and reviewing sanctions or limitations on licensure.	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 16-17, section 8.0 ON-GOING MONITORING AND REPORTING describes processes for ongoing monitoring **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Collecting and reviewing complaints. • Collecting and reviewing information from identified adverse events. • Implementing appropriate interventions when it identifies instances of poor quality related to the above. *42 CFR 438.214(d)(1)* NCQA CR5—Element A	Page 20, section 5.2 Ongoing Monitoring, Paragraph C describes the collection and review of Medicare and Medicaid sanctions or limitations on licensure. Page 21, Paragraph F describes the review of quality concerns and/or adverse events *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 14, section 9.1, describes the process for collecting and reviewing Medicare and Medicaid sanctions, sanctions or limitations on licensure, complaints, adverse events as well as implementing appropriate interventions when necessary.	
11. The Contractor has policies and procedures for taking action against a practitioner who does not meet quality standards that include: • The range of actions available to the Contractor. • Making the appeal process known to practitioners. *Examples of range of actions: how the organization reviews practitioners whose conduct could adversely affect members' health or welfare; the range of actions that may be taken to improve practitioner performance before termination; reporting actions taken to the appropriate authorities.* NCQA CR6—Element A	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 18-19, section 9.0 QUALITY IMPROVEMENT OF LICENSED PARTICIPATING CLINICIANS AND PARTICIPATING ORGANIZATIONAL PROVIDERS describes processes for taking action against practitioner when applicable. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 21, section 5.3 Action Based on Ongoing Monitoring Page 22, section 6 Appeal Process These describe the appeals process. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 13-14, sections 8.2 and 9.2 describes the process for taking action against a provider who does not meet quality standards. Page 16, section 8.3 describes the appeals process.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of *organizational* health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter: 12.A. The Contractor confirms that the organizational provider is in good standing with State and federal regulatory bodies. *Policies specify the sources used to confirm good standing—which may only include the applicable State or federal agency, agent of the applicable State or federal agency, or copies of credentials (e.g., State licensure) from the provider. Attestations are not acceptable.* *42 CFR 438.214(d)(1)* NCQA CR7—Element A1	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 12-14, section 6.0 Credentialing and Recredentialing of Organizational Providers Pages 16-17, section 8.0 On-going Monitoring and Reporting These describe processes to ensuring ongoing assessments every 36 months **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH*, Section 3 - Credentialing Process, Pages 11-16 describes the initial and ongoing assessment. Page 14, section 3.4 Recredentialing Process describes the recredentialing process and specifies at least every 36 months. *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 12, section 7.1 and 7.2, describe written policies and procedures for the initial and ongoing assessment of organizational health care delivery providers and specifies that before it contracts with a provider, and for at least every 36 months thereafter.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12.B. The Contractor confirms that the organizational provider has been reviewed and approved by an accrediting body. *Policies specify the sources used to confirm accreditation—which may only include the applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, or copies of credentials (e.g., licensure, accreditation report, or letter) from the provider. Attestations are not acceptable.* NCQA CR7—Element A2	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 12, section 6.1 Criteria for Credentialing Organizational Providers, A, details organizational provider must be in good standing with state and federal regulatory bodies. **Prime-specific:** *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 12, section 7.1 describes the process for confirming that the organizational provider has been reviewed and approved by the accrediting body.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
12.C. The Contractor conducts an on-site quality assessment if the organizational provider is not accredited. *Policies include on-site quality assessment criteria for each type of unaccredited organizational provider, and a process for ensuring that the provider credentials its practitioners.* *The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: The CMS or State review is no more than three years old; the organization obtains a survey report or letter from CMS or the State, from either the provider or from the agency, stating that the facility was reviewed and passed inspection; the report meets the organization's quality assessment criteria or standards. (Exception: Rural areas.)* NCQA CR7—Element A3	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 13-14, sections 6.2 Organizational Providers that are Not Accredited or Certified describes how the contractor conducts a site review if the organizational provider is not accredited. **Prime-specific:** *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 26, Attachment D describes how the contractor conducts an on-site quality assessment if the organizational provider is not accredited.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor's organizational provider assessment policies and processes includes: • For behavioral health, facilities providing mental health or substance abuse services in the following settings: – Inpatient – Residential – Ambulatory NCQA MBHO CR7—Elements B and C NCQA MBHO CR7—Element B	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 3, "Organizational Providers" provides the definition of provider types. **Prime-specific:** *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 24, Attachment C describes that the PH providers indicated are part of the credentialing process and have required credentialing.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
14. The Contractor has documentation that it assesses providers every 36 months. NCQA MBHO CR7—Elements D and E NCQA MBHO CR7—Element C	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 11, section 5.1 General A Page 14, section 6.4 Recredentialing of Participating Organizational Provider, A These describe that the contractor assess providers every 36 months. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 14, section 3.4 Recredentialing Process, indicates assessments every 36 months *VIII_1-14_UnitedHealthcare Credentialing Plan 2023_2025* Page 10, section 5.1 Page 12, section 7.2 These describe the documentation that the Contractor assesses providers every 36 months.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The MCE shall submit a monthly Credentialing and Contracting Report to the Department with information about Provider contracting timelines, using a format determined by the Department. RMHP Prime Contract Amendment 19: Exhibit M-18—9.1.7.5.5	**Both RAE and Prime:** *VIII_15_R1_RM_CredConRpt_10-24* This deliverable report is completed monthly by RMHP for both RAE and PRIME credentialing and contracting statistics. **Prime-specific:** see above	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
16. If the Contractor delegates credentialing/recredentialing activities, the Contractor has a written delegation document with the delegate that: • Is mutually agreed upon. • Describes the delegated activities and responsibilities of the Contractor and the delegated entity. • Requires at least semiannual reporting by the delegated entity to the Contractor (and includes details of what is reported, how, and to whom). • Describes the process by which the Contractor evaluates the delegated entity's performance. • Specifies that the organization retains the right to approve, suspend, and terminate individual practitioners, providers, and sites, even if the organization delegates decision making. • Describes the remedies available to the Contractor (including circumstances that result in revocation of the contract) if the delegate does not fulfill its obligations, including revocation of the delegation agreement. NCQA CR8—Element A	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 24, section 13.2 Delegation Agreement describes requirements for delegation agreements **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Pages 27-31, section 9 - Delegated Credentialing describes processes applicable *VIII_16,18-19_Del Cred Oversight Policy* Page 1, Purpose, indicates that the contractor evaluates the delegates capacity to meet NCQA requirements.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. For new delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity to meet NCQA requirements before delegation began. *The requirement is NA if the Contractor does not delegate or if delegation arrangements have been in effect for longer than the look-back period.* NCQA CR8—Element B	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Pages 25-26, section 13.4 Pre-Assessment Responsibilities of UBH describes the contractor evaluates the delegates capacity to meet NCQA requirements ***Note:*** No delegation agreements have been in effect less than 12 months. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 27, section 9 - DELEGATED CREDENTIALING describes requirements for written delegation document with delegate.	**Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
18. For delegation agreements in effect 12 months or longer, the Contractor: • Annually reviews its delegate's credentialing policies and procedures. • Annually audits credentialing and recredentialing files against its standards for each year that delegation has been in effect. • Annually evaluates delegate performance against its standards for delegated activities. • Semiannually evaluates regular reports specified in the written delegation agreement. • At least annually, monitors the delegate's credentialing system security controls to ensure the delegate	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 26, sections 13.5 Annual Evaluation and 13.6 Review of Oversight and Monitoring Reports describe processes for annual evaluations of delegates **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 27, section 9 - DELEGATED CREDENTIALING describes requirements for written delegation document with delegate. *VIII_16-19_Del Cred Oversight Policy* Page 5-6, section H describes ongoing oversight and reviews/reporting to include improvements as applicable	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
monitors its compliance with the delegation agreement or with the delegates policies and procedures. • At least annually, acts on all findings from above monitoring for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. NCQA CR8—Element C		
19. For delegation agreements that have been in effect for more than 12 months, at least once in each of the past two years, the Contractor identified and followed up on opportunities for improvement, if applicable. NCQA CR8—Element D	**Both RAE and Prime:** *VIII_1-14,16-19_Credentialing Plan_BH* Page 26, section 13.7 Required Follow-Up describes activities to review and develop improvement plans as applicable. **Prime-specific:** *VIII_1-12,14,16-19_2024 CRM Program_PH* Page 27, section 9 - DELEGATED CREDENTIALING describes requirements for written delegation document with delegate. *VIII_16-19_Del Cred Oversight Policy* Page 5-6, section H describes ongoing oversight and reviews/reporting to include improvements as applicable	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	32	**Total Score**		=	31
				Total Score ÷ Total Applicable		=	97%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCE onboards and informs members and their families regarding the services provided by EPSDT. This includes: • Informing the member about the EPSDT program generally within 60 days of the member's initial Medicaid eligibility determination, or after a member regains eligibility following a greater than 12-month period of ineligibility, or within 60 days of identification of the member being pregnant. • At least one time annually, the MCE outreaches members who have not utilized EPSDT services in the previous 12 months in accordance with the American Association of Pediatrics (AAP) "Bright Futures Guidelines" and "Recommendations for Preventive Pediatric Health Care." • Information about benefits of preventive health care, including the AAP "Bright Futures Guidelines," services available under EPSDT, where services are available, how to obtain services, that services are without cost to the member, and how to request transportation and scheduling assistance. RMHP Prime Contract Amendment 19: Exhibit M-18—7.3.12.1, 7.6.2	**Both RAE and Prime:** *XI_1,2_QI_EPSDT Flyer_ENG 7.25.24 FINAL.pdf* *XI_1,2_QI_EPSDT Flyer_SPA 7.25.24 FINAL.pdf* This 2024 flyer was included in communications to caregivers and Members 0-20 to inform about the EPSDT program, including the services available to them without cost. *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* This document describes RMHP's annual process for notifying eligible members and their caregivers, in clear and nontechnical language, of EPSDT benefits. Pages 5-7 of the P&P describes outreach and methods of contact, including the process for informing Members within 60 days, gap analysis, outreach, and preventative care. These following letters were sent in 2024 to caregivers and Members 0-20 to inform about the EPSDT program, including the services available to them without cost. *XI_1,2_QI_EPSDT Quarterly_ENG 18+_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18+_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 0-17_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 0-17_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 18+_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18+_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_October 2024.pdf*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_1,2_QI_EPSDT Quarterly_SP 0-17_October 2024.pdf *XI_1,2_QI_EPSDT Quarterly_ENG 18-20_October 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18-20_October 2024.pdf* *XI_1,2_QI_Pfizer_CO_Postcard_MissedDose -Postcard and IVR* *XI_1,2_QI_Pfizer_CO_Postcard_WellVisit -Postcard and IVR* *XI_1,2_QI_UHC_CO_Postcard_16_17YO -Postcard* *XI_1,2_QI_UHC_CO_Postcard_15monthWellVisit* These materials were used in an outreach campaign in 2024. The campaign included monthly postcard mailings to the target population of children who missed an immunization between six months and 18 months of age, children identified as due for a 12-month well child visit, and adolescents who missed an immunization between 16-18 years of age. *XI_1_WelcomeCallToolbox-Colorado_Toolbox for rep resources* This document identifies scripts, resources and information for Member Service Reps to support Members. One phone number per line of business is maintained, staffed, and published for Members to call regarding customer service or care coordination issues. The call center serves Members and providers. *XI_1_CO_PR17_Welcome_Script-PrimeRAEChild.1* *XI_1_CO_PRYA_Welcome_Script-RAE PrimeYoungAdult-Pregnant.1*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These scripts show the initial Member Services portion of the welcome call, that then leads into the Welcome Screener Script. Within the Welcome Screener, Member's are notified of the availability of EPSDT services and benefits. **Prime-specific:** *XI_1_CO-PRIME-WelcomeKit-EN* Page 3 section- Getting Care, Know your options, explains how members can receive EPSDT benefits through their PCP *XI_1_CO-RMHP-PRIME-Handbook-EN* Page 49-51, Section: Keeping Your Child Healthy describes the EPSDT benefit to Members.	
2. The EPSDT informational materials use a combination of oral and written approaches to outreach EPSDT-eligible members to ensure members receive regularly scheduled examinations, including physical and mental health services: • Mailed letters, brochures, or pamphlets • Face-to-face interactions • Telephone or automated calls • Video conferencing • Email, text/SMS messages RMHP Prime Contract Amendment 19: Exhibit M-18—7.6.6	**Both RAE and Prime:** *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* This document describes RMHP's annual process for notifying eligible members and their caregivers, in clear and nontechnical language, of EPSDT benefits. Pages 5-7 of the P&P describes outreach and methods of contact, including the process for informing Members within 60 days, gap analysis, outreach, and preventative care. These following letters were sent in 2024 to caregivers and Members 0-20 to inform about the EPSDT program, including the services available to them without cost. *XI_1,2_QI_EPSDT Quarterly_ENG 18+_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18+_February 2024.pdf*	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_1,2_QI_EPSDT Quarterly_ENG 0-17_February 2024.pdf *XI_1,2_QI_EPSDT Quarterly_SP 0-17_February 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 0-17_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 18+_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18+_June 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 0-17_October 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 0-17_October 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_ENG 18-20_October 2024.pdf* *XI_1,2_QI_EPSDT Quarterly_SP 18-20_October 2024.pdf* *XI_1,2_QI_Pfizer_CO_Postcard_MissedDose -Postcard and IVR* *XI_1,2_QI_Pfizer_CO_Postcard_WellVisit -Postcard and IVR* *XI_1,2_QI_UHC_CO_Postcard_16_17YO -Postcard* *XI_1,2_QI_UHC_CO_Postcard_15monthWellVisit* These materials were used in an outreach campaign in 2024. The campaign included monthly postcard mailings to the target population of children who missed an immunization between six months and 18 months of age, children identified as due for a 12-month well child visit, and adolescents who missed an immunization between 16-18 years of age. **Prime-specific:** see above	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The MCE makes network providers aware of the Colorado Medicaid EPSDT program information by: • Using Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. RMHP Prime Contract Amendment 19: Exhibit M-18—12.8.3.4, 12.9.2.5	**Both RAE and Prime:** *XI_3_CI_Screenshot_EPSDT Prov Trainings* This section of the website provides links to the training webinars on key EPSDT topics requested by providers. *XI_3_CI_EPSDT Provider Guidebook_Final_12.10.24* This annual publication is shared with providers to make them aware of the Colorado Medicaid EPSDT program *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* Page 11, "Provider Engagement," Describes provider engagement activities and trainings related to the benefits of EPSDT *XI_3,4,5_PNM_2024 Provider Manual* Pages 51-53 describe the Colorado Medicaid EPSDT program and includes references to the Health First Colorado website and how to access EPSDT materials. The manual provides indication to outreach to RMHP for any questions or supports related to EPSDT services. The manual also provides information on public health programs such as the Vaccines for Children Program (page 53). The following documents are examples of notifications, training materials and roster of providers who were invited and/or attended webinars regarding EPSDT benefits in 2024 *XI_3_EPSDT_DecCQINewsroom_ Email Edition_12.18.24* *XI_3_EPSDT Provider Guidebook follow up email_12.18.24* *XI_3_CI_EPSDT Provider Guidebook_Final_12.10.24* *XI_3_CI_Screenshot_EPSDT Prov Trainings*	**Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_3_EPSDT Rocky Presentation-Prov Trn_3.6.24 March Provider Training for EPSDT was communicated to providers in the February and March CQI Newrooms. There were 35 attendees in this training and a recording is available and distributed to providers via the CQI Newsroom. Providers also have the on-demand training available on the website **Prime-specific:** see above	
Findings: While RMHP Prime provided evidence of provider education, the evidence and process described did not demonstrate how updates on EPSDT were made available to network providers every six months.		
Required Actions: RMHP Prime must ensure that updates on EPSDT are made available to network providers every six months.		
4. For children under the age of 21, the MCE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). The MCE: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screenings to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services.	**Both RAE and Prime:** *XI_4_QI_EPSDT 2024 Analysis Report* RMHP conducts an annual audit of a small sample of provider medical records in QHN to verify EPSDT screenings and examinations are documented in the medical record. This report summarizes the results of this longitudinal audit of QHN records. *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* This written Policy and Procedure describes RMHP's process for providing EPSDT services to members ages 20 and under. This policy describes the methods RMHP employs to assure that appropriate preventive care and screening, to include mental/behavioral health developmental screenings, are provided to members.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures screenings are age appropriate and performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record and include, at a minimum, identified problems, negative findings, and further diagnostic studies and/or treatments needed, and the date ordered. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* RMHP Prime Contract Amendment 19: Exhibit M-18—7.7.5 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	Page 11, section 6.18 Staff Training and page 8, section 6.12.4 This states that RMHP provides care coordination that is committed to promoting culturally competent care that is delivered in a linguistically sensitive manner. Page 8-9; section 6.12 - Children with special needs and their families This provides that RMHP Care Management will arrange or refer members to access diagnostic and treatment services for all physical or mental illnesses or conditions discovered by any screening or diagnostic procedure – even if the service is not covered by the health plan. *XI_3,4,5_PNM_2024 Provider Manual* Page 53, first paragraph states that: - Providers qualified to furnish primary medical and/or mental health services should perform screenings. - Instructs providers that screenings should be performed in a culturally and linguistically sensitive manner. - Instructs providers to record the results of screenings and examinations in the child's medical record. - Diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure are covered. Page 88-89 Cultural Competence section communicates to providers RMHP's expectation that services are provided in a culturally competent manner. RMHP advocates for continued education and diversity training. **Prime-specific:** see above	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61–62* RMHP Prime Contract Amendment 19: Exhibit M-18—7.7.5 10 CCR 2505-10 8.280.4.C	**Both RAE and Prime:** *XI_5_CI_EPSDT Screenshot of Member Info* On the RMHP (CO) landing page, a tile is available for members and the general public to provide information describing what EPSDT is and high level description of services. This section refers the member to the handbook and the Bright Futures scheduled for more information. The plan specific pages (links in evidence document) provide the link to additional information on the Health First Colorado website along with the links to the handbooks, and contact information to RMHP Member Services and Care Coordination for any questions or supports needed. *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* Pages 10 & 11, "Treatment," Describes how RMHP provides referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. This section also demonstrates that RMHP care coordination offers assistance with transportation and scheduling appointments. *XI_3,4,5_PNM_2024 Provider Manual* Page 53, Third paragraph states that medically necessary treatments for conditions discovered by any screening or diagnostic procedure — even if they are not covered by First Health Colorado — may be covered by RMHP under the EPSDT program. The manual goes on to explain how a request for an EPSDT exception may be submitted. Contact information for the RMHP Care Management department is also provided on page 7 of the manual.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: *XI_1,5_CO-RMHP-PRIME-Handbook-EN* Pages 49-50 provide information to members about when and how to contact RMHP for EPSDT services. Pages 8, 18, 30, 43-44, & 53 explain how to get help to arrange transportation.	
6. The Contractor defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Assists the member to achieve or maintain maximum functional capacity. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider nor primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child.	**Both RAE and Prime:** *XI_1-6_RMHP EPSDT Policy and Process_Final 11.8.24* Pages 1, "Definitions," Describes RMHP's definition of medical necessity for EPSDT services, which comports with the definition set forth in regulation and in the contract. **Prime-specific:** see above	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is not experimental or investigational. • Is not more costly than other equally effective treatment options. RMHP Prime Contract Amendment 19: Exhibit M-18—7.7.5 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E		
7. The Contractor provides or arranges for the following for children/youth from ages 0 to 21: intensive case management, prevention/early intervention activities, clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (except for respite and vocational rehabilitation).* RMHP Prime Contract Amendment 19: Exhibit M-18—14.5.7.1, 2.1.1	**Both RAE and Prime:** *XI_7_CI_1915(b)(3) Services by CSNPs_Final_12.15.24* CSNPs within RAE Region 1 provide or arrange 1915(b)(3) services for children from ages 0 to 21. This document includes these 1915(b)(3) services. The CSNPs in RAE Region 1 are Axis Health System, Eagle Valley Behavioral Health, SummitStone Health Partners and Mind Springs Health. **Prime-specific:** Note: The Prime Contract Amendment 9: Exhibit M-18. The citation, 14.5.7.1 is not found in the A19, M-18 contract amendment for PRIME. Please see RAE information for this content.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard XI—EPSDT Services							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	86%

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

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

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	****	****	****	****	****	****	****	****	****	****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	LAC/LCSW	MD	APN	CSW	LPC	PA	LCSW	LPC	LPC	LPC
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Social Worker	Obstetrics and Gynecology	Nurse with RX	Social Worker	Professional Counselor	Physician Assistant	Social Worker	Masters Level Counselor	Professional Counselor	Masters Level Counselor
Date of Completed Application [MM/DD/YYYY]	1/24/2024	2/22/2024	4/2/2024	4/26/2024	5/16/2024	6/18/2024	7/9/2024	8/21/2024	9/12/2024	10/15/2024
Date of Initial Credentialing [MM/DD/YYYY]	1/26/2024	2/27/2024	4/3/2024	4/30/2024	5/17/2024	6/21/2024	7/16/202	8/26/2024	9/19/2024	10/18/2024
Completed Application for Appointment Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	NA	Yes	Yes	NA	NA	NA	NA	NA	NA	NA
Evidence of Board Certification Met? [VIII.6]	NA	Met	Met	NA	NA	NA	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	Yes	Yes	NA	NA	Yes	NA	NA	NA	NA
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	Met	Met	NA	NA	Met	NA	NA	NA	NA
Evidence of Education/Training Verification Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Education/Training Verification Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Work History (most recent five years or, if less, from the time of initial licensure) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Work History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.8]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.7]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Comments: **N/A**										

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

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Applicable Elements	7	9	9	7	7	8	7	7	7	7
Compliant (Met) Elements	7	9	9	7	7	8	7	7	7	7
Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	80									
Total Compliant Elements	80									
Total Percent Compliant	100%									

Notes:

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

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

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

365 Calendar Days
- Signed application/attestation
- Work history

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

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

Requirement	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Provider ID #	****	****	****	****	****	****	****	****	****	****
Provider Type (e.g., MD, PA, NP, LCSW, PsyD, DDS, DMD)	APN/RN	LPC	PHD	PHD	DO	LPC	LPC/LMFT	MD	MD	NP
Provider Specialty (e.g., PCP, surgeon, therapist, periodontist)	Nurse with RX	Masters Level Counselor	Psychologist	Psychologist	Obstetrics and Gynecology	Masters Level Counselor	Marriage and Family Therapist	Physician Psych	Physician Psych	Nurse Practitioner
Date of Last Credentialing [MM/DD/YYYY]	4/16/2021	12/14/2021	4/15/2021	5/27/2021	9/23/2021	6/27/2022	7/29/2022	5/16/2022	9/23/2021	1/20/2022
Date of Recredentialing [MM/DD/YYYY]	1/30/2024	3/6/2024	4/25/2024	5/23/2024	6/18/2024	7/9/2024	8/2/2024	8/27/2024	9/26/2024	10/9/2024
Months From Initial Credentialing to Recredentialing	33	26	36	35	32	24	24	27	36	32
Time Frame for Recredentialing Met? [VIII.9] Is completed at least every three years (36 months)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Verification of Current and Valid License Yes, No, Not Applicable (NA)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Verification of Current and Valid License Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Board Certification Yes, No, NA	Yes	NA	NA	NA	Yes	NA	NA	Yes	Yes	NA
Evidence of Board Certification Met? [VIII.6]	Met	NA	NA	NA	Met	NA	NA	Met	Met	NA
Evidence of Valid DEA or CDS Certificate (for prescribing providers only) Yes, No, NA	NA	NA	NA	NA	Yes	NA	NA	Yes	Yes	Yes
Evidence of Valid DEA or CDS Certificate Met? [VIII.6]	NA	NA	NA	NA	Met	NA	NA	Met	Met	Met
Evidence of Malpractice History Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice History Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Malpractice Insurance/Required Amount (minimums = physician—$500,000/incident and $1.5 million aggregate; facility—$500,000/incident and $3 million aggregate) Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Malpractice Insurance/Required Amount Met? [VIII.6]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Yes, No, NA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evidence of Ongoing Verification That Provider Is Not Excluded From Federal Participation Met? [VIII.10]	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Comments: **N/A**										

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

Scoring	File 1	File 2	File 3	File 4	File 5	File 6	File 7	File 8	File 9	File 10
Total Applicable Elements	6	5	5	5	7	5	5	7	7	6
Total Compliant (Met) Elements	6	5	5	5	7	5	5	7	7	6
Total Percent Compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Total Applicable Elements	**68**									
Total Compliant Elements	**68**									
Total Percent Compliant	**100%**									

Notes:

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

   Prior to Credentialing Decision
   - DEA or CDS certificate

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

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