CHP+

Child Health Plan *Plus*

Fiscal Year 2023–2024 Compliance Review Report

for

Rocky Mountain Health Plans

April 2024

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), a UnitedHealthcare (UHC) company, showed a strong understanding of federal regulations, with no findings identified for the Member Information Requirements, Provider Selection and Program Integrity, and Quality Assessment and Performance Improvement (QAPI) standards, and only one finding overall for the Subcontractual Relationships and Delegation standard.

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

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
V. Member Information Requirements	21	21	21	0	0	0	100% ^
VII. Provider Selection and Program Integrity	16	16	16	0	0	0	100% ^
IX. Subcontractual Relationships and Delegation	4	4	3	1	0	0	75% ~
X. Quality Assessment and Performance Improvement (QAPI)**	17	17	17	0	0	0	100% ~
Totals	**58**	**58**	**57**	**1**	**0**	**0**	**98%**

*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.

**The full name of Standard X is Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems.

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

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

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

Standard V—Member Information Requirements

Evidence of Compliance and Strengths

RMHP used a process to provide member information to members during their initial enrollment, as well as when requested, at no cost, in English and prevalent non-English languages and in alternative formats. RMHP staff members reported that member services assisted members by providing guidance during calls when members had questions or concerns. Member services representatives were trained on member benefits via onboarding, periodic training, and real-time communications. Welcome calls were conducted following member enrollment, and members were sent materials, including a new member ID and a welcome packet, which directed members to the current member handbook and additional critical information hosted on the RMHP website.

RMHP described in detail how member materials were reviewed and tested for reading level and compliance with Section 508 of the Rehabilitation Act (Section 508). Member materials were tested for grade-level accuracy through member and staff collaboration. RMHP staff members also reported using PDF Ally to ensure compliance with Section 508. When asked how errors were found and addressed, RMHP staff members described the process to identify errors and communicate with points of contacts, and how they quickly resolved the errors by resubmitting documents through PDF Ally for validation. RMHP submitted evidence of accessibility certifications to meet the Section 508 requirements.

Interpretation services were made available free of charge to members upon request. RMHP staff members described a process for the members to receive language assistance by being connected with bilingual staff members who are employed by RMHP or LanguageLine Solutions. Internal staff members who identify as bilingual were tested thoroughly upon initial hire to ensure fluency.

Opportunities for Improvement and Recommendations

HSAG reviewed multiple member letters and member notices that could be mailed to the member upon request. Taglines in some member letters and member notices were not consistent with each other or did not include the same components in both English and Spanish. HSAG recommends that RMHP conducts a review of its written member materials to ensure that all taglines are consistent in both English and Spanish.

Required Actions

HSAG identified no required actions for this standard.

Standard VII—Provider Selection and Program Integrity

Evidence of Compliance and Strengths

RMHP submitted policies, procedures, and other evidence demonstrating a comprehensive provider participation and compliance program. During the interview, RMHP provided an overview of its credentialing program, including how it addresses recruitment and retention, how it reviews provider applications, and how the credentialing process captures the required information for vetting.

Credentialing and recredentialing policies aligned with the National Committee for Quality Assurance (NCQA) and included procedures to ensure that RMHP did not discriminate against providers. Verification sources such as the National Practitioner Data Bank and List of Excluded Individuals/Entities, were used to verify work history, education, and licensure, and ensure that RMHP did not employ or contract with providers or other individuals or entities excluded from participation in federal healthcare programs.

UHC's chief compliance officer (CCO) strategically governed the compliance program at the highest level. The compliance oversight committee at RMHP reported up through the executive levels of the UHC executive compliance oversight committee (ECOC) to the UHC CCO. Compliance training was provided to staff members upon hire and then annually.

RMHP provided evidence of a comprehensive compliance program with detailed oversight, monitoring, and reporting processes. Within its FY 2024 Anti-Fraud, Waste, and Abuse Plan, UHC and RMHP described methods for prevention, detection, and correction of fraud waste and abuse (FWA). The plan included the roles of the individuals supporting compliance activities and the activities that are performed, including risk assessments, provider education, controls, claim edits, provider profiling, and surveillance. Both RMHP and UHC share an active role in ongoing monitoring for overutilization and potential FWA. In addition, the quality improvement (QI) program described multiple avenues of monitoring for overutilization and underutilization.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG identified no required actions for this standard.

Standard IX—Subcontractual Relationships and Delegation

Evidence of Compliance and Strengths

RMHP submitted written delegation agreements for the following services: pharmacy benefit management, credentialing, and utilization management (UM). HSAG reviewed a sample of the delegation agreements to determine compliance with federal requirements.

During the compliance interview, RMHP staff members presented an overview of the contract management process from procurement to execution of subcontractor agreements. Per RMHP staff members, monitoring of subcontractor agreements is accomplished via routine reporting, joint operating committees, and dashboards. Oversight of the subcontractor agreements is assigned to senior-level executives.

RMHP staff members discussed the use of pre-delegation audits to evaluate a potential subcontractor's ability to perform the functions of the agreement and comply with regulatory requirements. During the interview, RMHP staff members discussed the monitoring processes related to the delegation agreements selected for review.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG reviewed a sample of contracts across the delegated activities and found that three out of the four written agreements did not include the required language.

RMHP must ensure, via revisions or amendments, that all subcontractor agreements include the following language:

- 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.

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems

Evidence of Compliance and Strengths

RMHP submitted its quality work plan, quality improvement plan (QIP) description, and QI annual evaluation documents, which together provided a thorough overview of the quality initiatives for all lines of business. The quality work plan was a spreadsheet outlining all quality objectives, the responsible individual and committee, the expectation for each objective and the reporting frequency. The plan included an array of topics with several activities delineated under each topic. Topics included performance monitoring, UM, clinical safety, programming, delegation oversight, and file review. The QIP description included a list of QI goals, objectives, and top priorities. In both the QIP description and the QI annual evaluation, RMHP included a table listing each goal, the fiscal year objective, and a status update describing the progress for each goal. In addition, RMHP provided testing kits (for A1c and colon cancer) that members could use to collect samples at home without having to go into an office for screenings, a process that was aimed at helping members comply with recommended testing without the inconvenience of driving to an appointment, which was of benefit particularly for members in rural and frontier areas.

In addition to monitoring quality goals and implementing interventions, RMHP shared a few videos highlighting recent achievements in bridging accessibility gaps. These videos demonstrated its outreach aimed at improving access for members who prefer Spanish-language communication, members who identify as lesbian, gay, bisexual, transgender, queer or questioning, intersex, or asexual (LGBTQIA+), and indigenous Americans.

During the period under review, UHC provided RMHP with approved, evidence-based professional society clinical guidelines and resources to guide its quality and health management programs. RMHP conducted an internal review of the guidelines with RMHP providers and made them available on the RMHP website for both providers and members. In addition, RMHP provided an update about the resources in its January 2023 provider newsletter, informing providers of each available guideline and where it was sourced.

During the interview, RMHP discussed its health information system, including daily member enrollment encounter data processing, and various reporting mechanisms. On a quarterly basis RMHP provides the Department of Health Care Policy & Financing (the Department) with a flat file of data. The flat file data team is comprised of RMHP participants and a data vendor. The RMHP health information system rests on Optum technology as the main foundation.

Opportunities for Improvement and Recommendations

HSAG identified no opportunities for improvement for this standard.

Required Actions

HSAG identified no required actions for this standard.

3. Background and Overview

Background

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

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

In order to evaluate the CHP+ MCOs' compliance with federal managed care regulations and State contract requirements, the Department determined that the review period for fiscal year (FY) 2023–2024 was calendar year (CY) January 1, 2023, through December 31, 2023. This report documents results of the FY 2023–2024 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 2023–2024 compliance monitoring review. Section 4 describes follow-up on the corrective actions required as a result of the FY 2022–2023 compliance review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B lists HSAG, CHP+ MCO, and Department personnel who participated in some way in the compliance review process. Appendix C describes the corrective action plan (CAP) process the CHP+ MCO will be required to complete for FY 2023–2024 and the required template for doing so. Appendix D 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.[3-1]

[3-1] 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: Aug 8, 2023.

Overview of FY 2023–2024 Compliance Monitoring Activities

For the FY 2023–2024 compliance review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information Requirements, Standard VII—Provider Selection and Program Integrity, Standard IX—Subcontractual Relationships and Delegation, and Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems. 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 CHP+ MCO's contract requirements and regulations specified by the federal Medicaid and CHIP managed care regulations published May 6, 2016. Additional revisions were released in December 2020 and February 2023. 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 January 1, 2023, through December 31, 2023. HSAG reviewed materials submitted prior to the compliance review activities, materials requested during the compliance review, and considered interviews with key CHP+ MCO personnel to determine compliance with federal managed care regulations and contract requirements. Documents consisted of policies and procedures, staff training materials, reports, committee meeting minutes, and member and provider informational materials.

The compliance review processes were consistent with the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Appendix D 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 2023–2024 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 III—Coordination and Continuity of Care; Standard IV—Member Rights, Protections, and Confidentiality; Standard VI—Grievance and Appeal Systems; Standard VIII—Credentialing and Recredentialing; and Standard XII—Enrollment and Disenrollment.

Objective of the Compliance Review

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

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

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

FY 2022–2023 Corrective Action Methodology

As a follow-up to the FY 2022–2023 compliance review, each CHP+ MCO that received one or more *Partially Met* or *Not Met* scores was required to submit a CAP to the Department addressing those requirements found not to be fully compliant. If applicable, the CHP+ MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the CHP+ MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with RMHP until it completed each of the required actions from the FY 2022–2023 compliance monitoring review.

Summary of FY 2022–2023 Required Actions

For FY 2022–2023, HSAG reviewed Standard I—Coverage and Authorization of Services, Standard II—Adequate Capacity and Availability of Services, Standard VI—Grievance and Appeal Systems, and Standard XII—Enrollment and Disenrollment.

Related to Standard I—Coverage and Authorization of Services, RMHP was required to complete one required action:

- Update its notice of adverse benefit determination (NABD) template for the CHP+ line of business to remove all references to continuation of benefits.

Related to Standard II—Adequate Capacity and Availability of Services, RMHP was required to complete one required action:

- Revise the Standards for Practitioner Office Sites policy to include the correct standards for timely access to care related to urgent services and non-urgent care visits, and include the exceptions related to when well-care visits should be scheduled prior to one month.

Related to Standard VI—Grievance and Appeal Systems, RMHP was required to complete two required actions:

- Update the CHP+ member handbook and UM program description to remove any references that require a member to submit appeal information in writing.
- Revise its Appeals Policy and Procedure to specify that continuation of benefits is not applicable to CHP+ members.

Related to Standard XII—Enrollment and Disenrollment, HSAG identified no required actions for this standard.

Summary of Corrective Action/Document Review

RMHP submitted a proposed CAP in June 2023. HSAG and the Department reviewed and approved the proposed CAP and responded to RMHP. RMHP submitted final documentation and completed the CAP in November 2023.

Summary of Continued Required Actions

RMHP successfully completed the FY 2022–2023 CAP, resulting in no continued corrective actions.

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood and is readily accessible by members. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and World Wide Web Consortium Web Content Accessibility Guidelines 2.0 Level AA and successor versions.* *42 CFR 438.10(c)(1)* CHP+ Contract Amendment 2: Exhibit B2—7.2.5 and 7.2.7.5	These Policy and Procedures are written to assure that all materials intended for distribution to RMHP Medicaid and CHP+ Members are reviewed and edited to promote ease of use for RMHP enrollees, and to assure that they are readily accessible. *V_1,3,4,5,7_CO Creation Member Materials Policy_Final* Page 1, IV-POLICY, bullet 1, indicates that RMHP will accommodate Members with visual or hearing-impairments using auxiliary aids and services and by providing Member materials in alternative formats. Page 1, IV-POLICY, bullet 6, indicates written materials that are critical to obtaining services are member tested through the RMHP's Member Advisory Council. *V_1,9,20_CO Orientation Member Materials_Final* Page 2, IV. Policy, 2nd paragraph, indicates that all member materials will be created to meet the requirements of 42 CFR 438.10, contractual requirements, and any additional required language provided by HCPF. *V_1,10_CO Development and Distribution of Member Letters and Notices_Final* Page 3, Procedures, describes that all information created for Members or potential Members	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	will meet the information requirements outlined in 42 CFR § 438.10. The documents listed below are examples of materials demonstrating that member information is provided in a manner and format that is easily understood. *CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023(will have PDF-UA at interview)* *V_CHP-WelcomeKit-ENG_Jan2023_PDF-UA.pdf* *V_CHP-Provider-Directory-ENG-SPA_Aug 2023 (will have PDF-UA at interview)* *V_4,5,6_CO RMHP Member PDL 20231101 v3 (will have PDF-UA at interview)* *V_1,2_CS_Sorry We Missed You CHP Child English 7.14.23* *V_1,2_CS_Sorry We Missed You CHP YA English 7.14.23* The Accessibility Reports listed below show that these required member documents have passed 508 accessibility remediation. *V_CHP-WelcomeKit-ENG_Jan2023_PAC_UA_Rpt* *V_CHP-WelcomeKit-SPA_Jan2023_PAC_UA_Rpt* The Adobe Acrobat accessibility report below indicates the sections of the formulary that passed or failed accessibility compliance. At the time of audit	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	submission, the *V_4,5,6_CO RMHP Member PDL 20231101 v3* document was undergoing a comprehensive 508 accessibility review and remediation to produce a 508 compliant PDF-UA document as well as the PAC-UA certification report. The compliant documents and certification report will be available at the virtual site review. *V_1,5,6_508_Accessibility Report_RMHP PDL 110123 v3* The PAC-UA reports below were not available at the time of audit submission. *V_CHP-Provider-Directory-ENG-SPA_Aug 2023_PAC_UA_Rpt* *CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* They were undergoing the comprehensive 508 accessibility review and remediation to produce a 508 compliant PDF-UA document as well as the PAC-UA certification report. The compliant documents and certification reports will be available at the virtual site review.	
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.5	*V_2,5,6,14,20_CHP+ Screenshots_ Mmbr Material info-UHCCP* Page 1, screen shot from www.uhc.com/community plan (UHCCP) provides information about the RMHP CHP+ plan and its role as a CHP+ MCO.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CSCO23MD0074543_001_Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023 The CHP+ Member Handbook includes information to help Members understand the requirements and benefits of the plan. The RMHP Member Services number is listed in multiple locations, but also in the footer of each page in the handbook. *V_CHP-WelcomeKit-ENG_Jan2023_PDF-UA.pdf* This document includes important information to help Member understand the requirements and benefits of the RAE and PRIME plans. It also includes information about how to access valuable information on the RMHP webpage. It is mailed to new Members upon enrollment. *V_2_CS_CO_CHP_Child Welcome_Script* This is a copy of the CHP+ Child Welcome script *V_2_CS_CO_PRYA_Welcome_Script (Medicaid version)* This is a copy of the Young Adult (18-20) and Pregnant EPSDT Welcome script - Unfortunately a CHP+ specific young adult/prenatal script was not developed for the customer/member services transition. This script was used in CY2023 for those populations. This error is already being remediated as a high priority process correction.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_2_CS_Sorry We Missed You CHP Child English *V_2_CS_Sorry We Missed You CHP Child Spanish* *V_2_CS_Sorry We Missed You CHP YA English* *V_2_CS_Sorry We Missed You CHP YA Spanish* The above are temples of the letters that are sent to the Member if they are not reached during the Welcome Call. The following documents are all designed to assist Members to understand the requirements and benefits of the plan. These are the assessments indicated in the CHP Welcome Script. *V_2_CM_CHP+ Prenatal Welcome Call Screener* All CHP+ prenatal Members receive this care management welcome call screener in addition to the customer/member services welcome call. *V_2_CM_CHP+ Child Only Intake Screener*	
3. For consistency in the information provided to members, the Contractor uses the following as developed by the State: • Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization,	*CSCO23MD0074543_001_Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* The CHP+ Member Handbook includes a glossary section for the definitions as identified in the contract with the Department. *V_1,3,4,5,7_CO Creation Member Materials Policy_Final*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* CHP+ Contract Amendment 2: Exhibit B2—3.2 and 7.2.7.5	Page 2, V-PROCEDURE, A-1, states that RMHP will use the definitions for managed care terminology developed by HCPF in the Member Handbooks. *V_3_CHP+NOABDTemplate_082021_Clean* This is the model notice of adverse benefit determination that was provided by the Department to use when mailing these notices to CHP+ Members. *V_3_UM_CHP Denial Letter Example* This is the sample RMHP notice that is modeled after the Department's approved template. This denial letter is for all denials in physical and behavioral health. ASAM criteria is inserted into the notice when applicable.	
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include, at a minimum, provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12 point. – Be available in alternative formats and through provision of auxiliary aids and service that takes	**Bullet 1:** Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. The documents listed below are examples of documents that are available to Members in Spanish. Spanish is the prevalent non-English language in the RMHP CHP+ service-area. *V_4_CSCO23MD0074543_001_Eng_CO_RMHP_CHP+_Handbook-PR_08-2023* *V_4_CSCO23MD0074544_001_Spa_CO_RMHP_CHP_Handbook-WEB_08-2023*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in conspicuously visible font size and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats. *42 CFR 438.10(d)(2-3) and (d)(6)* CHP+ Contract Amendment 2: Exhibit B2—7.2.7.3.1 and 7.2.7.5-7	*V_4_CSCO23MD0074544_001_Spa_CO_RMHP_CHP_Handbook-PR_08-2023* *V_CHP-WelcomeKit-ENG_Jan2023_PDF-UA* *V_CHP-WelcomeKit-SPA_Jan2023_PDF-UA* *V_2_CS_Sorry We Missed You CHP Child English 7.14.23* *V_2_CS_Sorry We Missed You CHP Child Spanish 7.14.23* *V_2_CS_Sorry We Missed You CHP YA English 7.14.23* *V_2_CS_Sorry We Missed You CHP YA Spanish 7.14.23* *V_4,7,8_CO_CHP+_Eng_NonDiscrim_CRN-MLIS* *V_4,8_CO_CHP+_SPA_NonDiscrim_CRN-MLIS* *V_4,5,6_CO RMHP Member PDL 20231101 v3* *V_CHP-Provider-Directory-ENG-SPA_Aug 2023* Note: The document below is sent to translation when we note a Member's preferred language is Spanish. *V_4_AG_CO_CHP_Member Upheld Partially Overturned (translated when indicated)* *V_4_UM_CHP Denial Letter Spanish Example* This is an example of an adverse benefit decision letter translated into Spanish. This denial letter is for all denials in physical and behavioral health. ASAM criteria is inserted into the notice when applicable.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_4,8_CO_CHP_ENG_NonDiscrim_CRN-MLIS This document indicates in 16 different languages that language assistance services are available to Members free of charge. This notice is inserted in all written materials that are critical to obtaining services. **Bullet 2:** *V_4,7_CS_Written Material in Alternate Language or Format* This job aid outlines the steps to accommodate written materials in alternate Languages and formats. *CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Page 140, in the "Civil Rights Notice" of the CHP+ Member Handbook tells Members how to access the information in alternative formats. **Bullet 2, dash 1:** *V_1,3,4,5,7_CO Creation Member Materials Policy_Final* Page 1, IV-POLICY, indicates that UHCCP (RMHP) will create Member material that is easy to use and understand, and that RMHP will make materials available in non-English languages and alternative formats without charge.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet 2, dash 2, 3, 4, 5: *V_1,3,4_CO Creation Member Materials Policy_Final* Page 2, V. PROCEDURE, section A, explains that RMHP ensures its written materials for Members include all elements indicated in bullet 2. **Bullet 2, dash 4:** *V_4,8_CO_CHP_ENG_NonDiscrim_CRN-MLIS* This document indicates in 16 different languages that language assistance services and alternative formats are available to Members free of charge. This notice is inserted in all written materials that are critical to obtaining services.	
5. If the Contractor makes information available electronically—Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of readily accessible above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five (5) business days.	**Bullet 1:** *V_CHP-WelcomeKit-ENG_Jan2023_PAC_UA_Rpt* *V_CHP-WelcomeKit-SPA_Jan2023_PAC_UA_Rpt* The Accessibility Reports listed above show that these required member documents posted on the website have passed 508 remediation. The Adobe Acrobat accessibility report below indicates the sections of the formulary that passed or failed accessibility compliance. At the time of audit submission, the *V_4,5,6_CO RMHP Member PDL 20231101 v3* document was undergoing a comprehensive 508 accessibility review and remediation to produce a 508 compliant PDF-UA document as well as the PAC-UA certification report.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(c)(6) CHP+ Contract Amendment 2: Exhibit B2—7.3.12.1.1-5	The compliant documents and certification report will be available at the virtual site review. *V_1,5,6_508_Accessibility Report_RMHP PDL 110123 v3* The PAC-UA reports below were not available at the time of audit submission. *V_CHP-Provider-Directory-ENG-SPA_Aug 2023_PAC_UA_Rpt* *CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023_PAC_UA_Rpt* They were undergoing the comprehensive 508 accessibility review and remediation to produce a 508 compliant PDF-UA document as well as the PAC-UA certification report. The compliant documents and certification reports will be available at the virtual site review. *UHCCP RMHP- CO Landing Page VPAT 2.4 Rev508 WCAG 2.1 AA 2024-Jan-1* *UHCCP RMHP- RAE and CHP+ and PRIME VPAT 2.4 Rev508 WCAG 2.1 AA 2024-Jan-1* *UHCCP RMHP- CHP+ VPAT 2.4 Rev508 WCAG 2.1 AA 2024-Jan-1* These reports verify that the CHP+ webpages on UHCCP.com website are 508 compliant.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullets 2 & 3: *V_2,5,6,14,20_CHP+ Screenshots_ Mmbr Material info-UHCCP* Pages 2-4 screenshots demonstrate where Member materials can be found on the UHHCP website and can be electronically printed and retained as well as are readily accessible. **Bullet 4 & 5:** *V_1,3,4,5_CO Creation Member Materials Policy_Final* V. Procedure, Section A, explains that member materials will comply with content and language requirements. V. Procedure, Section A, Number 11, explains that enrollment materials will be available in paper form or alternative formats through the use of auxiliary aids and services without charge and will be sent in 5 business days. *CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Page 7 explains to Members that they can get a new CHP+ Member Handbook any time they want it – they can ask RMHP Member Services to mail it or it is accessible online at www.uhccp.com/rmhp-prime or myuhc.com/communityplan/co.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor makes available to members in electronic or paper form information about its formulary: • Which medications are covered (both generic and name brand). • What tier each medication is on. • Formulary drug list must be available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)(i)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.1.2-3	*V_2,5,6,14,20_CHP+ Screenshots_ Mmbr Material info-UHCCP* Pages 2-4, screenshots demonstrates that CHP+ Members can electronically obtain the formulary with details about the pharmacy coverage. *CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Page 75 explains how to access the formulary online. *V_CHP-WelcomeKit-ENG_Jan2023_PDF-UA* Page 6 explains how to access the formulary online and how to request a paper copy at no charge. *V_4,5,6_CO RMHP Member PDL 20231101 v3* Page iii, the formulary which demonstrates generic and brand medications covered and what tier the medications are at. The Adobe Acrobat accessibility report below indicates the sections of the formulary that passed or failed accessibility compliance. At the time of audit submission, the *V_4,5,6_CO RMHP Member PDL 20231101 v3* document was undergoing a comprehensive 508 accessibility review and remediation to produce a 508 compliant PDF-UA document as well as the PAC-UA	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	certification report. The compliant documents and certification report will be available at the virtual site review. *V_1,5,6_508_Accessibility Report_RMHP PDL 110123 v3*	
7. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. *42 CFR 438.10(d)(4)* CHP+ Contract Amendment 2: Exhibit B2—7.2.6.2, 7.2.6.4, and 7.2.6.5	V_1,3,4,5,7_CO Creation Member Materials Policy_Final IV Policy, bullet 3 explains that required member materials are translated into the non-English prevalent language(s) and are available to Members within 5 business days at no cost. *V_4,7,8_CO_CHP_ENG_NonDiscrim_CRN-MLIS* This document indicates in 16 different languages that language assistance services are available to Members free of charge. This notice is inserted in all written materials that are critical to obtaining services. The Civil Rights Notice indicates that RMHP provides: -Free auxiliary aids and services to people with disabilities such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats) and other languages for those whose primary language is not English. -This document is inserted in all member material that is considered critical to the Member receiving services. It is found in the PRIME Member	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Handbook on pages 109-110. Members are told that they may access these services by calling RMHP Member Services. *CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Pages 4, 8 & 140-141 indicate that for callers who do not speak English or Spanish, RMHP uses Language Line Services. RMHP provides interpretation services, provision of auxiliary aids, or other formats at no cost to Members. Members are advised to tell RMHP if they need interpreter services or help in other languages. *V_7_CS_Language Line Process* This job aid outlines the steps to accommodate Members with Communication Barriers. Customer Service provides the following services: - For non-English speaking Member, CS offers assistance utilizing the Language Line, In-office Interpreter and Sign Language requests are also available. *V_7_CS_TTY* This job aid outlines the steps on how to assist the member with a Telephone Relay Service (TRS), Teletypewriter (TTY), Video Relay Services (VRS) and Language Line to assist callers who do not speak English or having hearing impairments.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_4,7_CS_Written Material in Alternate Language or Format This job aid outline the steps to accommodate written materials in alternate languages and formats. *V_7_CS_Accomodations for Members With Special Needs PP* This P&P describes how Members can gain access to interpreter services at our physical location as well as when they are at their provider office.	
8. The Contractor notifies members that oral interpretation is available for any language, written translation is available in prevalent languages, and auxiliary aids and services are available upon request at no cost for members with disabilities, and how to access them. *42 CFR 438.10(d)(5)* CHP+ Contract Amendment 2: Exhibit B2—7.2.6.4.1-3	*V_4,8_CO_CHP_ENG_NonDiscrim_CRN-MLIS* *V_4,8_CO_CHP_SPA_NonDiscrim_CRN-MLIS* The CRN-MLIS indicates that RMHP provides: Rocky Mountain Health Plans provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as: • Qualified American Sign Language interpreters • Written information in other formats (large print, audio, accessible electronic formats, other formats) Rocky Mountain Health Plans provides free language services to people whose primary language is not English, such as: • Qualified interpreters • Information written in other languages This document is inserted in all member material that is considered critical to the Member receiving	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	services. It is found in the CHP+ Member Handbook on page 140. Members are informed that they may access these services by calling RMHP Member Services. *CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Pages 4, 7, 8 & 140-141 of the PRIME Member Handbook explains how Members can access materials in other languages and formats. Hours of operation for customer service are specified.	
9. The Contractor provides each member with a member handbook in both electronic and paper format within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10(g)(1)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.1	*V_CHP-WelcomeKit-ENG_Jan2023_PDF-UA* Explains that RMHP sends the Welcome Kit to tell CHP+ Members how to access material on the website or how to request paper copies. *V_1,9,20_CO Orientation Member Materials Policy_Final* IV. Policy, paragraph 2 describes that ID cards and welcome kits will be produced and mailed within 10 business days of receipt of the enrollment file. Information is included in the Welcome Kit on how Members can obtain a PRIME Member Handbook online as well as a print copy upon request at no charge.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* CHP+ Contract Amendment 2: Exhibit B2—7.2.7.5	*V_1,10_CO Development and Distribution of Member Letters and Notices Policy_Final* IV. Policy, describes that the health plan will provide notification to Members of any significant changes at least 30 days before the intended effective date of the change. V. Procedure, F, describes the process for notification to Members of any ad hoc changes in benefits or service notices to ensure they are distributed timely. Note: No significant changes were necessary to communicate to Members in 2023.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
11. The Contractor makes a good faith effort to give written notice of termination of a contracted provider by the later of 30 calendar days prior to the effective date of the termination, or within 15 days after the receipt or issuance of the termination notice to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* CHP+ Contract Amendment 2: Exhibit B2—7.3.9.1	*V_11_CS_MCD PCP Term Notice Template* *V_11_CS_MCD Specialist Term Notice Template* These notice templates are used to provide written notice of the termination of a participating provider. *V_11_Potential and Actual Provider Terminations P&P* This document is the overarching P&P for guidance on Provider Terminations and notification of said termination to Members. The documents below are the related job aides to the Potential and Actual Provider Terminations P&P. *V_11_Provider Term Member Notice Rules-Timeline C&S-CO Excerpt*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_11_Provider Term-Member Notice Rule_CO Specific *V_11_Member Notification of Provider Termination_BH* Details the process for letting Members know that their Behavioral Health provider is no longer contracted with RMHP. *V_11_PH_C&S Pharmacy Network Oversight P&P* The P&P outlines the process for tracking and reporting termination of pharmacies from the network. *V_11_Termination Process Document 2023_Final_ORx policy* Page 3, 4th bullet This describes the ORx process when a pharmacy terms from the network and the turnaround times for notifications to Members. *V_11_PH_CS_TERMED Rpt July 2023_redacted* Shows which pharmacies were termed during the month. One pharmacy in CO was termed which outlines when it was sent the notice and when Members were notified.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor shall develop and maintain a customized and comprehensive website that includes: • The CHP+ MCO's contact information. • Member rights and responsibilities. • Member handbook. • Grievance and appeal procedures and rights. • General functions of the CHP+ MCO. • Provider directory. • Access to care standards. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. CHP+ Contract Amendment 2: Exhibit B2—7.3.8	*V_12_CHP+Screenshots of Member Material Items-UHCCP* This document shows the location on the website of each of these requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers, and LTSS providers (as applicable): • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), whether the providers will accept new members. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office,	*V_CHP-Provider-Directory-ENG-SPA_Aug 2023* The CHP+ Provider Directory is available on the RMHP website in both electronic and paper form. The paper directory includes the provider's name, group affiliation, street address, and specialty. In addition, the paper provider directory indicates: -Languages offered - footer states that all providers are proficient in English, unless otherwise noted --Page 64, Example - J.McMurren - demonstrates this provider is proficient in Spanish -New patients - footer states that all providers accept new patients, unless otherwise noted	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly and quarterly for a mobile enabled or electronic directory.* *Electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* CHP+ Contract Amendment 2: Exhibit B2—7.3.8.1.7-8	--Page 79, Example, Jennifer Bowe, demonstrates that this provider does not accept new patients -Handicap accessibility through use of a wheelchair indicator of "W", and accommodations for people with physical disabilities in the office and exam rooms through use of an indicator of "T" --Page 77, Example, Jessica Marsh - Ped Partners of SW, is an example of the use of the "W" and "T" indicators -Page 101, Example, Melissa Schmalz, is an example of a provider who has completed Cultural Competency Training. *V_13_PNM_Provider Directory Online Policy AND V_13_PNM_provider Directory Paper Creation Policy* P&P policy for including requirements and guidelines for validating the accuracy of information in provider directories, as well as how often directories are updated.	
14. Provider directories are made available on the Contractor's website in a machine readable file and format. *42 CFR 438.10(h)(4)* CHP+ Contract Amendment 2: Exhibit B2—7.3.8.1.9	*V_2,5,6,14,20_CHP+ Screenshots_ Mmbr Material info-UHCCP* Page 3 Shows where Members can download a copy of the Provider Directory from the website. *V_CHP-Provider-Directory-ENG-SPA_Aug 2023* Provider directory is available for download and is in a machine-readable file and format. (At the time of	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	submission, the machine readable was not available. Will provide at virtual audit.) The PAC-UA reports below were not available at the time of audit submission. *V_CHP-Provider-Directory-ENG-SPA_Aug 2023_PAC_UA_Rpt* *CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* They were undergoing the comprehensive 508 accessibility review and remediation to produce a 508 compliant PDF-UA document as well as the PAC-UA certification report. The compliant documents and certification reports will be available at the virtual site review.	
15. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. • The extent to which and how members may obtain benefits, including family planning services, from out-	*CSCO23MD0074543_001_ Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* **Bullet 1:** Pages 42-88, Covered Services, describe the amount, duration and scope of benefits available as well as on pages 15-16, "Summary of Covered Benefits." **Bullet 2:** Procedures for obtaining benefits are explained as follows: Page 31, Getting Care, explains the general bases of access care for services and the importance of selecting a PCP.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
of-network providers. This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider. • The process of selecting and changing the member's primary care provider. • Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service or CHP+ covered benefit that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered because of moral or religious objections and how and where the member can obtain the services. *42 CFR 438.10(g)(2)(iii, iv, vi, vii, x) and (g)(ii)(A-B)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.5-7, 7.2.7.2.1.9-10, and 10.3.2	Page 33, "Specialty Care" explains that referrals are not needed to see a specialist that works with RMHP. Page 34 explains how to get hospital care, pregnancy care, prescription drugs. Page 36 explains preauthorization requirements. **Bullet 3:** Page 29, Member's Rights & Responsibilities, bullet 10, indicates the right to get family planning services from any enrolled provider in or out of RMHP's network, with no referral. Pages 49, "Family Planning/Reproductive Health", indicates that family planning/reproductive health services do not require pre-authorization or referral for any provider regardless of whether they are in-network or not. This could be a PCP or an OB/GYN. Page 34, "Doctors that do not work with RMHP", explains that in general Members must obtain services from network providers, but that this requirement does not apply to emergency or urgent care or family planning services. The section goes on to instruct the Member to call RMHP if they need care from a doctor that does not work with RMHP. In this case, RMHP may give permission to see the OON doctor and the Member will not have to pay for the care. **Bullet 4:** Page 12,"Pick a Primary Care Provider" explains to Members how to pick a primary care provider.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 14, "How to Change your PCP," explains how a Member may change their primary care provider. **Bullet 5:** Note: Restriction of choice among network providers: RMHP does not restrict choice among network providers. **Bullet 6:** Page 36. Note: RMHP does not exclude any counseling or referral services due to moral or religious objections.	
16. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Members have the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her 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.	*CSCO23MD0074543_001_Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Pages 29-30, Member Rights & Responsibilities, enumerate the member rights and protections set forth in 42 CFR 438.100. This information is set forth in the member handbook in accordance with the information requirements set forth in 42 CFR 438.10 (e.g., in a manner and format that is easily understood and readily accessible).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.10(g)(2)(ix)* CHP+ Contract Amendment 2: Exhibit B2—7.3.6.3 and 7.3.7.2.1.16.		
17. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and time frames: • The right to file grievances and appeals. • The requirements and time frames for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.23	*CSCO23MD0074543_001_Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Pages 110-115, "Complaints, Appeals & Grievances, Quality of Care concerns", explains the process for filing grievances and appeals, including timeframes for filing, the right to request a State Review, assistance that is available, as well information regarding reporting potential quality of care concerns.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2.1.8.1-2, 7.3.7.2.1.8.4, and 7.3.7.2.1.8.7	*CSCO23MD0074543_001_Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Pages 45-47, Covered Services, "Emergency and Urgent/After-Hours Care," explains how after-hours and emergency coverage are provided. Pages 47 describe Emergency medical condition (including examples). Pages 48 discuss Emergency services that are covered. Page 48 explains the fact that prior authorization is not required for emergency services. Page 45-46 explains that a Member can get urgent or emergency care anywhere in the United States and that permission from RMHP is not required.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
19. The member handbook provided to members following enrollment includes: • Cost-sharing, if any is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. • The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. • Information on how to report suspected fraud or abuse. • How to access auxiliary aids and services, including information in alternative formats or languages.	*CSCO23MD0074543_001_Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* **Bullet 1:** Pages 17, "Copayments (Cost-sharing)," explains all cost sharing imposed at all income levels on services under the CHP+ plan. **Bullet 2:** N/A **Bullet 3:** Pages 15,56, & 86 provide explanation of transportation services for emergency ambulance services and for transplants that are covered. No other transportation (including non-emergency medical	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(g)(2)(ii, viii, xiii, xiv, xv) CHP+ Contract Amendment 2: Exhibit B2—7.3.7.2, 7.3.7.2.1.2, 7.3.7.2.1.19.1, and 7.3.7.2.1.21	transportation) is a covered benefit under the CHP+ plan. **Bullet 4:** The toll-free telephone number for member services can be found in the footer of every page and on page 8 "How to Contact Rocky Mountain Health Plans." On page 37-39, under "How to Contact RMHP Care Coordination," a telephone number for Member Services is provided that a Member may use to ask from help with care coordination. **Bullet 5:** Pages 99, "Fraud Activity," provides information to Members about how to report suspected fraud or abuse. **Bullet 6:** Page 140, CRN/MLIS provides information about how to access auxiliary aids and services, including alternative formats and languages.	
20. The Contractor provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the Contractor's website and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with	**Bullets 1 & 2:** *V_1,9,20_CO Orientation Member Materials Policy_Final* IV. Policy, last paragraph, states that RMHP will make materials available to a Member in paper form via U.S. mail and without charge within 5 days of request. Page 4, Distribution of Member Requested Materials, describes the process for sending member materials	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* CHP+ Contract Amendment 2: Exhibit B2—7.3.12	upon request by mail or electronically (meeting electronic delivery standards). **Bullet 3:** *CSCO23MD0074543_001_Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Page 7, informs Members that they can get a CHP+ Member Handbook at any time, and that they can ask RMHP to mail a copy or they can access it online. Page 10, lists the RMHP website URL under Important Websites, and informs Members that they can go to the website for information about providers, for a copy of the CHP+ Member Handbook and more. Page 11, tells Members that the CHP+ Handbook and Provider Directory are at UHCCP.com where they can view or print these documents. They can also ask Member Services to mail a copy at any time at no cost. Page 75 tells Members that the most up-to-date list of prescription medications covered under the CHP+ plan in the formulary. Page 76 tells Members about the mail order program and how to access that information on the websites. Page 75 describes that a paper copy of the formulary is available by calling RMHP Member Service or by downloading from website.	

Standard V—Member Information Requirements		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet 4: *V_CHP-WelcomeKit-ENG_Jan2023_PDF-UA* Page 6, Find Helpful Documents, Informs Members that they can request a copy of the CHP+ Member Handbook from Member Services, that it is available online at UHCCP.com and they can additionally get a printed copy, free of charge. *V_2,5,6,14,20,CHP+ Screenshots_ Mmbr Material info-UHCCP* Page 3, describes where Members can obtain a copy of the CHP+ Member handbook.	
21. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* CHP+ Contract Amendment 2: Exhibit B2—7.3.5.1.13	*CSCO23MD0074543_001_Eng_CO_RMHP_CHP+_Handbook-WEB_08-2023* Page 100, "No Withholding of Coverage of Necessary Care" states that Members can call Member Services to receive information on RMHP's physician incentive plans. *V_21_CS_Colorado Provider and Physician Incentive* The job aid outline how a Member can obtain information on provider incentives.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard V—Member Information Requirements							
Total	Met	=	21	X	1.00	=	21
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	21	**Total Score**		=	21
				Total Score ÷ Total Applicable		=	100%

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* CHP+ Contract Amendment 2: Exhibit B2—9.1.7 and 9.1.10	*VII_1_2_3_4_6_PNM_UnitedHealthcare Credentialing Plan 2023_2025* Page 7, Section 4; defines a consistent credentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for credentialing of its providers. Page 22, Attachment A; Credentialing Criteria Page 10, Section 5; defines a consistent recredentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for recredentialing of its providers. Page 22, Attachment A; Credentialing Criteria *VII_1,2,3,4,6_2023 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. *VII_1,2,4,6_Clinician Credentialing Process_BH* *VII_1,2,4,6_Clinician Recredentialing Process_BH* *VII_1,2_CO Addndm Credentialing Policies_BH* *VII_1,2,4,6_Orgnztnl Prvdr Credentialing_Recred_BH*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_1,3_Types of Clinicians and Eligibility Criteria_BH These Policies and Procedures define a consistent credentialing and recredentialing process for practitioners applying to the RMHP Behavioral Health panel in compliance with federal regulation and NCQA standards for credentialing of its providers.	
2. The Contractor follows a documented process for credentialing and recredentialing of providers that complies with the standards of the National Committee for Quality Assurance (NCQA). The Contractor shall assure that all laboratory-testing sites providing services under this contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration. *42 CFR 438.214(b)* CHP+ Contract Amendment 2: Exhibit B2—9.2.3 and 9.2.3.3	*VII_1_2_3_4_6_PNM_UnitedHealthcare Credentialing Plan 2023_2025* Page 7, Section 4; defines a consistent credentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for credentialing of its providers. Page 22, Attachment A; Credentialing Criteria Page 24, Attachment C; Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. And Page 26, Attachment D; Describes minimum criteria which includes CLIA certification. *VII_1,2,3,4,6_2023 CRM Program_PH* Section 3 pages 10-15	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Contractor complies with NCQA standards and guidelines for credentialing and recredentialing its Physical Health providers. *VII_1,2,4,6_Clinician Credentialing Process_BH* *VII_1,2,4,6_Clinician Recredentialing Process_BH* *VII_1,2_CO Addndm Credentialing Policies_BH* *VII_1,2,4,6_Orgnztnl Prvdr Credentialing_Recred_BH* The Contractor complies with NCQA standards and guidelines for credentialing and recredentialing its Behavioral and Physical Health providers.	
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* CHP+ Contract Amendment 2: Exhibit B2—9.1.8-9	*VII_1_2_3_4_6_PNM_UnitedHealthcare Credentialing Plan 2023_2025* Page 6, first paragraph describes that decisions are made in a non-discriminatory manner. *AM_ VII_3_NCC P-P 135 Confidentiality, Conflict of Interest and Non-discriminatory Agreements* The National Credentialing Center (NCC) and committee members are subject to all UHG P&Ps regarding confidentiality, conflict of interest, and non-discriminatory practices. *VII_1,2,3,4,6_2023 CRM Program_PH* Page 6, Section 2.2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This policy describes the process used to monitor for and prevent against discriminatory credentialing practices for Physical Health. These policies describe the process used to monitor for and prevent against discriminatory credentialing practices for Behavioral Health. *VII_1,3_Types of Clinicians and Eligibility Criteria_BH* Page 1, Policy Statement and Purpose, bullet 3 *VII_3_Non-Discrimination_BH* Page 1, Policy Statement and Purpose	
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members.	*VII_1_2_3_4_6_PNM_UnitedHealthcare Credentialing Plan 2023_2025* Page 6, section 3.5; This section explains the notification procedure for practitioners applying to the RMHP panel and being denied. Page 13; section 8.2, 2nd paragraph, last sentence: This section explains the notification procedure for practitioners applying to the RMHP panel and being denied. Page 14, section 9.2; This section explains the process for notifying a provider of the reduction, suspension or termination of a health care provider's contracting status for cause.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.12(a-b) CHP+ Contract Amendment 2: Exhibit B2—9.1.11	*VII_1,2,3,4,6_2023 CRM Program_PH* Page 18, Section 4.6 Notice of CRMC Decisions This section explains the notification procedure for practitioners applying to the RMHP panel and being denied for Physical Health participation. *VII_1,2,4,6_Clinician Credentialing Process_BH* Page 7, Section 8.1 This section explains the notification procedure for practitioners applying to the RMHP panel and being denied for Behavioral Health participation. *VII_1,2,4,6_Clinician Recredentialing Process_BH* Page 7, Section 10 This section explains the notification procedure for practitioners not approved for continued participation for Behavioral Health. *VII_1,2,4,6_Orgnztnl Prvdr Credentialing_Recred_BH* Page 4, Section 11 This section explains the notification procedure for Behavioral Health Organizational Providers.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* CHP+ Contract Amendment 2: Exhibit B2—9.5.1.1	*VII_5,8,13,16_Physicians Medical Services Agreement* Page 4, Paragraph GG, "Participating Physician" Provides that the term "participating physician" means a person who holds a degree of Doctor of Medicine or Doctor of Osteopathy, is licensed by the State of Colorado to practice medicine, has a written agreement directly with RMHP. *VII_5,8,16_Hospital Services Agreement* Page 4, Paragraph X, "Hospital Services" defines those services which are provided at a Hospital Facility. *VII_5,8,13,16_Optum Provider Agreement_PH* Page 14 of this template demonstrates the provider agreement signature page for Physical Health Services *VII_5,8,13,16_ProfessionalServicesAgreementAll LOB* Page, 6 Paragraph MM, "Professional Health Care Services" provides the term "Health Care Professional" who is legally authorized to provide services under Colorado law and under their licensure and or certification. This agreement is used for all behavioral health providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. • The Contractor performs monthly monitoring against HHS_OIG's List of Excluded Individuals. *(This requirement also requires a policy.)* *42 CFR 438.214(d)* *42 CFR 438.610* CHP+ Contract Amendment 2: Exhibit B2—9.1.20	*VII_1_2_3_4_6_PNM_UnitedHealthcare Credentialing Plan 2023_2025* Page 7, Section 4; This section of the plan defines the credentialing process for Practitioners applying to the RMHP panel. Page 8, number 5; If a provider is on the OIG's list of debarred providers, credentialing/contracting will not be initiated. Page 9, number 10; RMHP's credentialing verification sources include License Sanction Status Page 8, number 5 AND page 12, number 3; and Medicare/Medicaid Sanction Status. *VII_1_2_3_4_6_PNM_UnitedHealthcare Credentialing Plan 2023_2025* Page 12, section 7 number 3; Provides that before credentialing can begin, General Services Administration, OFAC and OIG websites must be checked to ensure provider is not excluded from participation in federal healthcare programs. *VII_1_2_3_4_6_PNM_UnitedHealthcare Credentialing Plan 2023_2025* Page 15, Section 9.5, A; Describes RMHP's process for accessing the NPDB for all new practitioners and all currently contracted practitioners. This serves as primary source verification of sanctions against or	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	limitations on licensure, sanction activity by Medicare and Medicaid, and malpractice history. *VII_1,2,3,4,6_2023 CRM Program_PH* Page 11, Section 3.2, Credentialing Criteria of Providers, A.6 This policy section defines the Minimum Administrative Criteria for Participation in Physical Health. The applicant must not be ineligible, excluded or debarred from participation in the Medicare and / or Medicaid or related state and federal programs, or terminated for Medicare or any state's Medicaid or CHIP program and must be without any sanctions levied by the OIG, the CMW Preclusion List or other disciplinary action by any federal or state entities identified by CMS. *VII_1,2,4,6_Clinician Credentialing Process_BH* Pages 5-6, Sections 4.6-4.13 These policy sections discuss that before credentialing for Behavioral Health can begin, SAM and OIG websites must be checked to ensure provider is not excluded from participation in federal healthcare programs. *VII_1,2,4,6_Clinician Recredentialing Process_BH* Page 5, Sections 6.7-6.8; 6.14	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These policy sections discuss that before recredentialing for Behavioral Health can begin, SAM and OIG websites must be checked to ensure provider is not excluded from participation in federal healthcare programs. *VII_1,2,4,6_Orgnztnl Prvdr Credentialing_Recred_BH* Page 3, Sections 4.4.4- 4.4.5, 4.4.7 These policy sections discuss that before recredentialing for Behavioral Health can begin, SAM and OIG websites must be checked to ensure provider is not excluded from participation in federal healthcare programs. *VII_6_Ongoing Monitoring of Sanctions and Complaints_BH* This policy discusses the process for ongoing monitoring of sanctions and complaints for Behavioral Health providers. *AM_VII_6_Data Disclosure of Ownership* This policy describes that Optum may refuse to enter into or renew a provider agreement in regard to ownership or controlling interest or debarred, suspended, etc. *VII_6_Economc Sanctions and Monitoring P&P*	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This policy describes the process for ensuring that RMHP does not hire, continue to employ or contract with ineligible persons. *VII_6_Comp_OFAC_Sanctions Check* This document provides an example of various database searches, to include the HHS OIG's list of Excluded individuals. *VII_6,7_New Hire and Periodic Employee Sanction Review P&P* This policy describes the process for ensuring that RMHP does not hire, continue to employ or contract with ineligible persons. *AM_VII_6_OPTUM_Provider Sanctions Monitoring Policy and Procedure* This policy/procedure describes the process for monitoring provider sanctions monthly	
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, subcontractor, or owner (owning 5 percent or more of the Contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549.	*VII_6,7_New Hire and Periodic Employee Sanction Review P&P* This policy describes the process for ensuring that RMHP does not hire, continue to employ or contract with ineligible persons. *VII_6,7_Economic Sanctions and Monitoring P&P*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.610 CHP+ Contract Amendment 2: Exhibit B2—15.9.4.2	Page 2, Section "General," demonstrates that RMHP is prohibited from engaging in activities with, provide goods, insurance or services or employ or contract with individuals or entities prohibited by law.	
8. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* CHP+ Contract Amendment 2: Exhibit B2—11.11.10	*VII_5,8,13,16_Physicians Medical Services Agreement* Pages 13 Paragraph U, "Expressing Disagreement" -RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual. -RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with Members and will not penalize providers for such discussions. -Page, 13, Paragraph V, "Medicaid Recipients Right to Participation" RMHP recognizes the member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. -Page 23, Paragraph G, "Limitations on Adverse Actions"	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with the Member whether covered by the health plan or not. *VII_5,8,16_Hospital Services Agreement* Page 16, Paragraph V, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual. *VII_5,8,13,16_Optum Provider Agreement_PH* Page 3, Section 2.5, 2.6 demonstrate that what care is to be provided remains with the provider and the member. *VII_8,13,16_Regulatory Appendix (CO)_PH* Page 8, Section 4.4 RMHP may not prohibit or restrict provider from advising or advocating on behalf of the member who is the provider's patient, for the following: The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered; Any information the	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	member needs in order to decide among all relevant treatment options; The risks, benefits, and consequences of treatment or non-treatment. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *VII_5,8,13,16_ProfessionalServicesAgreementAll LOB* -Page 14, Paragraph Q, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual. -Page, 14, Paragraph R, "Medicaid Recipients Right to Participation" RMHP recognizes the member's right to participate in decisions regarding the Member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. -Page 24, Paragraph G, "Limitations on Adverse Actions" RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision or for discussing	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	treatments or treatment alternatives with the Member whether covered by the health plan or not. *VII_5,8,16_Hospital Services Agreement* Page 16, Paragraph V, "Expressing Disagreement" RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for Members that is described in the provider manual.	
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(a)(2)-(b)* CHP+ Contract Amendment 2: Exhibit B2—11.7	NOTE: RMHP does not have objections to providing services on moral or religious grounds; therefore, this requirement is not applicable.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse and includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to	**Bullet 1 -** *VII_UHC Compliance Program_2023 FINAL* Page 1, Introduction: Explains that the Compliance Program Promotes compliance with applicable legal requirements,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices to ensure compliance with requirements of the contract and reports directly to the Chief Executive Officer and Board of Directors. • The establishment of a Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and	fosters ethical conduct with the company, and provides guidance to its employees and contractors. Page 1, Purpose: Articulates that as part of the UHG/RMHP Program, the company has adopted a Code of Conduct, which is a guide to acceptable and appropriate business conduct by the company's employees and contractors. Page 2: Key Elements of Compliance/Written Standards, Policies and Procedures: Explains that compliance polices and procedures are posted and accessible online to employees. **Bullet 2 –** *VII_RMHP Compliance Plan Addendum Reviewed 072723* Page 1: Compliance Plan and Program Integrity Infrastructure: Notes the designation of an RMHP compliance officer who reports directly to the CEO and Board of Directors; the compliance officer is responsible for developing and implementing policies and procedures designed to ensure compliance with RMHP's contractual obligations. **Bullet 3 –** *VII_UHC Compliance Program_2023 FINAL* Page 3: Compliance Committee Structure Describes the Compliance Committee structure.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract Amendment 2: Exhibit B2—15.1.1 and 15.1.5.1-7	*VII_RMHP Compliance Plan Addendum Reviewed 072723* Page 1: Key Preventive Structures and Processes/bullet 1, Provides information regarding program governance, including a regulatory compliance oversight committee. **Bullet 4 –** *VII_UHC Compliance Program_2023 FINAL* Page 3: Effective Training and Education Describes the annual company training and education requirements for all employees, which includes the Compliance Officer, management, and staff as well as vendors. *VII_10_Enterprise-Required-Course-List-and-Details* This is the list of annualy required courses for ALL RMHP employees. *VII_RMHP Compliance Plan Addendum Reviewed 072723* Page 1: Key Prevention Structures and Processes/bullet 3, Discusses training and education topics, training processes and record retention.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Bullet 5 – *VII_UHC Compliance Program_2023 FINAL* Pages 4-5: Effective Lines of Communication Explains the various reporting mechanisms and communication mechanisms utilized to achieve effective communication to implement a successful compliance program. *VII_RMHP Compliance Plan Addendum Reviewed 072723* Page 1: Key Preventive Structures and Processes/bullet 4, Describes communication mechanisms available to employees, Members and others to report issues and concerns to the RMHP Compliance Officer. **Bullet 6 –** *VII_UHC Compliance Program_2023 FINAL* Page 6: Enforcement and Disciplinary Guidelines Provides company expectations regarding compliance with laws, regulations and policies; it also notes that the enforcement and disciplinary guides are publicized in the code of conduct (the "Code"). *VII_UHG Code of Conduct*	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 4: About the Code of Conduct/Violations of the Code of Conduct and Policies This section explains that violations may result in discipline, up to and including termination and possible legal action, including referral to law enforcement. **Bullet 7 -** *VII_UHC Compliance Program_2023 FINAL* Page 6, Auditing and Monitoring This section describes RMHP's procedures and system for routine internal monitoring and auditing of compliance risks. *VII_RMHP Compliance Plan Addendum Reviewed 072723* Page 2, Key Detection Structures and Processes Describes elements of compliance auditing and monitoring. *VII_10_UHC Compliance Auditing & Monitoring Policy* Page 2, Procedures for Policy Compliance Describes internal compliance audits and monitoring of compliance risks.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	AM_VII_10_Policy ID 36483 UHC FWA Pre Payment Provider Reviews and Analytics Page 2, Policy Provisisions, paragraph 2 This section describes RMHP's procedures and system for routine internal monitoring and auditing of compliance risks. *AM_VII_10_UHC Compliance Reporting Policy* Page 1-2, Policy Definitions, Compliance Hotline Management and Fraud Tip Hotline Management Describes mechanisms for reports of compliance isuues and suspective fraud. **Bullet 8 -** *VII_UHC Compliance Program_2023 FINAL* Page 7: Responding to Identified Issues Describes internal coordination to respond promptly to suspected misconduct and to ensure appropriate corrective action and reporting. *VII_RMHP Compliance Plan Addendum Reviewed 072723* Page 2: Key Correction Structures and Processes Describes the program's commitment to prompt response to identified issues and credible allegations and effective corrective action plans.	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	AM_VII_10,11_UHC Anti-FWA Compliance Program_2023-2024 Page 2, Program Goals and Oversight This demonstrattes that the Anti-FWA program encourages strategies to promote compliance and the detection of any potential violations, to ensure ensure organizational accountability for compliance with legal, regulatory, and business requirements applicable to FWA functions. *AM_VII_10_Policy ID 364713 UHC FWA Post Payment Analytics* Page 2, Policy Provisions, paragraph 2 This describes the procedure for prompt response to compliance issues as they are raised, including identification of referral, preliminary review, conducting the review, reporting internally and reporting to Regulatory Agencies.	
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, subcontractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the Department and any potential fraud to the State Medicaid Fraud Control Unit.	**Bullet 1 -** *AM_VII_11_UHC Control FWA Policy* Provides high-level depiction of how RMHP follow identified guidelines. *VII_11_False Claims Act Compliance Policy* Provides information regarding fraud, waste and abuse as it relates to the False Claims Act.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.23.) *42 CFR 438.608 (a)(6-8)* CHP+ Contract Amendment 2: Exhibit B2—1.14.1, 15.1.5.9, 15.1.6, and 15.7.1 10 CCR 2505-10, Section 8.076	Page 3, Section F, Whistleblower and Whistleblower Protections This describes the prohibition of retaliation when an employee provides any truthful information to a law enforcement officer that is related to any possible federal offense. *VII_11_UHG Non-Retalation Policy* This also describes the prohibition of retaliation when an employee provides a good faith report of unethical behavior or violation of law, regulations or company policy. **Bullet 2 -** *VII_RMHP Annual FWA Plan 102323* Page 4, Anti Fraud, Waste and Abuse Plan activities This describes the process for prompt referral of any potential fraud to State Regulatory Agencies. *AM_VII_10,11_UHC Anti-FWA Compliance Program_2023-2024* Page2, Program Goal and Oversight, bullet 5 & 6 This describes programatic goals including the promotion of compliance and detecton of any pototential violations of potential FWA. Additionally, the programmatic goals include	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	ensuring organization accountability for compliance with regulatory FWA functions. *AM_VII_Policy ID 36521 v1 UHC Anti-FWA Program - Retrospective Fraud and Abuse Investigations* Page 2, Policy Provisions, paragraph 2, bullet 4 This describes the prompt referrals of any substantiated FWA investigation to State Regulatory Agencies. **Bullet 3 -** *AM_VII_11_ Provider Payment Suspension Placement SOP_12052023* *AM_VII_11_Provider Payment Susp Withhold SOP_12052023* These describe the processes for suspension of payments for which the State determines any credible allegation of potential fraud.	
12. The Contractor's Compliance Program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying the overpayments due to potenial fraud. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence and member death.	**Suggested Document:** Most recent Monthly Program Integrity Compliance and Fraud, Waste, and Program Abuse Activity Report **Submitted Documents:** **Bullet 1 & 3** *VII_12_MonthlyFWARpt_MM-YY*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608 (a)(2-5)* CHP+ Contract Amendment 2: Exhibit B2—15.1.5.7.6, 15.3.1.1, and 15.3.1.3.2.1	This document is produced monthly and sent to the Department to report FWA activity as well as overpayment recoveries and Provider Termination from the RMHP network. (This is an example of the template used monthly) Note: Actual monthly report will be available on site as it contains PHI. **Bullet 2 -** *VII_12_BO_Notice to State_Enrollee Circumstance Change PP* This policy and procedure outlines the steps RMHP takes to notify the State when there is a change in a Member's circumstance which may affect the Member's eligibility. **Bullet 4 -** *VII_12_ VOS Process Overview PP RMHP Medicaid CHP* This process describes an overview of the Medicaid and CHP+ VOS. *VII_12_Sample VOS LETTER* This is an example letter sent to Members for VOS. *VII_12,_RMHP Annual FWA Plan 102323*	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 10, Paragraph 3 describes the process verification of services.	
13. The Contractor ensures that all network providers are enrolled with the State as CHP+ providers consistent with the provider disclosure screening, and enrollment requirements of the State. • The Contractor may execute network provider agreements pending the outcome of the State's screening and enrollment process of up to one-hundred and twenty (120) days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one one-hundred and twenty (120)-day period without enrollment of the provider, and notify affected members. *42 CFR 438.608 (b)* CHP+ Contract Amendment 2: Exhibit B2—15.9.2	*VII_5,8,13,16_Physicians Medical Services Agreement* Page 8, Paragraph F, "Enrollment Requirements" If the contractor serves Health First Colorado (Colorado Medicaid) or CHP+ Members, then the provider must be enrolled with Health First Colorado consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR Part 455, Subparts B and E and requirements of the State of Colorado. The provider must include in its RMHP enrollment application its Medicaid Identification number and the date of Health First Colorado enrollment or most recent validation. *VII_13_PNM_ Credentialing Plan State Federal Regulatory Addendum* Page 9, last paragraph; states that Contractor shall be enrolled with the State of Colorado in accordance with the disclosure, screening, and enrollment requirements of the State of Colorado for Medicaid and CHP+ providers. *VII_5,8,13,16_Optum Provider Agreement_PH* Page 13, 8.13 Regulatory Appendices states that one or more regulatory appendix may be attached to this agreement in order to satisfy regulatory requirements	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	under applicable law. See Regulatory Appendix (CO). *VII_8,13,16_Regulatory Appendix (CO)_PH* Page 2, Section 3.2(i) - State Program Participation. Provider is enrolled as, or has applied to enroll as, a participating provider with the State Program. United may terminate Provider from its State Program Provider network immediately upon notification from the State that Provider cannot be enrolled or has been terminated from the State Program, or the expiration of one 120 day period without enrollment of Provider. *VII_13_Welcome Packet_ DC CAM Job Aid_Medicaid_Resp Grid_PH* Page 2, #2: Optum Provider Data Management (PDM) validates the providers State Medicaid ID number and completeness of the application. If the provider has a valid Medicaid number a CP (Common Practitioner) will be created. If not, the request is returned to the PR Rep who notifies the applicant that a valid Medicaid ID number is required prior to the initiation of credentialing. Page 3, Public Sector NPC Responsibility Grid – identifies Optum Physical Health Colorado Attributes	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_5,8,13,16_ProfessionalServicesAgreementAll LOB Page 9, Paragraph E states that Contractor shall be enrolled with the State of Colorado in accordance with the disclosure, screening, and enrollment requirements of the State of Colorado for Medicaid and CHP+ providers. *VII_13_CO_RMHP Job Aid_BH* Pages 7-9, Medicaid Verification Process Section Optum Provider Onboarding Team validates the providers State Medicaid ID number and completeness of the application. If the provider has a valid Medicaid number, the provider will be sent a contract that includes the Medicaid addendum and fee schedules if they are an individual or will be added to the existing contract as a Medicaid provider if they are joining an existing group.	
14. The Contractor has procedures to provide to the State: • Written disclosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104)	**Bullet 1:** *VII_14_Government Sanctions Policy–U.S* This policy demonstrates that employees are monitored monthly for any prohibited affiliation. *VII_14_COMP_ProhibitedAffiliation Disclosure PP*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* CHP+ Contract Amendment 2: Exhibit B2—15.3.1.5.1.1, 15.9.4.3, and 15.10.4.2	This policy states that RMHP will disclose to HCPF any relationship RMHMO, A UnitedHealthcare Company, has with an individual or entity who is debarred, suspended or otherwise excluded from participating in a federal or state health care program. **Bullet 2:** *VII_14_Comp_Ownership & Control P&P* This policy indicates that RMHP will disclose to HCPF information on ownership and control in a form acceptable to HCPF, and delineates what the disclosures will include. **Bullet 3:** *VII_RI_14_Cap Reconciliation Process* This describes the procedure to identify and report within 60 calendar days any capitation or other payments in excess of the amounts specified in the contract.	
15. The Contractor has a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports semi-annually to the State on recoveries of overpayments.	*VII_15,16_PNM_CO-RMHP-Care-Provider-Manual 2023* Page 39, Refunding RMHPs This describes how providers can submit overpayment information. *VII_15_ClmsOvrpmntRfndFrm*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.608(d)(2) and (3) CHP+ Contract Amendment 2: Exhibit B2—15.1.5.8 and 15.3.1.2.4.4	This is the form that providers can use to submit overpayment information. *VII_15_CO_RMHP_BHManual* This is the applicable section of the BH Provider manual that discusses how providers can submit overpayment information to RMHP. *VII_15_RMHP Bi-Annual FWA report job aid* This describes the process to report semi-annually to the State on FWA and recoveries of overpayments. *VII_15_FWARpt_QQ-QQ FY YY-YY* This document is produced semi-annual and sent to the Department to report FWA activity as well as overpayment recoveries. (This is an example of the template used semi-annually) Note: Actual semi-annual report will be available on site as it contains PHI.	
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the health care	*VII_5,8,13,16_Physicians Medical Services Agreement* Page 12-13, Paragraph S, No Recourse Against Medicaid Recipients, sections (1), (2), (3): Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* CHP+ Contract Amendment 2: Exhibit B2—15.12.2-4	RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. *VII_5,8,16_Hospital Services Agreement* Page, 15-16 Paragraph T, No Recourse Against Medicaid Recipients, sections (1), (2), and (3): Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. *VII_5,8,13,16_Optum Provider Agreement_PH* Page 13, 8.13 Regulatory Appendices states that one or more regulatory appendix may be attached to this agreement in order to satisfy regulatory requirements under applicable law. See Regulatory Appendix (CO). *VII_8,13,16_Regulatory Appendix (CO)_PH* Page 5, 3.3, III, j, Hold Harmless section	

Standard VII—Provider Selection and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Provider contracts state that Members are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. *VII_5,8,13,16_ProfessionalServicesAgreementAll LOB* Page 13, Paragraph O, No Recourse Against Medicaid Recipients, sections (1), (2), and (3): Provider contracts state that Members are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the Member would owe if the Contractor provided the services directly. *VII_15,16_PNM_CO-RMHP-Care-Provider-Manual 2023* Pg. 25, Balance Billing The Member may not be balance billed for any costs not covered by either RMHP or the State.	

Results for Standard VII—Provider Selection and Program Integrity							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
				Total Score ÷ Total Applicable		=	100%

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR 438.230(b)(1)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.4	*IX_1_PNM_UCSMM 03 14 Delegated Credentialing Oversight Policy Procedure* Describes the process RMHP follows to evaluate whether a prospective delegate is capable of performing delegated credentialing activities. AND Describes policy and procedure to conduct pre-delegation and annual delegation audits, including issuance of findings, identification of areas for improvement and monitoring of implementation of audit recommendations. *IX_1_PNM_CR Assessment Report_Template* This questionnaire completed internally to determine whether the delegate can perform credentialing activities in compliance with government regulations and NCQA standards. AND This document is used internally to track the information and documents requested from the delegate prior to audit. AND Assessment Tool Tab, A 11.; Delegates are required to complete this reporting template that identifies practitioners approved, site visits for complaint monitoring, and any improvement activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_1_2_UM_Delegated Utilization Management Policy The Delegated Utilization Management policy describes the oversight process for delegated Utilization Management (UM) activities. Page 2, Section 3.2 and page 7, Section 5.1 describes pre-delegation activities undertaken to evaluate the prospective subcontractor's ability to perform UM activities. Page 2, Section 3.2, provides the process for monitoring and evaluating the delegated entity's performance within the first 12 months of the delegation. Page 3, Section 3.3, provides the process for monitoring and evaluating the delegated entity's performance for delegation arrangements in place for 12 months or longer. Pages 7, Section 5.0, sets forth the procedure for oversight. *IX_1_UM_eviCore Annual Delegation Report 2022* This is the annual report for delegation oversight of eviCore (the annual report for 2023 was not completed by the time of audit submission). *IX_1_UM_RMHP Delegation Oversight Score_eviCore 2022*	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This is the scoresheet used for delegation oversight in 2022 (the annual report for 2023 was not completed by the time of audit submission). *IX_1_UM_eviCore_2023Q1-Q2_Semi-Annual_Report* This is the semi-annual report for delegation oversight of eviCore in 2023. *IX_1_2_3_4_UM_CCN Contract_CareCore National_Redacted* Page 4-6, Paragraph 2.4, "Oversight" specifies that the delegated entity agrees to allow RMHP to maintain reasonable oversight and what that includes. Page 45, Exhibit 3, in its entirety sets forth the performance standards and monitoring that will occur under the agreement. *IX_1,2,3,4_PH_OptumRx (5599-L) CS 3rd AR PBM Agrmt 110116 with regulatory appendices - Executed Version_Redacted.CO.pdf* Page 2, 1.3 (b) outlines that UHC and RMHP use of subcontractors does not transfer requirements on the MCO to comply with applicable Laws and Regulations. That responsibility lies with the MCO. *IX_1_PH_Pharmacy Delegated Entity Oversight*	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP is a part to the inter-segment agreement between UnitedHealthcare and OptumRx. United performs the function of oversight of the PBM per the UHC Pharmacy Entity Oversight Policy. *IX_1,2_2023 CRM Program_PH* Pages 26-30, Section 9 - Delegated Credentialing Describes the process Physical Health follows to evaluate whether a prospective delegate is capable of performing delegated credentialing activities. *IX_1,2_Delegated Credentialing_BH* Page 3, Policy Provisions-1 Pre-delegation Describes the process Behavioral Health follows to evaluate whether a prospective delegate is capable of performing delegated credentialing activities. *IX_230101 ISA Oversight_BH* This MOU provides information for this standard regarding the components identified in the associated.	
2. All contracts or written arrangements between the Contractor and any subcontractor specify— • The delegated activities or obligations and related reporting responsibilities. • That the subcontractor agrees to perform the delegated activities and reporting responsibilities.	*IX_PNM_Delegated Credentialing Agmt* Page 2, Paragraph 2.A., and Exhibit A describe the delegated credentialing activities. Page 2, Paragraph 2.D., describes the reporting responsibilities of the delegate.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provision for revocation of the delegation of activities or obligations or specify other remedies in instances where the Contractor determines that the subcontractor has not performed satisfactorily. *Note: Subcontractor requirements do not apply to network provider agreements. In addition, wholly-owned subsidiaries of the health plan are not considered subcontractors.* *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.4	Page 1 sets forth the delegate's agreement to perform the delegated credentialing activities and reporting responsibilities. Pages 5-6, Paragraph 4, Revocation/termination of delegated activities is addressed. *IX_1,2,3,4,6_2023 CRM Program_PH* Pages 26-30, Section 9 Describes the delegate's agreement to perform the delegated credentialing activities and reporting responsibilities for Physical Health. *IX_1,2_Delegated Credentialing_BH* ("Delegation Agreement" under Policy Definitions, pg. 2) Describes the delegate's agreement to perform the delegated credentialing activities and reporting responsibilities for Behavioral Health. *IX_230101 ISA Oversight_BH* This MOU provides information for this standard regarding the components identified in the associated. *IX_1_2_UM_Delegated Utilization Management Policy*	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 1, Section 3.1, provides that a written agreement between the parties will describe the delegated activities. Page 2, Section 3.1.11, provides that the written agreement will describe the remedies available if the delegate does not fulfill its obligations, including the circumstances that would cause revocation. *IX_1_2_3_4_UM_CCN Contract_CareCore National_ Redacted* *(CareCore National, LLC d/b/a eviCore healthcare)* Obligations and reporting responsibilities in written delegation agreements: Pages 26-30, Exhibit 1, describes the delegated activities. Pages 27-29, Section 1.E, Reporting Requirements, describe the delegated entity's reporting responsibilities. Provisions for revoking or other remedies in delegated agreements: Page 9, Paragraph 3.6.1 Evaluation of Delegated Entity Services, provides that in the event of a deficiency, the delegated entity shall implement and submit a corrective action plan within 15 business days of notification of the deficiency. Page 21, Paragraph 10.3, "Termination or Suspension Upon Notice," provides for termination or suspension upon notice if the delegated entity is not performing	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	UM activities in compliance with NCQA requirements or applicable law. *IX_1,2,3,4_PH_OptumRx (5599-L) CS 3rd AR PBM Agrmt 110116 with regulatory appendices - Executed Version_Redacted.CO.pdf* Page 3, 1.4 (c) outlines that service levels must be met, as set forth in Exhibit G. Page, 574 (of PDF), Exhibit G outlines scheduled service reporting Page 3, 1.5 outlines potential termination if services are not performed in a manner satisfactory to RMHP/UHC. Page 13, 5.1 (a) outlines data collection reporting responsibilities	
3. The Contractor's written agreement with any subcontractor includes: • The subcontractor's agreement to comply with all applicable CHP+ laws, regulations, including applicable subregulatory guidance and contract provisions. *42 CFR 438.230(c)(2)* CHP+ Contract Amendment 2: Exhibit B2—2.5.4.6	*IX_PNM_Delegated Credentialing Agmt* Page 6, D-Governing Law and Venue This demonstrates the credentialing delegation agreement contains the required language regarding compliance with all applicable Medicaid & CHP+ Laws and regulations as stated in this element. *IX_PNM_Law Exhibit Template_Provider* Page 11, Section III, Paragraph 8, demonstrates the credentialing delegation agreement contains the required language regarding compliance with all applicable Medicaid Laws and regulations as stated in this element.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_LRA_Law Exhibit_Non-Provider 12-19 Page 9, Paragraph 23, demonstrates the credentialing delegation agreement contains the required language regarding compliance with all applicable Medicaid Laws and regulations as stated in this element. *IX_230101 ISA Oversight_BH* This MOU provides information for this standard regarding the components identified in the associated. *IX_1_2_3_4_UM_CCN Contract_CareCore National_ Redacted* *(CareCore National, LLC d/b/a eviCore healthcare)* Section 1.2 defines "applicable law" as "Such federal, state, and local laws, rules and administrative regulations and guidance, including manuals, guidelines, operational policy letters, any CMS directions or instruction, and any requirements, directions or instructions that are contained in any contract or agreement between Company and any state or federal governmental agency or department, adopted, and/or published by any federal or state regulatory agency or any other governmental body with authority over Company and/or Delegated Entity, including, but not limited to, CMS, the Colorado Division of Insurance (DOI), and the Colorado Department of Health Care Policy and	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Financing (CDHCPF), that relate to or apply to the parties' obligations under this agreement. There are many sections throughout the contract that refer back to this definition and the Delegated Entity's responsibility to follow all laws, regulations, guidance, and contract provisions. *IX_1,2,3,4_PH_OptumRx (5599-L) CS 3rd AR PBM Agrmt 110116 with regulatory appendices - Executed Version_Redacted.CO.pdf* Page 2, 1.3 (a) & (b) outlines that UHC and RMHP can adjust the requirements at any time to meet State Contract requirements or requirements of applicable Laws and Regulations.	
4. The written agreement with the subcontractor includes: • 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.	*IX_PNM_Delegated Credentialing Agmt* Page 6, Exhibit B, J-Audits This section describes the requirements noted in bullet 1. *IX_PNM_Law Exhibit Template_Provider* Page 7, Section III, Paragraph 2, "Records and Audits" is part of the credentialing delegation agreement and contains the required language as stated in this element. *IX_LRA_Law Exhibit_Non-Provider 12-19*	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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. *42 CFR 438.230(c)(3)* CHP+ Contract Amendment 2: Exhibit B2—15.10.11	Page 4, Paragraph 11, "Medicaid and CHP+ Records and Audits" is part of the credentialing delegation agreement and contains the required language as stated in this element. *IX_230101 ISA Oversight_BH* This MOU provides information for this standard regarding the components identified in the associated. *IX_1_2_3_4_UM_CCN Contract_CareCore National_ Redacted* *(CareCore National, LLC d/b/a eviCore healthcare)* Page 5, Paragraph 2.4.5, grants permission for federal, state and local governmental authorities to audit any and all documents and materials related to services under the agreement at the delegated entity's place of business. Page 6, Paragraph 2.4.10, provides that the period for retaining all data, information, records and documentation related to is performance of delegated entity services for the period required by law. *IX_1,2,3,4_PH_OptumRx (5599-L) CS 3rd AR PBM Agrmt 110116 with regulatory appendices - Executed Version_Redacted.CO.pdf* Page 9-10, Section 4.3 (b) outlines that the Administrator shall permit HHS, the Comptroller General, United, Client or their designees to inspect,	

Standard IX—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	evaluate and audit the facilities, offices, equipment, books, records, contracts, documents, papers and accounts relating to the Administrator's performance of this agreement.	
Findings: HSAG reviewed a sample of contracts across the delegated activities and found that three out of the four written agreements reviewed did not include the required information.		
Required Actions: RMHP 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. o 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. o 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. o 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.		

Results for Standard IX—Subcontractual Relationships and Delegation							
Total	Met	=	3	X	1.00	=	3
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	3
Total Score ÷ Total Applicable						=	75%

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42 CFR 438.330(a)(1)* CHP+ Contract Amendment 2: Exhibit B-2—14.1.1	The following documents describe the ongoing comprehensive Quality Assessment and Performance Improvement Program for services provided to our Members. *X_1,4,5_QI_2023 RMHP QI Program Description Final* *X_1,2,3,4,5_QI_RMHP 2023 Quality Work Plan* *X_1,2,3,4,6,7_QI_RMHP CY 2022 QI Annual Evaluation_FINAL* The following documents describe the ongoing comprehensive Quality Assessment and Performance Improvement Program for services provided to our Members. *R1&RM&CHP_QualityImprovePln_FY23-24* *R1&RM&CHP_QualityRpt_FY22-23*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The Contractor's QAPI Program includes conducting and submitting (to the State) annually and when requested by the Department performance improvement projects (PIPs) that focus on both clinical and nonclinical areas. Each PIP is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Each PIP includes the following: • Measurement of performance using objective quality indicators. • Implementation of interventions to achieve improvement in the access to and quality of care.	*X_1,2,3,4,5_QI_RMHP 2023 Quality Work Plan* Rows 134 to 136 This describes PIP reporting to QIC. *X_1,2,3,4,6,7_QI_RMHP CY 2022 QI Annual Evaluation_FINAL* Page 169 -171 This describes outcomes from prior FY PIPs. CHP+ specific current PIP activities:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Evaluation of the effectiveness of the interventions based on the objective quality indicators. • Planning and initiation of activities for increasing or sustaining improvement. *42 CFR 438.330(b)(1) and (d)(2) and (3)* CHP+ Contract Amendment 2: Exhibit B-2—14.2.1.1 and 14.3	*X_2_QI_CHP+_PIP Submission Form_SDoH* *X_2_QI_CHP+_PIP Submission Form_WCV* *X_2_QI_CHP+_PIP Intervention Worksheet_SDoH* *X_2_QI_CHP+_PIP Intervention Worksheet_WCV Live Agent Calls* *X_2_QI_CHP+_PIP Intervention Worksheet_WCV Member Rewards* *X_2,6_CI_2021-2022_CHP_TechRprt* For CHP+ PIPs: Pages 1-5 through 1-6, 3-60 through 3-64, and 4-1 through 4-2: describes the PIPs conducted during this review period. Activities include: measurement, implementation, and evaluation of the focused areas.	
3. The Contractor's QAPI Program includes collecting and submitting (to the State) annually: • Performance measure data using standard measures identified by the State. • Data, specified by the State, which enable the State to calculate the Contractor's performance using the standard measures identified by the State. • A combination of the above activities. *42 CFR 438.330(b)(2) and (c)* CHP+ Contract Amendment 2: Exhibit B2—14.4	*X_1,2,3,4,5_QI_RMHP 2023 Quality Work Plan* Rows 39 to 40 describe the HEDIS process. *X_1,2,3,4,6,7_QI_RMHP CY 2022 QI Annual Evaluation_FINAL* Pages 25-50, describes HEDIS data collection, validation and submission.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42 CFR 438.330(b)(3)* CHP+ Contract Amendment 2: Exhibit B-2—14.6	*X_1, 4, 5_QI_2023 RMHP QI Program Description Final* Pages 41-42, Over and Underutilization Monitoring This describes the overutilization and underutilization monitoring activities included in the QI program. *X_1,2,3,4,5_QI_RMHP 2023 Quality Work Plan* Rows 89 to 96 describes the over and underutilization activities in the QI program. *X_1,2,3,4,6,7_QI_RMHP CY 2022 QI Annual Evaluation_FINAL* These sections describe mechanism to detect under and overutilization of services. Page 119: Monitoring of Over/Under Utilization - concurrent review physical & behavioral health Page 124: Monitoring of Overutilization decrease ER visits *X_4_QI_CY 2022 Underutilization Report to UMC* This document describes RMHP gap-in-care program to help identify areas in which Members are underutilizing various services. The following materials were used in an outreach campaign in 2023 to address underutilization of immunizations and well child visits. The campaign included a postcard and follow-up phone call.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_4_QI_Flu_EncourageEmail *X_4_QI_Pfizer_Postcard_Missed Vaccine* *X_4_QI_Pfizer_Postcard_WellVisit* *X_4_QI_Teen Vaccine Postcard_16_17YO* *X_4_QI_Welltok Missed Vaccine Reminder Script* *X_4_QI_Welltok Well Visit Reminder Phone Script* Member mailings for gaps in care in 2023 examples below. The incentive program aims to address underutilization of wellness visits in the teen and pre-teen population, underutilization of preventive care screenings, and underutilization of chronic care management. *X_4_QI_MbrRewards_Incentive Mailer* *X_4_QI_MbrRewards_List of Measures* *X_4_QI_A1c_LGC Home Kit Letter* *X_4_QI_FIT_LGC Home Kit Letter* *X_4_QI_Kidney uACR+eGFR_LGC Home Kit* *X_4, 5_QI_2023 CYSHCN and EPSDT Analysis* *X_4_UM Program Description 2023* *Pages 29-30, Section XV describes how RMHP* monitors over and underutilization of service to ensure Members receive the necessary and appropriate care. *X_4_UM_2022 Monitoring of Overutilization Concurrent Review Annual Report*	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This report demonstrates how overutilization of concurrently reviewed services were monitored in 2022. *X_4_UM_2022 Over and Underutilization of Prior Authorization Requests Annual Report* This report demonstrates how over and underutilization of services requiring prior authorization were monitored in 2022. *X_4_UM Hospital Readmission within 30 Days Analysis Report* This report demonstrates how overutilization from hospital readmissions within 30 days were monitored in 2022. *X_4_UM_RMHP 2022 ED Analysis Report* This report demonstrates how emergency depart utilization was monitored in 2022. *X_4_UM_Program Evaluation CY 2022* Pages 21-24 evaluates over and underutilization of services requiring prior authorization with recommendations of actions to be taken in the following year for improvement. Pages 24-29 evaluates the under and overutilization of concurrently reviewed services with	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	recommendations of actions to be taken in the following year for improvement. Pages 29-38 evaluates hospital readmissions within 30 days with recommendations of actions to be taken in the following year for improvement. Pages 38-43 evaluates emergency department utilization with recommendations of actions to be taken in the following year for improvement. *X_4_UM_2023 UMC Charter* Pages 1-2 define the responsibilities of the Utilization Management Committee (UMC) to include the over and underutilization of services. *X_4_PH_C&S High Prescription Utilization Program* On 5/1/2023 RMHP transitioned the Drug Safety Program to a delegated UHC/OptumRx program called Pharmacy Home Program. Page 1-2 This program works similarly to the prior Drug Safety Program in that it is designed to identify Members that have overutilization of certain drugs including controlled substances. Once reviewed, if there are concerns with safety or overutilization, a Member may be restricted to one pharmacy.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *Note: Persons with special health care needs shall mean persons having ongoing health conditions that have a biological, psychological, or cognitive basis; have lasted or are estimated to last for at least one year; and produce one or more of the following: (1) a significant limitation in areas of physical, cognitive, or emotional function; (2) dependency on medical or assistive devices to minimize limitation of function or activities; (3) for children: significant limitation in social growth or developmental function; need for psychological, educational, medical, or related services over and above the usual for the child's age; or special ongoing treatments such as medications, special diets, interventions or accommodations at home or at school.* *42 CFR 438.330(b)(4)* CHP+ Contract Amendment 2: Exhibit B2—14.6.1	*X_1, 4, 5_QI_2023 RMHP QI Program Description Final* Pages 39, Special Health Care Needs Describes that the QI Program recognizes the need to assess and ensure the receipt of adequate quality services for Members with SHCN. *X_4, 5_QI_2023 CYSHCN and EPSDT Analysis* RMHP performs an annual internal quality audit in which medical record documentation is assessed for continuity and coordination of care, and to ensure the receipt of adequate quality health care services. *X_5,9_QI_2023 CPG for SHCN* *X_5,9_QI_2023 United CPGs* *X_5,9_QI_CYSHCN Preventive Pediatric Health Screening CPG* *X_5,9_QI_Links to RAE, PRIME & CHP CPGs* These are the clinical practice guidelines RMHP has adopted relating to children and adults with special health care needs. The guidelines are available on the website and upon request. *X_1, 2, 3, 4, 5_QI_RMHP 2023 Quality Work Plan* Row 132, Describes SHCN Audit activities within the QI Program.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_5_CM_Complex Campaigns Screener *X_5_CM_Complex Under 21 Campaigns Screener* These documents are the screeners used with Members during outreach to adult and pediatric Members who are identified as Complex or have Special Health Care Needs. Assessment and care plans are developed to help Members overcome barriers and achieve specific treatment goals.	
6. The Contractor monitors members' perceptions of accessibility and adequacy of services provided, including: • Member surveys. • Anecdotal information. • Grievance and appeals data. • Call center data. • Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[A-1] surveys. CHP+ Contract Amendment 2: Exhibit B-2—14.5.2-3	*X_1,2,3,4,6,7_QI_RMHP CY 2022 QI Annual Evaluation_FINAL* Page 135-163, VI. Member Experience This section describes the monitoring of Members' experience of care. The following documents provide documented discussions, presentations, survey results, and opportunities for improvement in regard to monitoring Members' perceptions of accessibility and adequacy of services. *X_6_QI_2022 Post-Call Survey Results.pptx* *X_6_QI_Appeal and Grievance Q4 2022* Slides 10-15 *X_6_QI_MEAC Minutes_03.01.23* *X_6_QI_NPS Presentation for MEAC 3.1.2023* *X_6_QI_August_ME IQWg Agenda_Minutes*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_6_QI_October_ME_IQWg Agenda_Minutes *X_6_QI_Nov_ME IQWg Agenda_Minutes* *X_6_QI_CAHPS Prime_CHP+_HOS_AG Analysis* *X_6_QI_HCPF CAHPS LC CHP PRIME RAE* *X_6,12_CI_RMHP CHP+ GrieveAppealRpt_Q1-FY 23-24(PDF)* This narrative report provides identified trends regarding timely response and completion of grievances and appeals, and any actions taken. The Appeals and Grievance team shares Members perception on access and availability of services with appropriate departments for follow up. *X_6,12_CI_RMHP CHP+ GrieveAppealRpt_Q1-FY 23-24*(Excel-onsite) Note: Grievance and Appeal approved excel template with Q1FY23-24 data will be available on site. *X_2,6_CI_2021-2022_CHP_TechRprt* Pages 3-79 and 5-18 reflect the CAHPS Survey results from FY2019-20 through FY21-22. This information is used to assist in the creation of the RMHP Quality Program Annual report in order to identify perceptions of accessibility and adequacy of services provided to Members.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program at least annually. *42 CFR 438.330(e)(2)* CHP+ Contract Amendment 2: Exhibit B-2—14.2.5	*X_1,2,3,4,6,7_QI_RMHP CY 2022 QI Annual Evaluation_FINAL* Pages 7-9, Describes that program activities are structured around an ongoing process of quality monitoring, reporting, and assessment. A detailed evaluation of the Quality Improvement Program and its activities is conducted annually. This report is a formal summary of the annual evaluation of quality improvement activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
8. The Contractor adopts or develops practice guidelines that meet the following requirements: • Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. • Consider the needs of the Contractor's members. • Are adopted in consultation with participating providers. • Are reviewed and updated periodically, as appropriate. *42 CFR 438.236(b)* CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.2-4	*X_8, 9, 10, 11_QI_UHG CPG P&P* *X_8,9,10,11_QI_UHG CPG P&P_2024* Page 1, Background and Page 2, Step 3 This describes that guidelines are based on published clinical evidence or based upon a national consensus of scientific experts and to ensure transparency and consistency and to identify safe and effective health services for UHC Members. Page 3, Step 8 This describes that clinical guidelines are subject to periodic review, every 12 months or more often as needed. *X_8,10,11_QI_2023 MAC Charter Final - Final 03.10.2023* This document describes that RMHP's MAC oversees the approved list of UHG CPG, however, the MAC is responsible for oversight and selection of Medicaid CGPs and is done on an annual basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_8_QI_03.10.2023 QIC Minutes-MAC Charter Approval These committee minutes provide the approval of the MAC Charter (in relation to CPG review and approval) *X_8_04.27.2023 MAC Minutes-CPG Approval* These committee Minutes provide the approval by the MAC of the CPGs for 2023. *X_8_10_11_UM_ Clinical Criteria for UM Decisions* Page 1-2, Sections 1 and 3, describes the process used to apply written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services. Page 3, Section 3.2.4.5, states that practitioners with professional knowledge or clinical expertise in the relevant area have an opportunity to give advice or comment on development, review and adoption of UM criteria and on instructions for applying criteria. Page 3-4, Section 3.3.2, states that throughout the process of making a determination, RMHP considers many sources of clinical information. Page 4, Section 3.3.3 states that RMHP considers individual Member needs when making utilization decisions.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 4, Section 3.3.4 states that RMHP considers characteristics of the local delivery system when making utilization decisions. Page 6, Section 3.5 states that RMHP reviews clinical criteria and procedures for applying clinical criteria at least annually and revises as needed. *X_8_UM_New Technology Evaluation* Page 2, Section 4.1 states that the New Technology Assessment and Guideline Physician Advisory Committee (NTAG) is comprised of RMHP staff and non-staff network external physician consultants who evaluate new technology and new application of existing technology for medical procedures, behavioral health procedures, and devices. Page 4, Section 5.2 states that if a new technology requires prior authorization, Medical Directors will develop clinical criteria for medical necessity coverage. The criteria will incorporate decision variables appropriate for the new technology as identified from documentation by appropriate government regulatory bodies, from published scientific evidence, and from input received from relevant specialists and professionals who have expertise in the technology. Page 4, Section 5.3 states that, at least annually, provider feedback will be elicited through the provider newsletter for developed RMHP clinical criteria.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	X_8_UM_Example of Provider Request for Input on Criteria This is an example of how RMHP requests provider input on clinical criteria.	
9. The Contractor adopts or develops practice guidelines for the following: • Perinatal, prenatal, and postpartum care. • Conditions related to persons with a disability or special health care needs. • Well-child care. CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.1	*X_8, 9, 10, 11_QI_UHG CPG P&P* *X_8,9,10,11_QI_UHG CPG P&P_2024* These P&Ps describe the process used for review of the guidelines as well as the operational procedures for adopting practice guidelines. *X_5, 9_QI_2023 CPG for SHCN* This is the guideline that has been adopted for SHCN. *X_5, 9_QI_Links to RAE, PRIME & CHP CPGs* *X_CO_Clinical-Practice-Guidelines* This the downloaded list of CPGs adopted by RMHP. *X_5, 9_QI_CYSHCN Preventive Pediatric Health Screening CPG* This is the Bright Futures Periodicity Schedule, promoting health for CYSHCN *X_9, 10, 11_QI_Clinical Practice Guidelines 2023 Process*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This shows that these noted CPGs have been adopted by RMHP.	
10. The Contractor disseminates the guidelines to all affected providers and, upon request, members, and potential members. *42 CFR 438.236(c)* CHP+ Contract Amendment 2: Exhibit B-2—10.5.8	*X_CO-Clinical-Practice-Guidelines* This is the download of the CPG list from the UHC Website. *X_9, 10, 11_QI_Clinical Practice Guidelines 2023 Process* Describes that the CPGs were reviewed, approved and posted to websites in 12/2022 for 2023. *X_8, 9, 10, 11_QI_UHG CPG P&P* Page 1, Distribution, describes the distribution process for CPGs. *X_10_CM_CHP_Mbr Annual notice_2023* This CM Annual Notice includes the notification of CPGs to Members. *X_10_CM_FW_ Proof of Member mailings 2023* This documents the mailing of the Annual CM Notice, which includes the annual notification of CPGs to Members. *X_8_10_11_UM_ Clinical Criteria for UM Decisions*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 6, Section 3.6 states that providers and Members are notified in writing that criteria are available, free of charge, by request. *X_8_10_UM_New Technology Evaluation* Page 5, Section 5.7.1 and 5.7.2 state that criteria are available to providers and Members at no charge. *X_10_CHP+ Residential Denial Letter* This is an example of the letter used for Residential Denials until 09.01.2023. As of 09.01.2023 letter used CHP Denial Letter Current. This describes that Members can request criteria used for decision at no cost. *X_10_CHP+ Denial Letter Current* Letter used for all CHP+ Denials as of 09.01.2023 This describes that Members can request criteria used for decision at no cost. *X_10_11_Provider Insider Plus 1.2023* Page 2 indicates the criteria used to make a decision are available upon request at no cost to the Member or provider as well as provides an update to the clinical practice guidelines. The listed guidelines include: Pediatric Preventive Care, Prenatal Care, and Special Healthcare Needs—Children and Adults.	

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Providers are advised how to obtain copies of these guidelines. *X_10_11_CO-RMHP-Care-Provider-Manual* Review Criteria, Page 66, This section includes how criteria is used in decision-making and is available, free of charge, to Physicians, Practitioners, facilities and Members upon request to RMHP.	
11. The Contractor ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42 CFR 438.236(d)* CHP+ Contract Amendment 2: Exhibit B-2—10.5.8.5	*X_8, 9, 10, 11_QI_UHG CPG P&P* This describes that RMHP ensures that decision making is consistent with adopted guidelines. *X_10_11_CO-RMHP-Care-Provider-Manual* Page 62, Chapter 5: Utilization and Care Management, addresses many aspects of the Care Management Program. It describes the organizational structure that is in place to support correct and consistent development and application of clinical guidelines. page 67, last paragraph of "UM," describe how consistency is maintained including inter-rater reliability testing, audits, and utilization clinical rounds. *X_8_10_11_UM_ Clinical Criteria for UM Decisions*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 7, Section 3.7 describes how RMHP assesses the consistency of UM decisions. *X_11_UM_IRR Annual Plan and Process 2022* This document outlines the plan and process of inter-rater reliability testing that was utilized to assess the consistency of UM decisions in 2022. *X_11_UM_IRR_Annual_Report_2022* This report shows the results of IRR testing for RMHP UM staff in 2022.	
12. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42 CFR 438.242(a)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.1 and 15.10.2	*X_12,15_QI_PHM3.1a Sharing Data With Providers* This document is provided as an example of how RMHP helps its provider network use data for purposes of improving the care provided to patients seen in the hospital and emergency department. *X_12_QI_ED Visits Provider Ed v2* *X_12,15_QI_2023 Practice Report Card* These two documents are provided as examples of how RMHP helps its provider network use data and health information exchange for purposes of improving the care provided to patients. *X_12,13,16_Flow Diagram_Mbr Elg, Claims, Encounters, Rptng* Page 2 and 3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Describes the steps the RMHP takes to process electronic and paper claims from providers. *X_12,13_HIT Marketecture _high-level* This flowchart illustrates the various health information systems used by RMHP to collect, analyze, integrate and report data. *X_6,12_CI_RMHP CHP+ GrieveAppealRpt_Q1-FY 23-24(PDF)* This narrative report provides identified trends regarding timely response and completion of grievances and appeals, and any actions taken. The Appeals and Grievance team shares Members perception on access and availability of services with appropriate departments for follow up. *X_6,12_CI_RMHP CHP+ GrieveAppealRpt_Q1-FY 23-24(Excel-onsite)* Note: Grievance and Appeal approved excel template with Q1FY23-24 data will be available on site.	
13. The Contractor's health information system provides information about areas including but not limited to utilization, claims, grievances and appeals, and disenrollment for other than loss of CHP+ eligibility. *42 CFR 438.242(a)*	*X_12,13_HIT Marketecture _high-level* *X_12,13,16_Flow Diagram_Mbr Elg, Claims, Encounters, Rptng* *X_13_A&G ETS Reporting Flow*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract Amendment 2: Exhibit B-2—8.1 and 13.1.1	These process flowcharts indicate the various reporting and analytics that are done in the areas of utilization, claims, grievances and appeals, etc. *X_13_BO_Medicaid and CHP+ Disenrollment Reporting_BO0003* RMHP has several processes and controls in place to ensure that each and every one of our eligible Members are able to obtain services. We track the incoming data from the Department and look for any anomalies. RMHP created disenrollment reports for our CHP+, RAE and PRIME populations in order to track the number of disenrollments we receive on a monthly basis and to look for any irregularities. On a quarterly basis, in our Member Experience IQWg, these results are reported and discussed the intent is to look for reasons of disenrollment other than loss of eligibility and subsequently take action for future prevention if necessary.	
14. The Contractor's claims processing and retrieval systems collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. • Contractor electronically submits encounter claims data in the interChange ANSI X12N 837 format directly to the Department's fiscal agent using the Department's data transfer protocol. The 837-format encounter claims (reflecting claims paid, adjusted, and/or denied by the	*X_14,17 Colorado_EncountersSOP_2023_11* Page 2, Encounter Submission Describes and provides general processing guidelines for Medicaid and CHP+ Encounter submission to HCPF. *Claims note regarding Mechanism for verifying accuracy of claims/encounter data:	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contractor) shall be submitted via a regular batch process. *42 CFR 438.242(b)(1)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.6.3	All Health Care Professionals must comply with adopted HIPAA standards and all ANSI claims submission requirements for acceptance of their claims. In addition, RMHP utilizes a series of national published correct coding guidelines to ensure Providers are submitting accurate claims. All claim data, including member and provider data are collected from the CSP Facets claim data extracts and stored in tables for encounter submission. All Health Care Professionals must comply with adopted HIPAA standards and all ANSI claims submission requirements for acceptance of their claims. In addition, RMHP utilizes a series of national published correct coding guidelines to ensure Providers are submitting accurate claims.	
15. The Contractor collects data on member and provider characteristics and on services furnished to members through an encounter data system (or other methods specified by the State). *42 CFR 438.242(b)(2)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.5.1 and 13.1.6.2	*X_12,15_QI_PHM3.1a Sharing Data With Providers* This describes how RMHP collects member data. Further, this describes that reports are enabled to allow practices to dive into specific Member level detail on the utilization of health services, cost of care, chronic health diagnosis, mental health diagnosis, risk score (HCC) and prescribed medication use. Additionally, providers can find Member level information on preferred language. *X_QI_12,15_2023 Practice Report Card*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This PCP Practice monthly report demonstrates how RMHP collects and uses data on Member and provider characteristics regarding services furnished to Members. The various worksheets provide practice summaries, patient summary, patient detail, Members who are assigned but unattributed, and enrollment and claims data.	
16. The Contractor ensures that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data, including data from network providers compensated through capitation payments. • Screening the data for completeness, logic, and consistency. • Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies used for CHP+ quality improvement and care coordination efforts. *42 CFR 438.242(b)(3) and (4)* CHP+ Contract Amendment 2: Exhibit B-2—13.1.6 and 13.1.7.1.2.1	*X_12,13,16_Flow Diagram_Mbr Elg, Claims, Encounters, Rptng* Describes the steps the RMHP takes to process electronic and paper claims from providers. *X_16_EDI_Inbound_Data Flow_Narrative* This document explains the inbound Data flow into the claim adjudication platform, CSP Facets, which includes data from capitated providers. It explains that this data is verified for accuracy and completeness using HIPAA SNIP edits Levels1-6. *X_16_2023 Outline of Proposed Audit Activities* This annual audit plan describes RMHP audit activities to verify accuracy and timeliness of reported data; screening data for completeness, logic and consistency; and collecting information in standardized formats. *AM_X_16_Policy ID 36483 UHC FWA Pre Payment Provider Reviews and Analytics*	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This policy demonstrates that FWA audit activities are another process to verify accuracy and timeliness of reported data; screening data for completeness, logic and consistency; and collecting information in standardized formats. *X_16,17_CHP+ Flat File Process* *X_16,17 CHP+ Flat File Specs SFY2022-2023* *X_16,17_CHP+ Flat File Specs SFY2023-2024* *X_16,17_CHP Flat File Specs Comparison SFY23 Vs SFY24* A general description of what happens between RMHP giving data to Leif (RMHP's data actuary) and Leif providing HCPF (The Department) monthly Flat Files. This would be for both FFS and encounter claims.	
17. The Contractor: • Collects and maintains sufficient member encounter data to identify the provider who delivers any items or services to members. • Submits member encounter data to the State in Accredited Standards Committee (ASC) X12N 837, National Council for Prescription Drug Programs (NCPDP), and ASC X12N 835 formats as appropriate. • Submits member encounter data to the State at the level of detail and frequency specified by the State.	*X_16,17_CHP+ Flat File Process* *X_16,17 CHP+ Flat File Specs SFY2022-2023* *X_16,17_CHP+ Flat File Specs SFY2023-2024* *X_16,17_CHP Flat File Specs Comparison SFY23 Vs SFY24* A general description of what happens between RMHP giving data to Leif (RMHP's data actuary) and Leif providing HCPF (The Department) monthly Flat Files. This would be for both FFS and encounter claims.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.242(c) CHP+ Contract Amendment 2: Exhibit B-2—13.1.6.2-3 and 13.1.6.4-5	*X_14,17_Colorado_Encounters_SOP_2023_11* Page 2, Vendor based Encounters, Describes and provides general processing guidelines for Medicaid and CHP+ medical and Pharmacy (NCPDP) Encounter submission to HCPF	

Results for Standard X—Quality Assessment and Performance Improvement (QAPI), Clinical Practice Guidelines, and Health Information Systems							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	17	**Total Score**		=	17
				Total Score ÷ Total Applicable		=	100%

Appendix B. Compliance Review Participants

Table B-1 lists the participants in the FY 2023–2024 compliance review of RMHP.

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

HSAG Review Team	Title
Gina Stepuncik	Associate Director
Cynthia Moreno	Project Manager III
Crystal Brown	Project Manager I

RMHP Participants	Title
Adrian Aitken	Senior Capability Manager, Government Operations (GO), Claims Operations
Alicia Muellner	Behavioral Health Credentialing Specialist
Amy Mounts	Associate Director, Business Processes, Payment Integrity Operations
Ashley Murphy	Interim Director, Utilization Management
Benjamin Bradford	Network Contract Manager, Optum Health Solutions
Beth McCloskey	Fraud, Waste, and Abuse Program Integrity Manager
Billie Bemis	Vice President, Long-Term Services and Supports
Braden Neptune	Director, Business Operations
Brett Oltmanns	Senior Claims Business Processes Consultant, GO, Business Enablement & Strategic Solutions
Cabree Cleveland	Claims Business Process Technician, GO, Business Enablement & Strategic Solutions
Chasity Hackbarth	Network Contract Manager, Optum
Chris Miller	Director, Provider Relations, Optum
Christy Hunt	Claims Manager
Claudia Stein	Regulatory Adherence Manager, GO, Business Enablement & Strategic Solutions
Dale Renzi	Vice President, Provider Network Strategy and Operations
David Moklaizky	Vice President, Equitable Health
Dawn Osborne	Senior Claims Representative, GO, Claims Operations
Glen McDaniel	Regional Chief Information Officer
Heather Cochrane	Lead, Colorado Encounters
Jeremiah Fluke	Director, Contract Administration
Jeri Applegate	Manager, Business Processes, Provider Data Operations
Jim Hart	Compliance Consultant, UHC Audit Management
Kayla Lemke	Associate Director, Colorado Encounters

RMHP Participants	Title
Keli Deemer	Network Program Specialist, Provider Data Operations
Kendra Peters	Contract Manager, Child Health Plan *Plus*
Kim Herek	Director, Quality Improvement
Kim Nordstrom	Chief Marketing Officer
Kimberly Johnson	Business Processes Manager, Business & Education Correspondence & Readiness
Kiran Kalluri	Business Processes Consultant, Provider Shared Services Support
Liz Mullin	Network Program Manager
Matt Cook	Director, Network Contract and Benefit Configuration
Matthew Candell	Claims Manager, GO, Claims Operations
Meg Taylor	Regional Accountable Entities Program Officer; Vice President, Behavioral Health
Melanie Maddocks	Analyst, Leif Associates
Michelle Burgess	Regulatory Adherence Specialist, GO, Business Enablement & Strategic Solutions
Monika Tuell	Chief Operating Officer
Nathan Sutheimer	Senior Compliance Analyst, UHC Audit Management
Nicole Nemec	Senior Enrollment Quality Analyst, Client Experience & Operations
Patricia Briody	Installation Manager, GO, Claims Operations
Patrick Gordon	Chief Executive Officer
Peggy Gaudet	Associate Director, Compliance Exam Management, Optum
Sara Seaberry	Physical Health Credentialing Manager
Steve Klinga	Enrollment & Eligibility Manager, Client Experience & Operations
Sue Baker	Manager, Customer Service
Todd Carlon	Compliance Officer
Todd Lessley	Vice President, Clinical Services
Vicente Saldivar	Network Program Consultant, Provider Data Operations
Vicki L. Watkins	Claims Supervisor, GO, Claims Operations
Violet Willett	Director, Care Management
Zach Kareus	Plan Pharmacy Director
Zachary Snyder	Business Operations Specialist, Medicare & Retirement Sales
Department Observers	**Title**
Russell Kennedy	Quality Program Manager
Helen Desta-Fraser	Quality Section Manager
Lindsey Folkerth	Managed Care Contract Specialist
Sandi Wetenkamp	ACC Program Team, Network Adequacy

Appendix C. Corrective Action Plan Template for FY 2023–2024

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 C-1—Corrective Action Plan Process

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

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

The CAP template follows on the next page.

Table C-2—FY 2023–2024 Corrective Action Plan for RMHP

Standard IX—Subcontractual Relationships and Delegation
☐ Plan(s) of Action Complete ☐ Plan(s) of Action on Track for Completion ☐ Plan(s) of Action Not on Track for Completion
Requirement
4. The written agreement with the subcontractor includes: • 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. *42 CFR 438.230(c)(3)* CHP+ Contract Amendment 2: Exhibit B2—15.10.11
Findings
HSAG reviewed a sample of contracts across the delegated activities and found that three out of the four written agreements reviewed did not include the required information.
Required Actions
RMHP 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. o 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.

Standard IX—Subcontractual Relationships and Delegation
○ 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.
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:

Standard IX—Subcontractual Relationships and Delegation
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 D. 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 D-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, 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 FY 2023–2024 Department-approved 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.