Colorado Medicaid
Managed Care Program

FY 2008–2009 Site Review Report
for
Rocky Mountain Health Plans

April 2009

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

HSAG HEALTH SERVICES ADVISORY GROUP
1600 East Northern Avenue, Suite 100 ◆ Phoenix, AZ 85020
Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

1. Executive Summary 1-1

Overview of FY 2008–2009 Compliance Monitoring Activities 1-1
Methodology 1-1
Objective of the Site Review 1-2
Summary of Results 1-2

2. Summary of Performance Strengths and Required Actions 2-1

Overall Summary of Performance 2-1
Standard I—Coverage and Authorization of Services 2-1
Standard II—Access and Availability 2-3
Standard VII—Provider Participation and Program Integrity 2-4
Standard IX—Subcontracts and Delegation 2-5

Appendix A. Compliance Monitoring Tool ..... A-i

Appendix B. Site Review Participants B-1

Appendix C. Corrective Action Plan Process for FY 2008–2009 ..... C-1

Appendix D. Compliance Monitoring Review Activities D-1

Overview of FY 2008–2009 Compliance Monitoring Activities

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

This is the first year that HSAG has performed compliance monitoring reviews of the PIHP. For the fiscal year (FY) 2008–2009 site review process, the Department requested a focused review of four areas of performance. HSAG developed a review strategy consisting of four standards for review of **Rocky Mountain Health Plans** (**RMHP**), which corresponded with the four areas identified by the Department. These were: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with federal regulations and contract requirements was evaluated through review of the four standards. This report documents results of the FY 2008–2009 site review activities for the review period—July 1, 2007, through June 30, 2008. Section 2 contains summaries of the findings, strengths, opportunities for improvement, and required actions for each standard. Appendix A contains details of the findings.

Methodology

In developing the data collection tools and in reviewing the four standards, HSAG used the PIHP's contract requirements and regulations specified by the BBA with revisions that were issued on June 14, 2002, and effective on August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a document review of materials provided on-site, and interviews of key PIHP personnel to determine compliance. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. Details of the review of the four standards follow in Appendix A.

The four standards chosen for the FY 2008–2009 site review represent a portion of the requirements based on Medicaid managed care contract and BBA requirements. Standards III—Coordination and Continuity of Care, IV—Member Rights and Protections, V—Member Information, VI—Grievance System, VIII—Credentialing and Recredentialing, and X—Quality Assessment and Performance Improvement will be reviewed in subsequent years.

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

Objective of the Site Review

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

- The PIHP's compliance with federal regulations and contract requirements in the four areas of review.
- The quality and timeliness of, and access to, health care furnished by the PIHP, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality the PIHP's service related to the area reviewed.
- Activities to sustain and enhance performance processes.

Summary of Results

Based on the results from the Compliance Monitoring Tool and conclusions drawn from the review activities, HSAG assigned each element within the standards in the Compliance Monitoring Tool a score of *Met, Partially Met, Not Met, or Not Applicable.* HSAG assigned required actions to any individual element within the Compliance Monitoring Tool receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for enhancement for some elements, regardless of the score. While HSAG provided recommendations for enhancement of PIHP processes based on these identified opportunities for improvement, they do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **RMHP** for each of the standards. Details of the findings for each standard follow in Appendix A.

Table 1-1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Coverage and Authorization of Services	25	25	22	3	0	0	88%
II	Access and Availability	14	14	13	1	0	0	93%
VII	Provider Participation and Program Integrity	16	15	15	0	0	1	100%
IX	Subcontracts and Delegation	8	8	7	0	1	0	88%
	Totals	**63**	**62**	**57**	**4**	**1**	**1**	**92%**

Overall Summary of Performance

For two of the four standards HSAG reviewed (i.e., Access and Availability, and Provider Participation and Program Integrity), **RMHP** received an overall percentage-of-compliance score of 90 percent or above, representing a clear strength. **RMHP** achieved a score of 88 percent for the remaining two standards (Coverage and Authorization of Services, and Subcontracts and Delegation). The Subcontracts and Delegation standard consisted of only eight scored requirements; therefore, a score or 88 percent might be misleading as it represented only one required corrective action.

Standard I—Coverage and Authorization of Services

Summary of Findings

A variety of evidence demonstrated that **RMHP** monitored its network of providers to ensure that services were provided in an amount, duration, and scope sufficient to achieve their purpose. **RMHP**'s policies and procedures for authorization of services and for emergency and poststabilization services met most of the requirements of the Medicaid managed care contract. The member handbook was written at a sixth-grade reading level and informed members that they had the right to complain if they felt the services they received were not the right services provided at the right place, at the right time, by the right person. **RMHP** may want to link this discussion to a definition of medical necessity since this is an easy-to-understand definition of medical necessity.

Summary of Strengths

The member handbook and the provider manual informed members and providers of **RMHP**'s processes and policies. The provider handbook included details about the care management (utilization management [UM]) program. The member handbook was written in easily understood language. In addition to its policies, **RMHP** provided employees with desktop procedures or manuals providing additional details to comply with Medicaid managed care regulations.

Summary of Required Actions

RMHP's policies and processes that addressed the requirement to send notices of action did not address the requirement to send a notice of action for limited authorizations (authorizations in an amount, duration, or scope that are less than requested). Although the policy did address notices of action for reduced services, per the BBA and the Code of Federal Regulations (CFR), 42 CFR 438.404c, reduced services refer to services that have been previous authorized and reduced prior to the end of the authorization period. **RMHP** must clarify its policies and/or written processes to

address sending notices of action for limited authorization of services (authorization in an amount, duration, or scope that is less than requested) to be consistent with **RMHP**'s reported practice.

RMHP's emergency services policy, which applied to all of **RMHP**'s lines of business, contained language indicating that members would be charged for emergency services if they had not notified **RMHP** of the emergency care and the condition of the member would not have prevented notification. **RMHP** must clarify its policies and written processes to delineate the policy specifically for the Medicaid line of business and clearly state that **RMHP** may not deny payment for emergency services previously rendered based on the member's failure to provide notice.

RMHP's policy that addressed preauthorization of services contained language indicating that **RMHP** required preauthorization for urgent services. **RMHP** must clarify any applicable policies and communicate with appropriate staff members to ensure that **RMHP** does not require preauthorization for urgent services.

Standard II—Access and Availability

Summary of Findings

RMHP's policies and processes regarding access and availability met all requirements of the Medicaid managed care contract. There was evidence that **RMHP** provided services by out-of-network providers for emergency care or for the purpose of continuity of care. Providers and members were informed of **RMHP**'s standards for access to care via the provider manual and member handbook, respectively.

Summary of Strengths

RMHP had a well-organized mechanism to monitor its network of providers and ensure that provider relationships were supported by written agreements. Members were informed via the member handbook of their rights regarding direct access to women's care, the right to choose and change their primary care provider (PCP), and the fact that no authorization is required for emergency care.

RMHP's cultural competency program was robust and represented a best practice for **RMHP**. The cultural competency discussion in the member handbook, as well as **RMHP**-developed cultural competency training provided to employees, was comprehensive and in-depth. In addition, periodic newsletters provided interesting cultural facts to providers.

Summary of Required Actions

RMHP's claims manual was unclear and indicated that Medicaid members could be charged for co-pays for second opinions if **RMHP** did not encourage the second opinion. In addition, while the member handbook informed members that second opinions are a covered benefit, it did not inform members that second opinions are available at no cost to the member. **RMHP** must clarify the claims manual and any applicable policies to inform staff members that second opinions are available to members at no cost to the member. In addition, **RMHP** must notify members (via the member handbook or other appropriate member materials) that second opinions are available at no cost to the member.

Standard VII—Provider Participation and Program Integrity

Summary of Findings

RMHP's policies and processes regarding provider participation and program integrity met all of the requirements of the Medicaid managed care contract. There was evidence that **RMHP** monitored covered services via aggregate measures such as Healthcare Effectiveness Data and Information Set (HEDIS), review of utilization data, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. There was also evidence that **RMHP** monitored the performance of providers via medical record audits.

Summary of Strengths

RMHP's compliance program also represented a best practice for **RMHP**. In addition to the standard features, such as clear methods for employee reporting and auditing activities, **RMHP**'s compliance program included frequent reminders to employees about compliance issues through biannual newsletters and annual compliance week activities. In addition, **RMHP**'s compliance training was comprehensive.

Summary of Required Actions

No corrective actions were required for this standard.

Standard IX—Subcontracts and Delegation

Summary of Findings

There was ample evidence that **RMHP** conducted ongoing monitoring and formal review of its delegates. **RMHP**'s policies regarding subcontracts and delegation met all the requirements of the Medicaid managed care contract.

Summary of Strengths

RMHP had a signed, executed agreement and a business associate agreement, compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with each delegate. Together, the agreements included all the requirements of the Medicaid managed care contract.

Summary of Required Actions

While **RMHP** had ample evidence that it monitored its delegates, **RMHP** did not have evidence that it monitored its delegates to ensure compliance with HIPAA regulations (45 CFR Parts 160 and 164). **RMHP** must revise its process for monitoring delegates that use member information to include an evaluation of delegates' compliance with HIPAA.

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services

References	Requirement	Score
42CFR438.210(a)(3) Contract: II.D.1.a Exhibit A	1. The Contractor provides or arranges for services and ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. The Contractor provides care coordination, utilization management, and disease state management for members to promote the appropriate and cost-effective utilization of covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:

The Preauthorization of Services for Medicaid Members policy (CM 4.1.1.08) and the Preauthorization of Services for Medicaid Members process (CM 4.1.1.08) described the procedures for using Rocky Mountain Health Plans' (RMHP's) Medical Necessity Guidelines, Milliman Care Guidelines,® and other appropriate resources (per the on-site interview, primarily RMHP-specific guidelines and Hayes criteria if Milliman® is not sufficient) to preauthorize selected covered services. The provider manual included a list of services requiring preauthorization and forms required for requesting those services.

The Care Management Program Description described the structure, goals, and processes of utilization review and care management. The case management section of the Care Management Program Description stated that RMHP uses case management for managing acute and chronic medical conditions and catastrophic illnesses, or assisting members in transitioning to RMHP from out-of-network providers. The Case Management policy and the Case Management process (CM 17.2.08) stated that case managers evaluate members for needs and the appropriateness of services and develop individualized care plans based on an individual needs assessment. Screen shots of a case example from the electronic case management system (Facets) demonstrated a comprehensive mechanism to identify members appropriate for case management and to assess those members with the appropriate, condition-specific assessment tools.

The member handbook described the process of choosing a PCP and obtaining services. The provider manual described the utilization management (care management) and case management programs and informed providers of how to obtain information about enrolling members in case management.

During the interview, RMHP staff confirmed that RMHP monitored covered services through processes such as preauthorization and concurrent utilization review and medical record review to ensure that the services provided were in an amount, duration, and scope sufficient to achieve their purpose. RMHP staff also described specific disease management programs (for diabetes, asthma, and heart disease, with future plans to develop chronic obstructive pulmonary disease and hypertension programs)

Required Actions:

None

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(a)(3) Contract: II.D.1.c	2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Preauthorization of Services for Medicaid Members policy and the Preauthorization of Services for Medicaid Members process (CM 4.1.1.08) stated that adverse determination (e.g., denial) decisions are made based on medical necessity and whether the request meets established criteria and coverage guidelines (medical necessity criteria, Milliman Care Guidelines,® RMHP guidelines, or Hayes criteria, as appropriate). During the interview, RMHP staff reported that adverse determinations are not based on diagnoses and are based on standard guidelines and criteria. An example of a service denial demonstrated the use of standard criteria for decision making.	
	Required Actions: None	
42CFR438.210(a)(3) Contract: II.D.2.a	3. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Care Management Program Description stated that the care management (UM) program uses standardized criteria for prospective, concurrent, and retrospective review and that care management (review) activities are performed to evaluate the medical necessity and medical appropriateness of health services. A utilization review case example demonstrated the process. Medical Management Project Team (MMPT) Committee meeting minutes demonstrated discussions regarding limits placed on authorizations for the purpose of utilization control and appropriateness of decisions.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(a)(4) Contract: Exhibit A	4. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State Medicaid program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: ▪ The prevention, diagnosis, and treatment of health impairments ▪ The ability to achieve age-appropriate growth and development ▪ The ability to attain, maintain, or regain functional capacity	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP's definition of "medically necessary services" was the definition found in RMHP's Medicaid managed care contract with the Department. The member handbook included a comprehensive list of covered services and informed members that services they receive must be medically necessary; however, the handbook did not include any discussion or an easily understandable definition (written at a sixth-grade reading level) of "medically necessary services." While the Care Management and Quality Improvement Program section of the member handbook informed members of the right to complain if they felt that they did not receive the right services at the right time by the right person, this discussion did not include specific discussion about medical necessity. RMHP may want to consider linking a discussion about the right services by the right person at the right time to a discussion about medical necessity or including an easy-to-understand definition (at a sixth-grade reading level) of medically necessary services. One example of a denial letter included an easily understood reason for the denial, which constituted a reason based on medical necessity, without using the term "medical necessity." The provider manual included a discussion of authorization processes and referred to medical necessity as a primary utilization review criteria. The provider manual also included discussions on particular services covered and referred providers to the Web site for further information about review criteria and medical necessity.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(b)	5. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Preauthorization of Services for Medicaid Members policy and the Preauthorization of Services for Medicaid Members process (CM 4.1.1.08) addressed both initial and continuing authorization of services. The Utilization Review of Inpatient Days—Medicaid Members (CM 4.1.7.08) addressed the concurrent and retrospective review process for inpatient admissions.	
	Required Actions: None	
42CFR438.210(b) Contract: II.I.1.b	6. The Contractor's written policies and procedures include mechanisms to ensure consistent application of review criteria for authorization decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Review of Criteria process (CM 2.3.08) stated that staff meetings, internal communication, clinical rounds, physician review, case management committee meetings, and Medical Direction Committee meetings were all used to communicate any changes and discuss consistent interpretation of the review criteria. RMHP staff members clarified that the above opportunities for communication were typically used to identify concerns regarding use of review criteria and to disseminate decisions made by the MMPT Committee, and that the MMPT Committee made policy decisions regarding use or application of the criteria. MMPT Committee meeting minutes demonstrated review of criteria and policy decisions regarding use and/or application of the criteria. The Review of Criteria process and the Case Management Program Description stated that interrater reliability (IRR) audits are used to ensure consistency of application of the review criteria and guidelines and that corrective action plans are used if deficiencies are identified. RMHP staff provided overall results of the 2008 IRR audits. The scores for preauthorization, durable medical equipment (DME) authorization, and concurrent review were 91percent, 84 percent, and 73 percent, respectively. RMHP staff reported that a score of 95 percent is the benchmark goal for RMHP. Staff provided the action plan to remedy the current scores.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(b)	7. The Contractor's written policies and procedures include the procedure to consult with the requesting provider when appropriate.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Preauthorization of Services for Medicaid Members process stated that the case management nurse will review the information and criteria, consulting with the medical director, the PCP, or the requesting provider as needed to make a determination. An example case demonstrated that the medical director was consulted to make a final authorization determination.	
	Required Actions: None	
42CFR438.210(b)(3) Contract: II.I.1.e	8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appropriate Professionals policy (CM 3.1.08) stated that all adverse determinations based on medical appropriateness are made by a medical director. Two notice of action letters (one a denial and one a limited authorization) were provided as examples and both were signed by a physician. In addition, a log of denial decisions for the fourth quarter of FY 2008 demonstrated that all denial decisions listed on the log were made by a physician.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(c) Contract: II.I.1.a	9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Preauthorization of Services for Medicaid Members policy and process (CM 4.1.1.08) included telephonic notification of the determination for the provider and written notification of the adverse determination to the member. Adverse determinations were defined in the Preauthorization of Services for Medicaid Members policy as determinations in which services were denied, reduced, or terminated. The definition of adverse action did not include actions for services authorized in an amount, duration, or scope that are less than requested. RMHP staff reported that RMHP sends notices if services are authorized in an amount, duration, or scope that are less than requested and clarified that the intent of the policy was for "reduced" services to include limited authorization, as well. RMHP provided an example of a notice of action sent to a member for a limited authorization.	
	Required Actions: Since the BBA refers to reduced services as services that have been previously authorized, RMHP must clarify the policies and/or written processes to address sending notices of action for limited authorization of services (authorization in an amount, duration, or scope that is less than requested) to be consistent with RMHP's reported practice.	
42CFR438.210(d) Contract: Exhibit B—8.209.4.A.3.c & 8.209.4.A.6	10. The Contractor's written policies and procedures include the time frames for making standard and expedited authorization decisions extending time frames, as specified in the Grievance System standard.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Preauthorization of Services for Medicaid Members policy included time frames for making standard and expedited authorization decisions. The policy also indicated that an authorization decision could be extended.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.210(e) Contract: II.I.1.a	11. The Contractor's written policies and procedures provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Case Management Program Description stated that care management determinations are based only on appropriateness of care and services and that RMHP does not offer incentives to providers or staff to issue denials or encourage inappropriate underutilization. Providers were informed via the provider manual.	
	Required Actions: None	
42CFR438.114(a) Contract: I.13 & II.D.4.c	12. The Contractor defines an emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ◆ Serious impairment to bodily functions ◆ Serious dysfunction of any bodily organ or part	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Emergency Services policy (CM 11.1.08) stated, "Rocky Mountain shall not deny benefits for conditions which a prudent lay person would perceive as Emergent Medical Conditions." The policy also addressed services necessary to screen and stabilize a covered person based on the prudent layperson standard of care. The member handbook included directions to the member regarding when to call 911 or go to the nearest emergency room, and was consistent with the State's definition of "emergency medical condition."	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.114(a) Contract: I.14	13. The Contractor defines emergency services as follows: ◆ Services furnished by a provider who is qualified to furnish these services under this title ◆ Services needed to evaluate or stabilize an emergency medical condition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP's definition of "emergency services" in the Emergency Services policy and the Emergency Services procedure was consistent with the State's definition. The Claims Medical Processing Manual included a definition of "emergency services" that was consistent with the State's definition. The Physician Services Agreement template informed providers that RMHP covers and pays for medical services provided only by qualified physicians and licensed health care providers acting within the scope of their licensure, and provided definitions of physician and health care professional.	
	Required Actions: None	
42CFR438.114 Contract: II.D.4.c	14. The Contractor does not: ◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or the State agency of the member's screening and treatment within 10 days of presentation for emergency services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: While the Claims Medical Processing Manual included a list of emergency diagnoses, the manual clearly indicated that the list should be used for processing claims, not for excluding any other diagnosis. The manual also clearly included language regarding the prudent layperson standard for reviewing claims in question.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.114(a) Contract: Exhibit A	15. The Contractor defines poststabilization care as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or that are provided to improve or resolve the member's condition.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Emergency Services policy stated that RMHP pays for poststabilization services that are medically necessary to maintain the covered person's stabilized condition.	
	Required Actions: None	
42CFR438.114(c)(1) Contract: II.D.4.a.2 & 4	16. The Contractor covers and pays for emergency services regardless of whether the provider who furnishes the services has a contract with the Contractor. Members temporarily out of the service area may receive out-of-network emergency and urgently needed services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Emergency Services policy stated that RMHP covers emergency services regardless of whether the provider is contracted with RMHP. The policy stated that members temporarily out of the service area may receive emergency services out of area if the travel was for a purpose other than to receive the medical care. The Claims Medical Processing Manual provided direction that emergency services are covered in- or out of network. The member handbook informed members that emergency services are covered out of the service area, and that follow-up is covered until the member is able to return to the service area. RMHP provided two examples of paid claims for emergency services provided by out-of-network providers.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.114(c)(1) Contract: II.D.4.a.4	17. The Contractor may not deny payment for treatment obtained under either of the following circumstances: ◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: ▪ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ▪ Serious impairment to bodily functions ▪ Serious dysfunction of any bodily organ or part ◆ A representative of the Contractor's organization instructed the member to seek emergency services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Emergency Services policy stated that RMHP shall not deny benefits for conditions that a prudent layperson would perceive as emergent medical conditions. The policy also stated that RMHP would not deny claims for emergency services if an authorized representative of RMHP authorized the services. (The policy clearly stated that RMHP does not require authorization of emergency services.)	
	Required Actions: None	
42CFR438.114(c)(2) Contract: II.D.4.d	18. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Emergency Services policy stated that RMHP shall not deny benefits for conditions that a prudent layperson would perceive as emergent medical conditions. The policy also stated that RMHP will not deny benefits for emergency services previously rendered based on the member's failure to notify RMHP in accordance with plan provisions, if the member's medical condition prevented timely notification. RMHP staff clarified that for some of RMHP's commercial plans, payment may be denied for emergency services if the member did not notify RMHP in a timely manner after the services occurred. RMHP staff also stated that all Medicaid emergency claims are paid based on the prudent layperson standard. The Claims Medical Processing Manual stated that Medicaid members do not pay any co-payments for emergency services.	
	Required Actions: RMHP must clarify the Emergency Services policy to delineate the policy for different lines of business and to indicate that RMHP does not deny payment for Medicaid emergency services previously rendered based on the member's failure to provide notice.	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
42CFR438.10.f.6.viii.B Contract: II.D.4.a.3	19. The Contractor does not require prior authorization for emergency or urgently needed services.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: While RMHP staff reported that authorization of urgent services is not required, the Preauthorization of Services policy (CM 4.1.1.08, Sections 14.2 and 17) contained language that indicated a preauthorization requirement for urgent services. During the interview, RMHP staff clarified that the language in question was intended to describe processes for expedited requests for services and urgent requests from physicians for authorization of services rather than requests for urgently needed services.	
	Required Actions: RMHP must clarify any applicable policies and communicate with appropriate staff members to ensure that RMHP does not require preauthorization of urgent services.	
42CFR438.114(d)(3) Contract: II.D.4.a.5	20. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Emergency Services policy stated that RMHP will cover emergency services if the attending physician or the provider treating the enrollee is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge. RMHP staff confirmed that the expectation of providers and facilities is that the treating physician is responsible for this determination.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
Contract: II.I.1.f	21. Utilization management activities are conducted under the auspices of a qualified clinician.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Appropriate Professionals policy stated that UM activities are conducted by licensed nurses and that all denials based on medical necessity are made by a medical director. RMHP staff confirmed that the Care Management (UM) Department staff members are nurses and that all adverse determination decisions are made by a physician. RMHP provided two examples of notice of action letters (a denial and a limited authorization). Both letters were signed by a physician. The organizational chart demonstrated (and staff confirmed) that UM activities are conducted under the supervision of a registered nurse (RN) with medical director consultation as needed.	
	Required Actions: None	
Contract: II.D.4.e.1.a	22. If the Contractor establishes a drug formulary for all medically necessary covered drugs with its own prior authorization criteria, the Contractor includes each therapeutic drug category in the Medicaid program.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP's formulary included each of the therapeutic drug categories listed in the Medicaid program.	
	Required Actions: None	
Contract: II.D.4.e.2.b	23. The Contractor provides a covered drug if there is a medical necessity that is unmet by the Contractor's formulary product.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Physician Requests for Formulary Exceptions policy described the process for reviewing requests for out-of-formulary drugs. Staff described the process for pharmacist review of requests for exception and stated that decisions are made on a case-by-case basis. RMHP provided an example of an authorization of an out-of-formulary drug.	
	Required Actions: None	

Standard I—Coverage and Authorization of Services		
References	**Requirement**	**Score**
Contract: II.D.4.e.2	24. If a member requests a brand name for a prescription that is included on the Contractor's drug formulary in generic form, the member may pay the cost difference between the generic and brand name drugs. The Contractor has a process to ensure that the member signs the prescription stating that he/she is willing to pay the difference to the pharmacy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook informed members that they must pay the brand-name co-pay if they choose a brand name rather than a generic drug. RMHP staff clarified that licensed pharmacists review requests for brand-name use (i.e., an exception) and that if an exception is approved, members are not asked to pay the difference in cost of the co-pay. Staff members also stated that they do not ask members to sign the prescription if the brand name is purchased. They consider the actual purchase to be the approval of the additional charge. (This is acceptable per the Department representative.)	
	Required Actions: None	
Contract: II.D.4.g.3	25. The Contractor informs its home health services providers and members that home health services after 60 consecutive calendar days are not covered services but are available to members under FFS and require prior authorization. If home health services after 60 consecutive calendar days are anticipated, the Contractor ensures that at least 30 days prior to the 60th day of home health services, its home health services providers coordinate prior authorization with the single-entry-point agency for adult members and with the Medicaid fiscal agent for adult members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Preauthorization policy stated that RMHP will inform the home health agency of the 60-day limit. RMHP staff reported that home health services are provided by an RMHP company and explained that the process is to inform the home health provider staff verbally and to enter documentation into the electronic care management system. RMHP staff provided an example case with documentation that UM staff informed home health staff of the 60-day limit and that the fiscal agent must be notified.	
	Required Actions: None	

Results for Coverage and Authorization of Services							
Total	Met	=	22	X	1.00	=	22
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	25	**Total Score**		=	22

Total Score ÷ Total Applicable	=	88%

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(1) Contract: II.E.1.a .2	1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to covered services. The Contractor considers Essential Community Providers and other providers when establishing the network. The Contractor ensures a provider-to-member caseload ratio as follows: ◆ 1:2,000 primary care physician (PCP)-to-member ratio. ◆ 1:2,000 physician specialist-to-member ratio. ◆ Obstetrician/gynecologists (OB/GYNs), gerontologists, and internal medicine physicians may be counted as either a PCP or specialist, but not both.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP's Access and Availability policy and procedure stated that it maintains a 1:2,000 physician-to-member ratio for all types of physicians. RMHP provided quarterly access reports that indicated an average physician-to-member ratio of 1:58. RMHP also provided executed contracts for several independent practitioners and organizational providers, including essential community providers.	
	Required Actions: None	
42CFR438.206(b)(1) Contract: II.E.1.a.3	2. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated Medicaid enrollment. ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services. ◆ The numbers of network providers who are not accepting new Medicaid patients. ◆ The geographic location of providers and Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Network Adequacy Strategic Plan for FY 2009 included an analysis of the numbers and types of providers in the network and the geographic location of providers and members using GeoAccess mapping. RMHP provided an Enrollment/Disenrollment report, which included RMHP's analysis of Medicaid trends per month for FY 2008. Minutes of the MMPT Committee meetings demonstrated analysis of utilization trends.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(2) Contract: II.E.1.a.4	3. The Contractor provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook informed members that they can go to any provider for women's services. The provider manual listed screenings that should be done for women. The Claims Medical Processing Manual provided direction that direct access to women's services is a benefit and is required by the Medicaid managed care contract.	
	Required Actions: None	
42CFR438.6(m) Contract: II.E.3.a	4. The Contractor allows, to the extent possible and appropriate, each member to choose his or her primary care physician.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook stated that members should choose a PCP after joining RMHP. The handbook explained that if a member is seeing a non-plan physician when joining, the member may be able to keep his or her PCP for continuity of care until the member is able to find a new PCP—or if the member is pregnant, until she delivers. The member handbook described how to choose a PCP, how to inform RMHP once a PCP has been chosen, and how to change PCPs if desired.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(3) Contract: II.E.1.a.5	5. The Contractor has a mechanism to allow members to obtain a second opinion from an appropriate, qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook informed members that second opinions are covered and directed members to call customer service; however, the handbook did not inform members that second opinions are provided at no charge to members. The Access Plan stated that members have a right to a second opinion and described how to arrange for one. The claims manual stated that if RMHP is unaware that the member sought a second opinion, a co-pay is charged, and if RMHP had encouraged the second opinion, then the co-pay should not be charged. RMHP staff members attempted to identify paid claims in the system that were second opinions, but they determined that the system was unable to specifically identify second opinions.	
	Required Actions: RMHP must clarify the claims manual and any applicable policies to inform staff members that second opinions are available to members at no cost to the member. In addition, RMHP must notify members (via the member handbook or other appropriate member materials) that second opinions are available at no cost to them.	
42CFR438.206(b)(4) Contract: II.E.1.b	6. If the Contractor is unable to provide necessary services to a member in-network, the Contractor must adequately and timely cover the services out of network for the member for as long as the Contractor is unable to provide them.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Preauthorization process provided direction and the procedure for authorizing services provided out of network. The provider manual informed providers of how to request out-of-network services for members. The Preauthorization policy (CM 4.1.1.08) stated that out-of-network providers may be approved if the request is for continuity of care or for medical necessity. The Access Plan stated that out-of-network services are authorized if in-network services are not available or if out-of-network services are required for continuity of care. RMHP provided examples of claims paid for services provided by out-of-network providers.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(b)(5) Contract: II.E.1.b	7. The Contractor requires out-of-network providers to coordinate with the Contractor with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Preauthorization policy stated that the UM reviewer negotiates the rate for services and the subcontractor must comply with Medicaid rules. The claims manual informed staff that the system allows for payment to nonparticipating providers at Medicaid rates. The Out-of-Network Authorization and Negotiation Letter template informed the provider of the negotiated rate (the Medicaid rate or other rate as negotiated) and that applicable Medicaid co-pays may be charged.	
	Required Actions: None	
42CFR438.206(c)(1) Contract: II.D.1.b	8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or that are comparable to Medicaid fee-for-service, if the provider serves only Medicaid members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provider agreement template required that providers be available 24 hours a day, 7 days a week. The provider manual informed providers that they must be available 24 hours a day, 7 days a week. The member handbook informed members that they may seek care 24 hours a day, 7 days a week, including after-hours care for urgent or emergent services.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(c)(1) Contract: II.E.1.d	9. The Contractor makes services available 24 hours a day, 7 days a week, when medically necessary, and has written policies and procedures for how this will be achieved.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provider agreement template required availability 24 hours a day, 7 days a week. The provider manual informed providers that they must be available 24 hours a day, 7 days a week. The member handbook informed members that they may seek care 24 hours a day, 7 days a week, including after-hours care for urgent or emergent services. The Access Plan delineates access standards, including availability 24 hours a day, 7 days a week, for urgent and emergent care.	
	Required Actions: None	
42CFR438.206(c)(1) Contract: II.E.1.d	10. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, and to take corrective action if there is failure to comply. The Contractor communicates the access standards to providers and has routine monitoring mechanisms to ensure that participating providers comply with access policies and procedures.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Access Plan delineated the access requirements. The provider manual informed providers of the access standards. RMHP staff reported that provider performance regarding timely access to services is monitored via review of the access items on the CAHPS survey and an RMHP-developed, provider-specific member satisfaction survey, which included items regarding timely access. Staff reported that the RMHP satisfaction surveys are distributed to members to evaluate PCP performance and specialty services every other year. Provider-specific results are then analyzed and each provider is sent the results. An example of provider-specific results was reviewed on-site. Staff reported that there were no corrective action plans required as a result of these particular monitoring mechanisms.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(c)(1) Contract: II.E.1.d.& e	11. The Contractor must meet, and require its providers (including use of corrective action when needed) to meet, the following standards for timely access to care: ◆ The Contractor has a comprehensive plan for triage of requests for services on a 24-hours-a-day, 7-days-a-week basis, including: ▪ An immediate medical screening exam by the PCP or hospital emergency room. ▪ Access to a qualified health care practitioner via live telephone coverage either on-site or through call-sharing or an answering service. ▪ Practitioner backups covering all specialties. ◆ Scheduling and waiting times: The Contractor has clinically appropriate scheduling guidelines for various types of appointments necessary for the provision of primary and specialty care, including routine physicals, diagnosis and treatment of acute pain or injury, and follow-up appointments for chronic conditions. ◆ Nonurgent care is scheduled within two weeks. ◆ Adult, nonsymptomatic well-care physical examinations are scheduled within four months ◆ Urgently needed services are provided within 48 hours of notification of the physician or Contractor.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provider manual required that providers have coverage 24 hours per day, seven days per week, and informed providers of all access standards. The member handbook directed members to the nearest emergency room for emergencies and informed members of all access standards. The provider manual also required providers to have after-hours, on-call coverage.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.206(c)(2) Contract: II.E.6.c	12. The Contractor participates in the Department's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. In addition to requirements for interpretation and written materials found at 42CFR438.10, the Contractor implements the following requirements: ◆ Establishes and maintains the following policies related to: ▪ Reaching out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups. ▪ Providing health care services that respect individual health care attitudes, beliefs, customs and practices of members related to cultural affiliation. ▪ How the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. ▪ How the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats. ▪ Ensuring compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. ◆ Makes a reasonable effort to identify members whose cultural norms and practices may affect their access to health care ◆ Develops and/or provides cultural competency training programs, as needed, to network providers and Contractor staff regarding: ▪ Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. ▪ The medical risks associated with the client population's racial, ethnic, and socioeconomic conditions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Case Management policy stated that initial contact (telephonic interview completed by the customer service department) included identification of cultural and linguistic needs. In addition, screen shots of the electronic case management system demonstrated the process of documenting cultural/linguistic needs for members in the case management program. The Culturally Sensitive Services process described the process for case managers during case management activities. RMHP's provider manual provided a comprehensive discussion about cultural competency and culture and included directions on how to obtain interpreter services. The Access Plan addressed interpreter services and how the health plans responds to requests. The member handbook	

Standard II—Access and Availability		
References	**Requirement**	**Score**
	informed members that a TTY number is available, that customer service representatives speak Spanish, and that interpreters are available. The welcome call script included evaluating for other languages spoken. The Interpretation Services for Documents and Calls policy included the process for using the AT&T language line. The Case Management Referral & Identification policy (CM 17.1.08) stated that health care information is provided in non-English languages and that interpretation services are free of charge. Cultural Insights newsletters provided in-depth information regarding cultural issues affecting health care. RMHP staff reported that these newsletters were sent to all Medicaid providers biannually. In addition, RMHP had developed and implemented new cultural competency training using a comprehensive PowerPoint presentation and provided rosters of RMHP staff attendance for sessions conducted in January 2009.	
	Required Actions: None	
42CFR438.207(b) Contract: II.E.2.c & d	13. The Contactor submits a network adequacy report (with assurances of adequate capacity) that uses geographic access standards, provider network standards (travel of 30 minutes or 30 miles), and population demographics, and that provides documentation that the Contractor: ◆ Has the capacity to serve the expected enrollment in its service area. ◆ Provides an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of members for the service area. ◆ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP's quarterly access reports for FY 2008 included an analysis of distance and/or time traveled for members to obtain care using GeoAccess mapping. Standards used for analysis were 30 minutes/30 miles for urban and suburban PCPs, 45 minutes/45 miles for urban specialists and rural PCPs, 60 minutes/60 miles for suburban specialists, and 90 minutes/90 miles for rural specialists. RMHP staff reported that approximately three years ago, RMHP had negotiated with the State to determine these alternative standards due to RMHP's challenging rural service area. A Department representative recalled these discussions and provided a copy of the original proposal.	
	Required Actions: None	

Standard II—Access and Availability		
References	**Requirement**	**Score**
42CFR438.207(c) Contract: II.E.2.c & d	14. The network adequacy report was submitted as required: ◆ At the time the Contractor entered into a contract with the State ◆ At any time there has been a significant change in the Contractor's operations that would affect adequate capacity and services, including: ▪ A change in services, benefits or geographic service area ▪ Enrollment of a new population ◆ Quarterly	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP provided evidence (e-mail confirmation) of quarterly submission to the Department for the network adequacy report. RMHP reported no significant change in operations or new populations to warrant additional network adequacy reports.	
	Required Actions: None	

Results for Access and Availability							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	13

Total Score ÷ Total Applicable	=	93%

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.230(b)(2) Contract: II.H.2	1. The Contractor has a written agreement with each subcontractor (subcontracted provider).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP's Contract Work Flow diagram described the process for contracting with providers and ensuring that each provider has an executed contract. RMHP provided templates and examples of executed contracts for provider group practices, specialty providers, pharmacy services, and facilities such as hospitals and skilled nursing facilities. RMHP staff reported that the claims management system does not allow payment to providers without executed contracts.	
	Required Actions: None	
42CFR438.102(a) Contract: II.E.3.c	2. 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 nontreatment ◆ 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	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The physician services and facility agreement templates included clauses informing the entity that RMHP does not restrict health care professionals, acting within the lawful scope of their practice, from advising or advocating on behalf of a member regarding any aspects of the member's treatment or treatment options. The provider manual contained the list of member rights from the member handbook, which included the right to discuss treatment and treatment options and the right to refuse treatment.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.12(a)(1) 42CFR438.214(c) Contract: II.G.1.f & II.G.10	3. The Contractor does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law solely on the basis of that license or certification, and does not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment. A policy is required, and there must be a provision in provider subcontracts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Nondiscriminatory Credentialing policy (CR.14.08) stated that RMHP does not discriminate against providers who serve high-risk populations or specialize in conditions that require costly treatment. RMHP staff described the credentialing process as nondiscriminatory as providers are evaluated against a standard set of requirements of the National Committee for Quality Assurance (NCQA). In addition, staff reported that the credentialing team tracked providers who were denied participation in the network and analyzed the list for trends.	
	Required Actions: None	
42CFR438.12(a)(1) Contract: II.G.10	4. If the Contractor declines to include individuals or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP's Credentialing Process policy (CR.1.08) stated that applicants will be notified of the decision. A sample letter that was sent to a provider applicant who had been denied inclusion in the network contained the reason for the decision.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.214(d) Contract: II.G.4.c	5. The Contractor does not employ or contract with providers excluded from participation in federal health care programs under either Section 1128 or 1128 A of the Social Security Act. A policy is required, and there must be a provision in provider subcontracts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Physician agreements required that physicians not be prohibited from participating in any federal programs. The Credentialing policy described the primary sources used for verification (i.e., the National Practitioner Data Bank [NPDB] and Office of Inspector General [OIG] list). RMHP staff provided an example of the credentialing checklist, which included a section to document the verification for lack of sanctions. The Mid-Cycle Credentialing policy (CR.7.08) described monthly review of the database of the Colorado Board of Medical Examiners (CBME), review of the OIG list and the NPDB alert report, and review of internal incidents. RMHP staff confirmed monthly review of these services to ensure that subcontracted providers are eligible for federal health care participation. The Credentialing policy stated that approval of applicants with sanctions is at the discretion of RMHP. RMHP staff clarified that State level-sanctions and monitoring may be considered with the credentialing packet, but that ineligibility for participation in federal health care programs prevents subcontracting with those providers.	
	Required Actions: None	
42CFR438.608 Contract: II.G.4.c	6. The Contractor may not knowingly have a director, partner officer, employee, subcontractor, or owner (owning 5 percent or more of the entity) who is debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Human Resources Process OIG list stated that prior to hire the OIG is referenced to ensure that the employee is not excluded from federal health care participation. The Compliance Plan contains an affirmative statement that board members and vendors must be eligible for federal health care participation. RMHP staff reported that the Human Resources Department checks the OIG list using a process similar to the credentialing department's process for providers.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.106 Contract: V.U	7. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor's debts in the event of the Contractor's or subcontractor's insolvency. ◆ Covered services provided to the member for which the State does not pay the Contractor. ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider who provides the services under a contract, 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.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The physician services and facility agreements included the provision that the subcontractor may not bill, charge, collect, or seek compensation from members in the above or any other circumstances. The Claims Manual stated that members cannot be balance-billed for a covered service.	
	Required Actions: None	
42CFR438.102(b) Contract: II.F.1.d.8.g	8. 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. ◆ To members before and during enrollment. ◆ To members within 90 days after adopting the policy with respect to any particular service (consistent with the format provisions in 42CFR438.10). (The Contractor need not furnish information on how and where to access the service.)	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
	Findings: RMHP staff reported that there are no services that RMHP would object to providing on moral or religious grounds.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.608 Contract: II.G.4.a	9. The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: ◆ Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards. ◆ The designation of a compliance officer and a compliance committee accountable to senior management. ◆ Effective training and education for the compliance officer and the Contractor's employees. ◆ Effective lines of communication between the compliance officer and the Contractor's employees. ◆ Enforcement of standards through well-publicized disciplinary guidelines. ◆ Provision for internal monitoring and auditing. ◆ Provision for prompt response to detected offenses and for development of corrective action initiatives related to the Medicaid managed care contract requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP had several Fraud and Abuse Deterrence Program policies and procedures, including policies and procedures that addressed documentation, training and education, disciplinary guidelines, internal audit pend codes, the Fraud and Abuse Detection Committee, goals and objectives, preparing cases, referrals and reporting, and confidentiality. RMHP also had a comprehensive compliance plan and standards of conduct. Each of RMHP's documents articulated RMHP's commitment to comply with federal and State standards applicable to fraud and abuse detection and prevention. Effective communication between RMHP's staff and the compliance officer (RMHP's vice president of legal and government affairs) consisted of compliance plan newsletters (two during FY 2008), an annual compliance summary, and an annual compliance week during which compliance topics are highlighted and publicized to employees. RMHP staff reported that the compliance committee did not keep written minutes to protect the confidentiality of the proceedings. Staff did, however, provide dates of each of the compliance meetings that were held during FY 2008. RMHP board meeting minutes demonstrated that the compliance committee provided the Board of Directors with periodic summary reports of compliance committee activities. The PowerPoint training presentation contained information about definitions and methods of reporting. RMHP reported that the presentation is provided at new-hire orientation. The compliance officer reported that he routinely reviewed laws and regulations for possible changes. RMHP provided examples of internal auditing activities.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
Contract: II.G.4.b	10. The Contractor reports possible instances of fraud to the Department within 10 business days of receipt of information. The referrals will include: ◆ Specific background information. ◆ The name of the provider. ◆ A description of how the Contractor became knowledgeable about the occurrence.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Fraud and Abuse Deterrence Program Policy and Procedure for Referrals and Reporting addressed reporting to the Department within 10 days after receipt of the report. RMHP staff reported that there were no incidents during FY 2008 involving the Medicaid line of business that required reporting to the Department.	
	Required Actions: None	
Contract: II.G 8.a	11. The Contractor notifies the Department in writing of its decision to terminate any existing participating provider agreement where such termination will cause the delivery of covered services to be inadequate in a given area. The written notice shall be provided to the Department at least 60 calendar days prior to termination of the services unless the termination is based upon quality or performance issues. The notice will include a description of how the Contractor will replace the provision of covered services at issue.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP staff reported no terminations of providers that caused the delivery of services to be inadequate in RMHP's service area during the fiscal year.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
	12. The Contractor monitors covered services rendered by subcontracted providers for quality, appropriateness, and patient outcomes.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Monitoring of covered services included quality improvement (QI) program activities such as performance improvement projects, review of HEDIS measures, and Medical Practice Review Committee (MPRC) review of complaints regarding quality of care. RMHP staff provided an example of an MPRC review of quality-of-care issues.	
	Required Actions: None	
Contract: II.G.11 & II.F.3.b	13. The Contractor monitors subcontracted providers for compliance with requirements for medical records, data reporting, and other applicable provisions of the Medicaid managed care contract. The Contractor also monitors for any requirements the Contractor imposes. Minimum medical record requirements include: ◆ Medical charts ◆ Prescription files ◆ Documentation sufficient to disclose the quality, quantity, appropriateness, and timeliness of services All records must be legible.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP's medical record review process included a review of patient records for appropriateness and quality of care and quality of documentation, including documentation of prescription information and reporting of encounter/billing data. Providers were informed about the process via the provider manual.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
42CFR438.230(a)(3) Contract: II.H.3	14. The Contractor has implemented written procedures for monitoring subcontracted providers' performance on an ongoing basis. The Contractor subjects subcontracted providers to formal review on a schedule consistent with industry standards.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Ongoing monitoring consisted of customer service department review of complaints and grievances, audits of billing and encounter data, and review of utilization data for outlier practices. Formal review consisted of medical record reviews. RMHP staff reported that a sample of medical records is reviewed each year and that the rotation ensures that new providers are reviewed and that each provider is reviewed at least once every five years, or more often if indicated (by other quality indicators).	
	Required Actions: None	
42CFR438.230(a)(4) Contract: II.H.4	15. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor take corrective actions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Reduction, Suspension, or Termination policy stated that the MPRC investigates and takes appropriate action in response to compliance issues or incidents. The provider manual described the corrective action plan process. RMHP provided an example of communication with a provider and a request for correction based on a medical record review. RMHP also provided an example of a termination of a provider agreement as a result of a review by the MPRC.	
	Required Actions: None	

Standard VII—Provider Participation and Program Integrity		
References	**Requirement**	**Score**
Contract: II.I.1.c	16. At the time an agreement is executed with a participating provider, the Contractor provides information to the provider about how the Contractor's utilization management (UM) program functions and is used to determine medical necessity. The information includes: ◆ Appropriate points of contact with the program. ◆ Contact persons or numbers for information or questions. ◆ Information about how to initiate appeals related to UM decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provider manual included a discussion about RMHP's care management program and included the fax number to submit requests for authorization. The provider manual described the appeals process and how to request an appeal. The beginning of the provider manual included a contact list for all RMHP departments.	
	Required Actions: None	

Results for Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	15

Total Score ÷ Total Applicable	=	100%

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
42CFR438.230(a)(1) Contract: II.H.1	1. The Contractor oversees and is accountable for any functions and responsibilities that it delegates to any subcontractor.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP delegated the following three services: care management to the Mesa, Delta, and Montrose county social services departments for case management of children with special health care needs; credentialing to The Montrose County Physician Hospital Organization (PHO); and pharmacy claims adjudication to Express Scripts. The Delegated Credentialing policy, the Subcontracted Case Management policy, and the Delegated Credentialing Audit Activities policy addressed oversight of delegates to ensure that RMHP remains accountable for delegated activities.	
	Required Actions: None	
42CFR438.230(b)(1) Contract: II.H.1	2. Before any delegation, the Contractor evaluates a prospective subcontractor's ability to perform the activities to be delegated.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Delegated Credentialing/Recredentialing policy, the Delegated Credentialing Audit Activities policy, and the Delegated Utilization Management policy addressed the predelegation evaluation of delegates. RMHP staff reported that there were no new delegation contracts entered into during FY 2008.	
	Required Actions: None	
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR 12—Element D	3. There is a written agreement with each delegate.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP provided a signed contract/agreement with each delegate.	
	Required Actions: None	

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR12— Element A Element B Element C	4. The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. For delegation of credentialing only, the agreement: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. ◆ Includes a list of allowed uses of protected health information (PHI). ◆ Includes a description of delegate safeguards to protect PHI from inappropriate uses. ◆ Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ Includes a stipulation that the delegate will provide individuals access to their PHI. ◆ Includes a stipulation that the delegate will inform the Contractor if inappropriate use of PHI occurs. ◆ Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. ◆ Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Each of the executed agreements specified the delegated activities, responsibilities, and report requirements. The agreements also included a provision for sanctions and possible revocation of the agreement if the subcontractors' performance was inadequate. All agreements reviewed on-site were signed by both parties. The credentialing agreement required quarterly reporting to RMHP and stated that the delegate must comply with NCQA standards for credentialing. The credentialing agreement also stated that RMHP would evaluate performance under the contract via review of regular reports and audits. There was no PHI language in the credentialing agreement. RMHP staff reported that its credentialing delegate did not use information that could identify members	

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
	during the credentialing process; therefore, the requirement for specific, HIPAA-compliant PHI language to be in the agreement is not applicable.	
	Required Actions: None	
42CFR438.230(b)(3) Contract: II.H.3	5. The Contractor implements written procedures for monitoring the subcontractor's (delegates and providers) performance on an ongoing basis. The Contractor subjects subcontractors to a formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Ongoing monitoring of the three county health departments consisted of monthly and annual reports submitted by the counties and reviewed by RMHP. RMHP also provided minutes from quarterly joint operating committee meeting minutes during which RMHP performed formal review activities. The Express Scripts performance report and the Express Scripts work plan (joint operating committee meeting minutes) demonstrated ongoing monitoring of claims adjudication activities delegated to Express Scripts. RMHP provided examples of audits evaluating the accuracy of claims adjudication, which demonstrated formal review of Express Scripts. Ongoing monitoring and formal review of credentialing consisted of review of reports submitted by the PHO and annual audits of the accuracy and completeness of credentialing performed by the PHO.	
	Required Actions: None	
42CFR438.230(b)(4) Contract: II.H.4	6. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance, the Contractor and the subcontractor take corrective action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: RMHP's delegation policies addressed corrective action when delegate performance is inadequate. Joint operating committee meeting minutes included action plans as appropriate. Monitoring of delegated credentialing and pharmacy claims adjudication demonstrated that corrective action was not required during FY 2008.	
	Required Actions: None	

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
45CFR Part 164	7. The Contractor ensures that any subcontractors agree to implement reasonable and appropriate safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of protected health information (PHI), including electronic information. Those safeguards include: ◆ Not using or disclosing PHI except as required by the contract. ◆ Using appropriate safeguards (physical security, security of electronic records, appropriate use of releases of information) to protect PHI. ◆ Implementing reasonable and appropriate policies and procedures related to the use, disclosure, and protection of PHI. ◆ Making PHI available in accordance with 45CFR164.524. ◆ Using business associate agreements with business associates of the subcontractor. ◆ Not using or disclosing the information for employment-related actions or decisions. ◆ Reporting to the health plan any use or disclosure of PHI that it becomes aware of that is inconsistent with the uses or disclosures provided for by the contract. ◆ Restricting access to and use of PHI to employees or classes of employees for which the information is required related to payment of, or performance of, health care operations. ◆ Providing an effective mechanism for resolving any noncompliance by employees. ◆ If feasible, returning or destroying all PHI received from the health plan and retaining no copies when such information is no longer needed for the purpose for which disclosure was made.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The county social service departments and Express Scripts signed business associate agreements with RMHP, which included the required HIPAA-compliant PHI language.	
	Required Actions: None	

Standard IX—Subcontracts and Delegation		
References	**Requirement**	**Score**
45CFR Part 164	8. The Contractor ensures that any subcontractors have implemented and complied with each requirement (see Requirement 7) with respect to use, disclosure, and protection of PHI.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: RMHP's monitoring of the three county social service departments and of Express Scripts did not include monitoring to ensure the delegates' compliance with HIPAA regulations (45 CFR Parts 160 and 164).	
	Required Actions: RMHP must revise its process for monitoring delegates that use member information to include an evaluation of the delegates' compliance with HIPAA.	

Results for Delegation Subcontracts							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	7

Total Score ÷ Total Applicable	=	88%

Appendix B. Site Review Participants for Rocky Mountain Health Plans

Table B-1 lists the participants in the FY 2008–2009 site review of **RMHP**.

Table B-1—HSAG Reviewers and PIHP Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
RMHP Participants	**Title**
Brett Antczak	Provider Network Manager
Matt Cook	Project Coordinator, Public Relations
Sandy Dowd	Director, Case Management
Steve ErkenBrack	President of Rocky Mountain Health Plans
Judi Everett	Manager of Claims Production Support
Laurie Fehlberg	Manager, Internal Audit
Nora Foster	Process Analyst, Customer Service
Kele Geisler	Contract Implementation
Patrick Gordon	Director, Government Programs
Carol Ann Hendrikse	Manager, Case Management
Kendra Henson	Administrative Assistant, Regulatory Affairs
Jackie Hudson	Quality Improvement Program Manager
Rhonda Ingram	Claims Manager
David Klemm	Manager, Government Programs
Theresa Kupecz-Louden	Director, Claims
Mike Luedtke	Regional Affairs, Staff Attorney
Kris Malean	Customer Service Director
Beverly Martin	Manager of Pharmacy Operations
Colleen Moss	Continuing Medical Education Coordinator/Special Projects
Steven Nolan	Pharmacy Director
Jim Quillin	Fraud Investigator
Sandy Randall	Provider Network Coordinator
Dale Renzi	Director, Network and Business Systems Development
Doug Speedie	Associate Medical Director
Lori Stephenson	Quality Improvement Director
LeAnna Stortz	Public Relations Manager
Melissa Treto	Contracts and Benefits
Laurel Walters	Chief Operations Officer
Terri Wright	Credentialing Manager
Department Observers	**Title**
Gloria Johnson	Contract Manager, HCPF

Appendix C. Corrective Action Plan Process for FY 2008–2009 for Rocky Mountain Health Plans

RMHP is required to submit to the Department a corrective action plan (CAP) 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 element that requires correction, the health plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. Supporting documents should not be submitted and will not be considered until the plan has been approved by the Department. Following Department approval, the PIHP must submit documents per the timeline that was approved.

Table C-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each PIHP will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or the file transfer protocol (FTP) site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must address the planned intervention(s) to complete the required actions and the timeline(s) for the intervention(s).
Step 2	**Prior approval for timelines exceeding 30 days**
	If the PIHP is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	The Department will notify the PIHP via e-mail whether: ◆ The plan has been approved and the PIHP should proceed with the interventions as outlined in the plan, or ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the PIHP has received Department approval of the plan, the PIHP should implement all the planned interventions and submit evidence of such intervention to HSAG via e-mail or the FTP site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the PIHP to submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

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

The template for the CAP follows.

Table C-2—FY 2008–2009 Corrective Action Plan *for* RMHP				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
I. Coverage and Authorization of Services 9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). **Findings:** The Preauthorization of Services for Medicaid Members policy and process (CM 4.1.1.08) included telephonic notification of the determination for the provider and written notification of the adverse determination to the member. Adverse determinations were defined in the Preauthorization of Services for Medicaid Members policy as determinations in which services were denied, reduced, or terminated. The definition of adverse action did not include	Since the BBA refers to reduced services as services that have been previously authorized, RMHP must clarify the policies and/or written processes to address sending notices of action for limited authorization of services (authorization in an amount, duration, or scope that is less than requested) to be consistent with RMHP's reported practice.			

Table C-2—FY 2008–2009 Corrective Action Plan *for* RMHP				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
actions for services authorized in an amount, duration, or scope that are less than requested. RMHP staff reported that RMHP sends notices if services are authorized in an amount, duration, or scope that are less than requested and clarified that the intent of the policy was for "reduced" services to include limited authorization, as well. RMHP provided an example of a notice of action sent to a member for a limited authorization.				
18. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. **Findings:** The Emergency Services policy stated that RMHP shall not deny benefits for conditions that a prudent layperson would perceive as emergent medical conditions. The policy also stated that RMHP will not deny benefits for	RMHP must clarify the Emergency Services policy to delineate the policy for different lines of business and to indicate that RMHP does not deny payment for Medicaid emergency services previously rendered based on the member's failure to provide notice.			

Table C-2—FY 2008–2009 Corrective Action Plan *for* RMHP				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
emergency services previously rendered based on the member's failure to notify RMHP in accordance with plan provisions, if the member's medical condition prevented timely notification. RMHP staff clarified that for some of RMHP's commercial plans, payment may be denied for emergency services if the member did not notify RMHP in a timely manner after the services occurred. RMHP staff also stated that all Medicaid emergency claims are paid based on the prudent layperson standard. The Claims Medical Processing Manual stated that Medicaid members do not pay any co-payments for emergency services.				
19. The Contractor does not require prior authorization for emergency or urgently needed services. **Findings:** While RMHP staff reported that authorization of urgent services is not required, the Preauthorization of Services policy (CM 4.1.1.08, Sections 14.2 and 17) contained	RMHP must clarify any applicable policies and communicate with appropriate staff members to ensure that RMHP does not require preauthorization of urgent services.			

Table C-2—FY 2008–2009 Corrective Action Plan *for* RMHP				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
language that indicated a preauthorization requirement for urgent services. During the interview, RMHP staff clarified that the language in question was intended to describe processes for expedited requests for services and urgent requests from physicians for authorization of services rather than requests for urgently needed services.				
II. Access and Availability 5. The Contractor has a mechanism to allow members to obtain a second opinion from an appropriate, qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. **Findings:** The member handbook informed members that second opinions are covered and directed members to call customer service; however, the handbook did not inform members that second opinions are provided at no charge to members. The Access Plan stated that	RMHP must clarify the claims manual and any applicable policies to inform staff members that second opinions are available to members at no cost to the member. In addition, RMHP must notify members (via the member handbook or other appropriate member materials) that second opinions are available at no cost to them.			

Table C-2—FY 2008–2009 Corrective Action Plan *for* RMHP				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
members have a right to a second opinion and described how to arrange for one. The claims manual stated that if RMHP is unaware that the member sought a second opinion, a co-pay is charged, and if RMHP had encouraged the second opinion, then the co-pay should not be charged. RMHP staff members attempted to identify paid claims in the system that were second opinions, but they determined that the system was unable to specifically identify second opinions.				

Table C-2—FY 2008–2009 Corrective Action Plan *for* RMHP				
Standard	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents to be Submitted as Evidence of Completion**
IX. Subcontracts and Delegation 8. The Contractor ensures that any subcontractors have implemented and complied with each requirement with respect to use, disclosure, and protection of PHI. **Findings:** RMHP's monitoring of the three county social service departments and of Express Scripts did not include monitoring to ensure the delegates' compliance with HIPAA regulations (45 CFR Parts 160 and 164).	RMHP must revise its process for monitoring delegates that use member information to include an evaluation of the delegates' compliance with HIPAA.			

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

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

Table D-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG…
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the PIHP to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff provided an orientation on October 3, 2008, for the PIHP and the Department to preview the FY 2008–2009 compliance monitoring review process and to allow the PIHP to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives responded to questions from the PIHP related to the process and federal managed care regulations to ensure that the PIHP was prepared for the compliance monitoring review. HSAG maintained contact with the PIHP as needed throughout the process and provided information to the PIHP's key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the PIHP's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the PIHP's contract, dated April 14, 2005, to develop HSAG's monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the PIHP in writing of the desk audit request and sent a documentation request form and an on-site agenda. The PIHP had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the four standards. ◆ Documents requested included applicable policies and procedures, minutes of key PIHP committee or other group meetings, reports, logs, and other documentation. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

Table D-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the PIHP's key staff members to obtain a complete picture of the PIHP's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the PIHP's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents needed that HSAG identified during its desk audit. ◆ HSAG requested and reviewed additional documents needed that HSAG identified during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with PIHP staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 2008–2009 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions to be required of the PIHP to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2008–2009 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the PIHP for review and comment. ◆ HSAG coordinated with the Department to incorporate the PIHP's comments and finalize the report. ◆ HSAG distributed the final report to the PIHP and the Department.