COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Rocky Mountain Health Plans Prime

May 2017

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, with revisions published May 2016, requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for Colorado's managed care plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the FY 2016–2017 site review activities for the review period of January 1, 2016, through December 31, 2016. For each of the three standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 contains graphical representations of results for all standards across two three-year cycles. Section 3 describes the background and methodology used for the 2016–2017 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2015–2016 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2016–2017 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

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

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

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I. Coverage and Authorization of Services	34	34	32	2	0	0	94%
II. Access and Availability	13	13	13	0	0	0	100%
XI. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	13	13	12	1	0	0	92%
Totals	**60**	**60**	**57**	**3**	**0**	**0**	**95%**

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

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

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	59	53	6	41	90%
Totals	**100**	**59**	**53**	**6**	**41**	**90%**

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

RMHP Prime's Care Management Program Description and Preauthorization of Services policy and procedure described the processes and criteria **RMHP Prime** used to ensure that services provided are medically necessary and appropriate, are cost-effective, and conform with the benefits of the plan. The Care Management Program Description described the reporting structure and delineated the roles and responsibilities of all persons involved in the process, from the chief medical officer and licensed nursing staff to the data analysts and census coordinators. These processes clearly communicated that all decisions to deny services based on medical necessity are to be made by a person with appropriate clinical expertise. The Clinical Criteria for Utilization Management (UM) Decisions policy and procedure describes the criteria used to make decisions of medical necessity as including MCG Health evidence-based care guidelines, Medicaid directives and bulletins, and **RMHP Prime**'s own clinical policies. **RMHP Prime**'s policies state, and staff members confirmed, that UM staff participate in annual inter-rater reliability testing. Any staff member who receives a score of less than 100 percent undergoes additional training. As needed, UM staff members also meet as a group to review and discuss individual cases.

The Preauthorization of Services policy and procedure provided staff with detailed instructions and time frames for processing both standard and expedited authorization requests and included the rules governing time frame extensions. The policy described the processes for providing notice to both the member and the requesting provider and for offering the requesting provider a peer-to-peer review. The policy described the content that must be included in notices of action. On-site record reviews demonstrated that **RMHP Prime** met the time frame requirements and that notices of action included required information written using easy-to-understand language.

RMHP Prime included in the member handbook, provider manual, and its Emergency Services policy and procedure definitions of "emergency medical conditions and services" consistent with both State and federal requirements. **RMHP Prime**'s member handbook: included examples of emergency medical conditions, stated repeatedly that no prior authorization is required for emergency services, and told members to call 9-1-1 or go to the nearest emergency room in such events. **RMHP Prime**'s member handbook also included an explanation of "poststabilization services" using appropriate, easy-to-understand language. **RMHP Prime**'s provider manual and its internal policies and procedures were compliant with all State and federal requirements. During the on-site interview, staff members articulated the requirements and processes consistent with the policies.

Summary of Findings Resulting in Opportunities for Improvement

RMHP Prime had a well-defined mechanism for consulting with providers prior to making authorization decisions. If the requesting provider is not immediately available, an **RMHP Prime** staff member leaves a message informing the provider that he or she has five days to request a post-denial consultation. **RMHP Prime**'s notice of action—mailed to the member and copied to the provider—

stated that providers have up to five days to request a peer-to-peer review. HSAG reminded staff that every post-denial re-determination for a Medicaid Prime service must be treated as an appeal. **RMHP Prime** should ensure that its provider consultation process is compliant with federal regulations concerning appeals (reviewed in another standard) when considering a post-denial redetermination. Furthermore, HSAG recommends that **RMHP Prime**, when in doubt about information provided, more assertively contact a provider prior to making a denial decision.

RMHP Prime's Preauthorization of Services policy and procedure clearly and accurately described the time frames associated with UM decisions and notices of action. **RMHP Prime** also provided UM staff members with a grid that clearly delineated time frames for each line of business. However, the time frames presented in **RMHP Prime**'s Timeliness of UM Decisions policy were inconsistent with time frames presented in the Preauthorization of Services policy and the Preauthorization Turnaround Times and Notification Requirements grid and with those required under federal and State regulation. Although the policy included a statement referencing time frames that reads, "If State or Federal regulations shorten the time frames above, those would be followed," HSAG cautions that this statement could be overlooked and therefore result in noncompliance and/or staff confusion. HSAG suggests that **RMHP Prime** both revise the Timeliness of UM Decisions policy to more clearly indicate that time frames for Medicaid Prime UM decisions differ from those required for Medicare and commercial lines of business and provide clear instruction about where to find appropriate time frames.

Two of ten records reviewed on-site were cases in which **RMHP Prime** denied payment for skilled nursing. Both denial letters stated that skilled nursing was not a covered benefit and that "the member is responsible for payment." While skilled nursing may not be a benefit covered under the **RMHP Prime** plan, it could be covered under Medicaid fee-for-service. HSAG recommends that **RMHP Prime** modify its notice of action to include information on how the member can obtain services not covered under the **RMHP Prime** plan, but which may be covered by Medicaid fee-for-service).

Summary of Findings Resulting in Required Actions

RMHP Prime's Preauthorization of Services policy accurately described the content that must be included in notices of action, and on-site record reviews demonstrated compliance. However, two of ten records reviewed on-site were cases in which **RMHP Prime** denied payment for skilled nursing. Both denial letters stated that skilled nursing was not a covered benefit and that "the member is responsible for payment." This is incorrect information. While the health plan may deny payment to the provider, Medicaid members are not liable for payment of services. **RMHP Prime** must remove from the denial letter information which implies that the member is liable for payment.

RMHP Prime's policies and procedures described the process for notifying the requesting provider and member of any decision to deny a service or to authorize less than what is requested; however, for two of the 10 denial records reviewed on-site, **RMHP Prime** failed to notify the member of the denied payment. **RMHP Prime** must ensure that it provides members with notice of any decision to deny payment.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

RMHP Prime provided numerous documents that described its processes to maintain a network of providers adequate to meet the needs of its membership. **RMHP Prime** demonstrated that it considers anticipated enrollment; expected utilization; numbers, types, and specialties of providers; physical access for members with disabilities; and the geographic location of providers in relation to members. **RMHP Prime** allowed members direct access to all in-network providers and specialists and had procedures to provide members with adequate and timely access to out-of-network providers if and when in-network providers and services were not available.

RMHP Prime's policies accurately described the standards for timely access to care. **RMHP Prime** used its provider manual, provider newsletters, and website to notify providers of requirements related to hours of operation, scheduling guidelines, and standards for access to care. **RMHP Prime** monitored providers' adherence to access and availability requirements through use of audits, surveys, and member grievances. **RMHP Prime** also informed members about appointment availability standards using the member handbook and newsletters.

In addition to mandatory, annual cultural competency training for all staff members, **RMHP Prime** required that staff members who interact with members (e.g., care managers) participate in additional cultural competency training. **RMHP Prime**'s provider manual included a link to web-based training for which physicians may earn continuing education credit. The provider manual also included a link to the US Department of Health & Human Services Office of Minority Health's *Think Cultural Health* website, which offers articles, presentations, and newsletters related to ensuring culturally and linguistically appropriate health care services. **RMHP Prime**, in collaboration with the Colorado Cross-Disability Coalition (CCDC), has provided disability competency care training for more than 200 providers and those providers' staff members.

RMHP Prime provided member materials and interpreter services for members with limited English proficiency. During the site review, staff members discussed with reviewers a series of meetings with the deaf community in Larimer and Mesa Counties and how **RMHP Prime** can better meet the needs of this community. **RMHP Prime** staff members stated that **RMHP Prime** remains alert to and open concerning opportunities to learn more about the cultural needs within communities throughout its region, and to addressing those needs.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to access and availability.

Summary of Findings Resulting in Required Actions

HSAG identified no required actions for this standard.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

Summary of Strengths and Findings as Evidence of Compliance

RMHP Prime had a comprehensive EPSDT policy that included State and federal requirements, described the processes for informing providers and members about the benefits of the EPSDT program, and delineated the responsibilities of **RMHP Prime** staff members. **RMHP Prime** informed members about the benefits available under the EPSDT program using the member handbook, member newsletters, and well-care birthday card reminders and also reminders to those members identified as being past due for recommended well-care visits. These materials tell members why wellness visits are so important and delineate what to expect during well-care visits. EPSDT-specific information tells members about "special" coverage, delineates specific tests and screenings that children might be eligible for, and encourages members to ask their providers whether or not their children need any listed tests or screenings.

The EPSDT policy stated that **RMHP Prime** had implemented the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule. **RMHP Prime** included the AAP Bright Futures periodicity schedule in the member handbook and the provider manual. **RMHP Prime**'s website included links to the periodicity schedule and to additional EPSDT information available on the Department's website. **RMHP Prime**'s provider manual and website also included information about Healthy Communities and offered website links for any provider wishing to obtain additional information.

RMHP Prime conducted a study to compare data collected from the Health Information Exchange (HIE) with data collected during medical record review to determine the extent to which records from HIE can be used to monitor compliance with components of a comprehensive EPSDT examination. To monitor components of EPSDT screenings, **RMHP Prime** expected to supplement this baseline data with information gathered during discussions with providers. **RMHP Prime** staff stated that this combined collection of data and provider information will allow **RMHP Prime** to determine the most comprehensive and efficient approach for monitoring compliance with the EPSDT periodicity schedule.

Summary of Findings Resulting in Opportunities for Improvement

RMHP Prime should note that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that **RMHP Prime** update its EPSDT policies to include the comprehensive definition of "medical necessity" as outlined in the Findings section of Standard I, Element 4 of the compliance monitoring tool (as found in Appendix A).

At the time of on-site review, **RMHP Prime** was engaged in testing mechanisms to efficiently monitor compliance with the EPSDT periodicity schedule. HSAG recommends that **RMHP Prime** expedite implementation—beyond the testing mode—for monitoring and analysis of compliance with the EPSDT periodicity schedule.

Summary of Findings Resulting in Required Actions

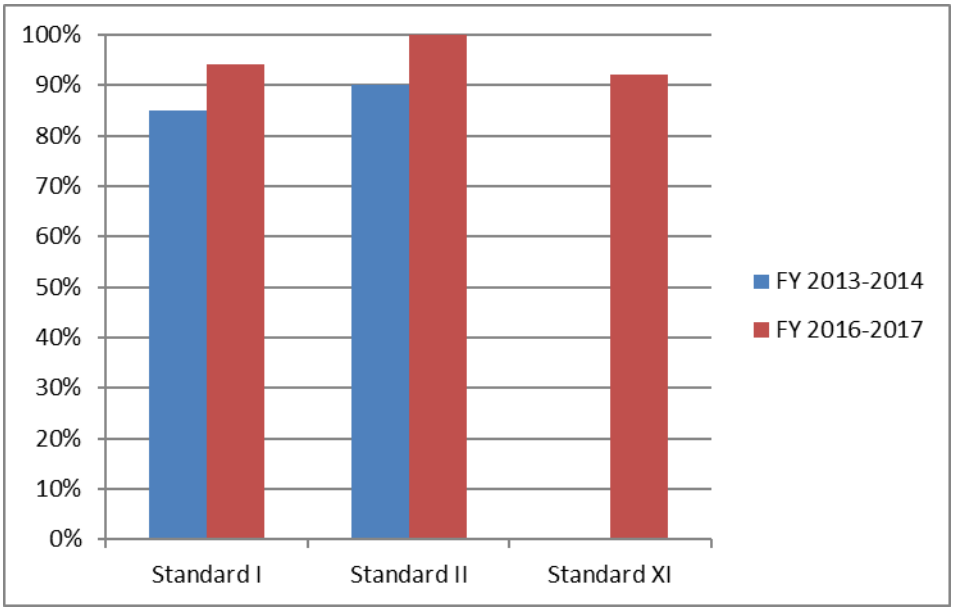
Through use of the provider manual and website, **RMHP Prime** notified providers about EPSDT benefits and the requirement that providers adhere to the AAP Bright Futures periodicity schedule; however, these mechanisms generally prove to be stagnant resources. While **RMHP Prime** did include EPSDT information in a provider newsletter, this newsletter was released late in the review period. **RMHP Prime** must develop and implement systematic—i.e., regular and periodic—communications with network providers regarding the Department's EPSDT requirements surrounding and provision of periodic health screens. **RMHP Prime** might consider approaches such as requesting feedback on EPSDT performance measures or offering a quarterly provider webinar series incrementally focused on different components of the EPSDT program.

Comparison of Results

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Figure 2-1 shows the scores from the FY 2013–2014 site review (when Standard I and Standard II were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **RMHP Prime**'s contract with the State did change in July 2014, and may have contributed to performance score changes noted in FY 2016–2017.

Figure 2-1—Comparison of FY 2013–2014 Results to FY 2016–2017 Results

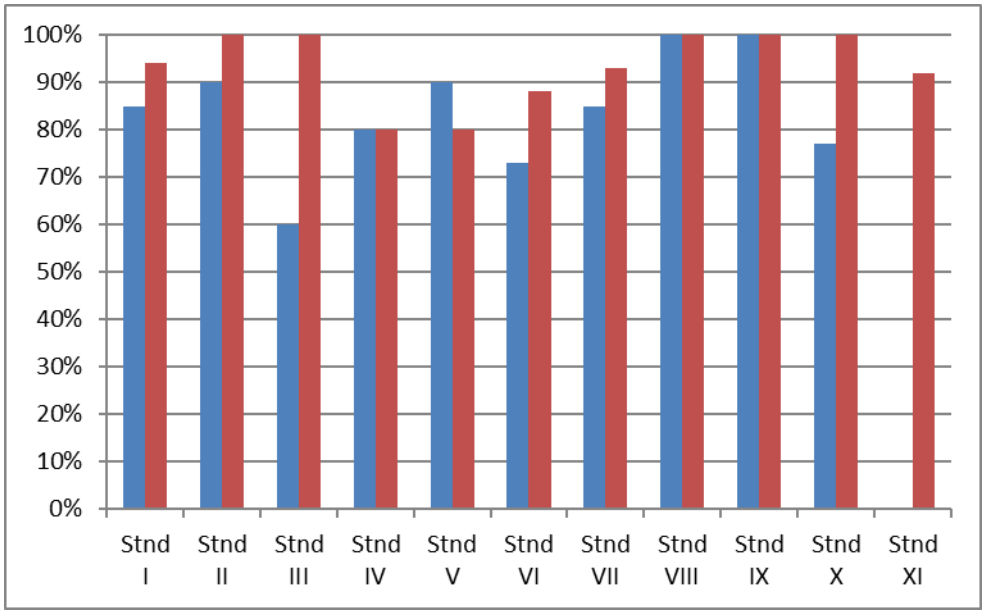


Note: FY 2016–2017 is the first year that HSAG reviewed Standard XI; therefore, results are shown for FY 2016–2017 only.

Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the last two three-year cycles of compliance monitoring. The figure compares the score for each standard across two review periods, as available, and may be an indicator of overall improvement. It should again be noted that performance score changes may be related to contract changes between review years.

Figure 2-2—Compliance Scores for All Standards



Note: Results shown in blue are from FY 2011–2012, FY 2012–2013, and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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

Table 2-1—List of Standards by Review Year

Standard	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
I—Coverage and Authorization of Services			X			X
II—Access and Availability			X			X
III—Coordination and Continuity of Care		X			X	
IV—Member Rights and Protections		X			X	
V—Member Information	X			X		
VI—Grievance System	X			X		
VII—Provider Participation and Program Integrity	X			X		
VIII—Credentialing and Recredentialing		X			X	
IX—Subcontracts and Delegation	X			X		
X—Quality Assessment and Performance Improvement		X			X	
XI—EPSDT Services						X

3. Overview and Background

Overview of FY 2016–2017 Compliance Monitoring Activities

For the fiscal year (FY) 2016–2017 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. FY 2016–2017 was the first year that the newly developed EPSDT standard was reviewed. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all three standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to health plan service and claims denials.

A sample of the health plan's administrative records related to Medicaid service and claims denials was reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable health plan Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012.[3-1] Appendix E contains a detailed description of HSAG's site review

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),*

activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2016–2017 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

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

Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Aug 24, 2016.

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

FY 2015–2016 Corrective Action Methodology

As a follow-up to the FY 2015–2016 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP Prime** until it completed each of the required actions from the FY 2015–2016 compliance monitoring site review.

Summary of FY 2015–2016 Required Actions

Based on the FY 2015–2016 site review, **RMHP Prime** was required to revised its policies to allow members to receive family planning services from any duly licensed provider, in or out of **RMHP Prime**'s network. This was the only required action for the review.

Summary of Corrective Action/Document Review

RMHP Prime submitted documents to demonstrate that it updated its policies to allow female members to obtain family planning services from any duly licensed provider, in or out of **RMHP Prime**'s network. HSAG and the Department reviewed the revised documents and determined that **RMHP Prime** had corrected the action.

Summary of Continued Required Actions

No required actions were continued from the FY 2015–2016 site review activities.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor 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. *42 CFR 438.210(a)(3)(i)* Prime Contract: Amendment 4, Exhibit A-3—3.5.1.1	*I_CM_Program Description 2016* Section 1, Program Overview: Care Management Program Scope & Philosophy, pages 1-2 describes that RMHP uses evidence based guidelines to ensure services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished. *2017 Provider Manual* The Preauthorization Policies and Procedures section, page 78 states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition. Further, RMHP may place appropriate limits on services so long as the limits allow for the services to be furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan. *I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 12, page 4 provides that as part of its procedure RMHP ensures services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor provides the same standard of care for all members regardless of eligibility category and furnishes services in an amount, duration, and scope that is no less than services furnished under fee-for-service Medicaid. *42 CFR 438.210(a)(2)* *(Requirement to be updated 7/2017—see appendix)* Prime Contract: Amendment 4, Exhibit A-3—3.5.1.2	*I_CM_Program Description 2016* Section 1, Program Overview, Care Management Program Scope & Philosophy, page 1 describes RMHP program of ensuring that medical services rendered to all Members regardless of line of business are medically necessary and/or appropriate, as well as in conformance with the benefits of the Plan. *I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 13, page 4, provides that RMHP provides the same standard of care for all members regardless of eligibility category and furnishes all services in amount, duration and scope that is no less than services furnished to non-Medicaid or CHP+ members within the same area.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. Utilization Management shall be conducted under the auspices of a qualified clinician. Prime Contract: 3.9.1.6	*I_CM_Appropriate Professionals for CM and Pharmacy 2016* This document describes that RMHP Utilization Management and Pharmaceutical medical necessity decisions are made by qualified health professionals through assessment of relevant clinical information. RMHP requires appropriately licensed professionals with an unrestricted license to supervise all medical necessity decisions. *I_CM_Program Description 2016* Section II, Program Reporting/Structure/Participants, page 3 describes that the RMHP Board of Directors (BOD) delegate decision making authority for the CM Program to the RMHP CMO. The CMO, Associate Medical Directors, Medical Advisory Council (MAC) and the Director of CM are responsible for administering the CM Program. The Pharmacy Director is responsible for administering the PM Program and related pharmacy benefits.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. 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. *42 CFR 438.210(a)(3)(ii)* Prime Contract: Amendment 4, Exhibit A-3—3.5.1.3	*2017 Provider Manual* The Preauthorization Policies and Procedures section, page 78 states that RMHP will 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. *I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 15.a., page 4 provides that RMHP does not arbitrarily deny or reduce the amount, duration of scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. 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 purposes. *42 CFR 438.210(a)(3)(iii)* *(Requirement to be updated 7/2017—see appendix)* Prime Contract: Amendment 4, Exhibit A-3—3.5.2.1.1	*2017 Provider Manual* The Preauthorization Policies and Procedures section, page 78 states that RMHP may place appropriate limits on services so long as the limits allow for the services to be furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan. *I_CM_Clinical Criteria for UM Decisions 2016* Sections I, II and III, pages 1-3 of this policy describes RMHP's intent to apply objective and evidence-based criteria when determining medical appropriateness (necessity) of health care services (page 1). Specific criteria utilized in decision making for Medicaid includes Medicaid coverage guidance found in Medicaid Directives and Bulletins published by HCPF (pages 2-3)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_CM_Preauthorization Policy & Procedure Section 6.0, Paragraph 15.e., page 5 provides that RMHP may place limits on service, but only on the basis of criteria applied under the State plan (medical necessity) or for purposes of utilization control.	
6. The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. – Is provided in accordance with professionally recognized standards for healthcare in the United States. – Is clinically appropriate in terms of type, frequency, extent, site, and duration. – Is not primarily for the economic benefit of the provider or primarily for the convenience of the member, caretaker, or provider. – Is delivered in the most appropriate setting(s) required by the member's condition. – Is not experimental or investigational.	*I_CM_Program Description 2016* Section 1, Program Overview, Care Management Program Scope & Philosophy, page 1 describes that RMHP's CM program is designed to ensure that medical services rendered to all Members regardless of line of business are medically necessary and/or appropriate, as well as in conformance with the benefits of the Plan. Section VI, Care Management Criteria, page 13 describes RMHP's use of nationally accepted evidence-based guidelines that span the continuum of care, such as MCG Care Guidelines and other nationally established criteria established by organizations such as the American Academy of Obstetrics, Gynecology or Pediatrics. Use of these criteria ensures that RMHP provides services in accordance with professionally recognized standards for healthcare in the United States. *I_CM_Clinical Criteria for UM Decisions 2016* Section II, pages 1-2, provides that RMHP applies written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services, and that RMHP clinical policies will be sound and based upon analysis of clear,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Is no more costly than other equally effective treatment options. • 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. *42 CFR 438.210(a)(4)* *(Requirement to be updated 7/2017—see appendix)* Prime Contract: Amendment 4, Exhibit A-3—3.9.1.1 and 1.1.7.1 through 1.1.7.7	professionally recognized evidence of effectiveness, and will be financially responsible. *2017 Provider Manual* The RMHP/Prime/CHP+ Members section, page 53 provides that a "Medically Necessary" health care good or service will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects, of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. Medical necessity means that a good or service: • Is clinically appropriate in terms of type, frequency, extent, site, and duration; • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider; • Is delivered in the most appropriate setting(s) required by the client's condition; • Is not experimental or investigational; and • Is not more costly than other equally effective treatment options. *I_CM_Preauthorization Policy & Procedure* Section 4.0, page 2, provides the definition of "medical necessity" that comports with 42 CFR 438.210(a)(4).	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**

Findings:

RMHP Prime defined "medical necessity" equivalent to the definition included in its contract and outlined in this requirement. However, the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—created a uniform definition of "medical necessity" to be used across all applicable Medical Assistance programs and included the addition of EPSDT-specific criteria. Therefore, HSAG advises RMHP Prime to immediately update the definition of "medical necessity" accordingly. Please reference 10 CCR 2505-10 8.076.1.8 (a–g) and 8.7016.1.8.1 for guidance:

8.076.1.8. Medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
b. Is provided in accordance with generally accepted professional standards for health care in the United States.
c. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
e. Is delivered in the most appropriate setting(s) required by the client's condition.
f. Is not experimental or investigational.
g. Is not more costly than other equally effective treatment options.

8.076.1.8.1 For EPSDT-specific criteria, see 10 CCR 2505-10, Section 8.280.4.E.

"For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth in Section 8.076.1.8(b–g)."

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor has in place written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR 438.210(b)* Prime Contract: Amendment 4, Exhibit A-3—3.9.1.2.1	*I_CM_Preauthorization Policy & Procedure* This policy addresses the processing of requests for initial and continuing authorization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has in place and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* Prime Contract: Amendment 4, Exhibit A-3—3.9.1.2	*I_CM_Clinical Criteria for UM Decisions 2016* This document demonstrates that RMHP applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Section VII, pages 4-5 of this policy describes how RMHP annually assesses the consistency with which reviewers apply UM criteria in decision making and how it acts on opportunities to improve consistency, if applicable. *I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 15, pages 4-6, provides the written procedure for ensuring that criteria for authorization decisions are applied consistently.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42CFR 438.210(b)(2)(ii)* Prime Contract: Amendment 4, Exhibit A-3—3.9.1.2	*I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 22.b.ii., page 8 allows discussion with the attending physician, PCP or requesting physician to collect necessary information to make a preauthorization decision. Section 6.0, Paragraph 26, page 12, allows a requesting provider to request a peer-to-peer review to discuss an adverse determination.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor has in place and follows written policies and procedures that 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 healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. *42 CFR 438.210(b)(3)* *(Requirement to be updated 7/2017—see appendix)* Prime Contract: Amendment 4, Exhibit A-3—3.9.1.5	*I_CM_Appropriate Professionals for CM and Pharmacy 2016* Section III, page 3 describes the process for Practitioner Review of Nonbehavioral Healthcare Denials. Section V, page 4 describes the process for Use of Board-Certified Consultants in those instances where RMHP Clinical Pharmacists and Associate Medical Directors do not have clinical expertise in the areas for which services or pharmaceuticals are being requested. *I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 14, page 4 cross-references the Appropriate Professionals for CM and Pharmacy for ensuring that UM decisions are made by individuals with knowledge and skills to evaluate working diagnoses and proposed treatment plans.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has in place and follows written policies and procedures that 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). *42 CFR 438.210(c)* 10CCR2505–10, Sec 8.209.4.A.1 Prime Contract: Amendment 4, Exhibit A-3—4.1.1.4.2	*I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraphs 22 and 23, pages 8-11 describe the procedures RMHP has in place to notify requesting providers and members of decisions to deny or modify service authorization requests.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* 10CCR2505–10, Sec 8.209.4.A (3)(c) Prime Contract: Amendment 4, Exhibit A-3—4.1.1.4.5	*I_CM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decision. *I_CM_Preauth TAT's and Notification Requirements* This document is a grid of regulatory timeframes RMHP follows for notification of preauthorization decisions. The grid indicates that RMHP provides notice of standard authorization decisions within 10 calendar days. *I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 22.b.i., page 8 sets forth the timing for issuing a notice for a standard authorization decision. It indicates that RMHP shall make a determination and notify the covered person and the covered person's provider of the determination within 10 Calendar days after the receipt of the preauthorization request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. For cases in which a provider indicates, or the Contractor determines, that the standard authorization timeframe could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service. *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)* 10CCR2505–10, Sec 8.209.4.A (3)(c) Prime Contract: Amendment 4, Exhibit A-3—4.1.1.4.5.2	*I_CM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_CM_Preauth TAT's and Notification Requirements* This document is a grid of regulatory timeframes RMHP follows for notification of expedited preauthorization decisions. *I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 22.c., pages 9-10 sets forth the process for issuing a notice for an authorization decision within 3 working days of receipt of the request for those instances when the member's condition requires an expedited decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b)and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* 10CCR2505–10, Sec 8.209.4.A.1 Prime Contract: Amendment 4, Exhibit A-3—4.1.1.3.3	*I_CM_Sample Denial Letter MD AND CHP+* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_CM_MD and CHP Appeal Language* This document demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. This "appeal language" is sent with every *CM Sample Denial Letter MD and CHP+*. *I_PH_ROC-MCAID_CHP+-DENY-PHM11* This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_CM_Preauthorization Policy & Procedure* Section 6, Paragraph 23.a., pages 10-11, provides that notification will be provided to a member in writing in a manner calculated to be understood by the member, and that the notice will be available in English and prevalent non-English languages spoken by members throughout the State.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. Notices of action must contain: • The action the Contractor (or its delegate) has taken or intends to take. • The reasons for the action. • The member's or provider's (on behalf of the member) right to file an appeal and procedures for filing. • The date the appeal is due.	*I_CM_Sample Denial Letter MD AND CHP+* This letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) in the below sections: • Why are you getting this letter • Our Decision	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's right to a State fair hearing. • The procedures for exercising the right to a State fair hearing. • The circumstances under which expedited resolution is available and how to request it. • The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. • The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42 CFR 438.404(b)* *(Requirement to be updated 7/2017—see appendix)* 10CCR2505–10, Sec 8.209.4.A.2 Prime Contract: Amendment 4, Exhibit A-3—4.1.1.4.2.2	*I_CM_MD and CHP Appeal Language* This document demonstrates that RMHP meets the information requirements of 42 CFR 438.404(b) in the following sections: • What you can do • Your right to a State Fair Hearing • There are Two Kinds of Appeal • Your Right to Ask That Your Benefits Continue During Your Appeal *I_PH_ROC-MCAID_CHP+-DENY-PHM11* This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b). *I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 23.b., page 11, describes the content of notices of action and includes the entire list of regulatory requirements.	
Findings: RMHP Prime's Preauthorization of Services policy accurately described the content that must be included in notices of action, and on-site record reviews demonstrated compliance. However, two of ten records reviewed on-site were cases in which RMHP Prime denied payment for skilled nursing. Both denial letters stated that skilled nursing was not a covered benefit and that "the member is responsible for payment." This is incorrect information. While the health plan may deny payment to the provider, Medicaid members are not liable for payment of services. In addition, while the benefits are not covered under the RMHP Prime plan, they may be covered under Medicaid fee-for-service; and the member should be provided information on how to obtain such services. HSAG recommends that RMHP Prime modify its notice of action (when denying payment for services not covered under the RMHP Prime plan but which may be covered by Medicaid fee-for-service) to include information on how the member can obtain the service. Furthermore, RMHP Prime must remove from the denial letter information which implies that the member is liable for payment.		
Required Actions: RMHP Prime must remove from the denial letter information which implies that the member is liable for payment.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except: – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands that service termination or reduction will occur. o The member has been admitted to an institution in which the member is ineligible for Medicaid services. o The member's address is determined unknown based on returned mail with no forwarding address. o The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.	*I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 22, page 8 incorporates the circumstances and timeframes by reference to Section 8.209 of State Medicaid Rules found in 10 CCR 2505-10. Section 6.0, Paragraph 4.a., page 3 indicates that for termination, suspension, or reduction of previously authorized Medicaid/CHP+-covered services, RMHP must notify the member at least 10 days before the date of action. Section 6.0, Paragraph 22.b.iv. (2) (d) page 9 indicates if RMHP fails to make a determination within the required timeframes in this section, it is deemed a denial, and RMHP will notify the Member of his/her appeal rights on the date the timeframe expires. Section 6.0, Paragraph 22.b.iv. (2) (a) page 9 provides that when RMHP requests an extension of the timeframe, RMHP will issue its decision and notify the member and the member's provider as expeditiously as the member's condition requires but no later than the date the extension expires. *2016_Internal Audit Report - Final* (This report will be available onsite upon request). Internal Audit tested the timeliness of a sample of Notices of Action/claim denial letters sent to Members. The NOA letters should be issued at the time the denial occurs. No instances of	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
○ A change in the level of medical care is prescribed by the member's physician. ○ The notice involves an adverse determination with regard to preadmission screening requirements. • For denial of payment, at the time of any action affecting the claim. • For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the time frame, as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.210 (d)* *42 CFR 438.404(c)* *42 CFR 431.211, 431.213, and 431.214* 10CCR2505–10, Sec 8.209.4.A.3 Prime Contract: Amendment 4, Exhibit A-3—4.1.1.4.3 through 4.1.1.4.5	untimely denial decisions or untimeliness of NOA letters were found in the samples reviewed.	
Findings: RMHP Prime's policies and procedures described the process for notifying the requesting provider and member of any decision to deny a service or to authorize less than what is requested; however, for two of the 10 denial records reviewed on-site, RMHP Prime failed to notify the member of the denied payment.		
Required Actions: RMHP Prime must ensure that it provides members with notice of any decision to deny a payment.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(2)* Prime Contract: Amendment 4, Exhibit A-3—4.1.1.4.5.1	*I_CM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decision. *I_CM_Preauth TAT's and Notification Requirements* This document is a grid of regulatory timeframes RMHP follows when it extends the standard or expedited decision timeframe. *I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 22.b.iii, and c.i.2., pages 8-9 describes the process for extending the standard or expedited authorization timeframe for up to 14 calendar days when the member requests an extension or RMHP justifies the need for an extension to the State.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. If the Contractor extends the time frame for making a service authorization decision, it: • Provides the member written notice of the reason for the decision to extend the time frame. • Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. *42 CFR 438.404(c)(4)(i)* 10CCR2505–10, Section 8.209.4.A.3 (c) (i) Prime Contract: Amendment 4, Exhibit A-3—3.9.1.1	*I_CM_Preauthorization Policy & Procedure* Section 6.0, Paragraph 22.b.iii, page 8 describes the content of the notice when RMHP extends the time frame for making a service authorization decision. The notice informs the member what information is necessary to complete the request, gives the member 14 days to provide it and provides notice that the member may file a grievance if the member disagrees with the decision to request an extension.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor has in place and follows written policies and procedures that provide that compensation to individuals or entities that conduct utilization management (UM) activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Prime Contract: Amendment 4, Exhibit A-3—3.9.1.1	*I_CM_Program Description 2016* Section 1, Program Overview, Care Management Program Scope & Philosophy, page 2 states that there are no financial incentives within the CM program or Physician, Practitioner and Provider contracts for denial of healthcare services. *I_CM_Appropriate Professionals for CM and Pharmacy 2016* Section VI, pages 4-5 describes RMHP's Affirmative Statement about Incentives.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The Contractor defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson 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. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—1.1.1.20	*I_CM_Emergency Services* Section II, A & B page 1 describes that RMHP Members can obtain needed emergency services in accordance with the prudent layperson standard. Page 2 of this policy includes the regulatory definition of "emergency medical condition." *2017 Provider Manual* Page 70 includes this regulatory definition of "emergency medical condition." *Prime Member Handbook* Page 10 informs Members about when to use the emergency room, describing the circumstances contained in the regulatory definition of "emergency medical condition" – written in a way that ensures ease of understanding.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—1.1.1.21	*2017 Provider Manual* Page 14 contains the definition of "Emergency/Life and Limb-Threatening Medical Care" including that emergency services means covered inpatient and outpatient services furnished by a provider qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition. *Prime Member Handbook* Page 13 defines emergency services for Members and informs that services for evaluation and stabilization are covered.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—3.5.4.1.4	*I_CM_Emergency Services* Section II specifies that RMHP covers emergency services provided by participating and non-participating practitioners and providers. *2017 Provider Manual* Page 53, Paragraph 5 provides that RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider. *Prime Member Handbook* Page 5 informs members that the requirement for obtaining care from doctors that work with RMHP does not apply to emergency care. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services, page 1. The Claims Manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services.	
23. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services. Prime Contract: Amendment 4, Exhibit A-3—3.5.4.1.2	*2017 Provider Manual* Pages 19 and 53 provide that members may receive emergency and urgent services while temporarily outside of the service area. *Prime Member Handbook* Pages 9 and 13 inform members that out of area emergency and urgent services are covered by RMHP. *2016 Prime Access Plan* Page 11 provides that members may receive emergency/urgent services while temporarily outside the service area.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor does not require prior authorization for emergency or urgently needed services. • The Contractor informs members that prior authorization is not required for emergency services. *42 CFR 438.10(f)(6)(viii)(B)* Prime Contract: Amendment 4, Exhibit A-3—3.5.4.1.3	*2017 Provider Manual* Page 19 provides that RMHP does not require prior authorization for emergency and urgently needed services. *I CM Program Description 2016* Section V, Page 10 states that RMHP does not require prospective review for urgent and emergent services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_CM_Preauthorization Policy & Procedure Section 6.0, Paragraph 6, page 3 provides that RMHP does not require prior authorization for emergency or urgently needed services. *Prime Member Handbook* In Case of Emergency section, page 9 informs members that they do not need an okay from RMHP to go to the emergency room for a true emergency.	
25. The Contractor may not deny payment for treatment obtained under the following circumstances: • A member had an emergency medical condition, and the absence of immediate medical attention ***would 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. • Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes:	*I_CM_Emergency Services* Section I provides that RMHP applies the prudent layperson standard to all emergency department services and will make payment for all such services, i.e., will not deny such claims for payment. Section II provides that RMHP will cover emergency department services when an authorized RMHP representative has authorized the provision of the services, e.g., advice nurse, physician, nurse practitioner, etc., directs the member to seek emergency services. *2017 Provider Manual* Page 70 defines emergent care and provides that RMHP will not deny payment for treatment obtained under the circumstances described in the regulation and contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– 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. *42 CFR 438.114(c)(1)(ii)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—3.5.4.1.4 and 3.5.4.3.1	*Prime Member Handbook* Pages 10 and 13 inform members about when to use the emergency room, explains the prudent layperson standard, and provides examples of when a person should go to the emergency room. Page 13 informs Members that these services are covered.	
26. The Contractor does not: • Limit what constitutes an emergency medical condition on the basis of 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 State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42 CFR 438.114(d)(1)* *(Requirement updated 7/2016—as shown)*	*I_CM_Emergency Services* Section I states that RMHP makes payment for all emergency department services at a claim processer level without medical necessity review. Appropriateness of services is assumed based on Prudent Layperson definition. RMHP does not refuse to cover emergency services due to lack of notification of the Member's presentation for emergency services. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Prime Contract: Amendment 4, Exhibit A-3—3.5.4.1.7 and 3.5.4.3.1	*Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services, page 1.* The Claims Manual states that these services are allowed (paid for) when rendered in an urgent care facility or in the emergency room. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services.	
27. The Contractor will be responsible for emergency services when: • The member's primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures. Prime Contract: Amendment 4, Exhibit A-3—3.5.4.7.2.1	*2017 Provider Manual* Page 70 provides that emergency services are covered by RMHP when a primary medical diagnosis with psychiatric conditions or procedures is present. *I_CL_BHO_Claims Manual_Screenshot* (available electronically onsite upon request) *Section 3: Behavioral Health Organization Criteria, Medical Specialties – Behavioral Health Organizations, pages 1 & 2.* The claims processing manual indicates that the following is the BHO responsibility: Any services, regardless of procedure code, billed with a primary diagnosis on the BHO Covered Diagnosis list. If not on this list it is Rocky Mountain Health Plans' Responsibility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. 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. *42 CFR 438.114(d)(2)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—3.5.4.1.6	*Prime Member Handbook* Page 13 defines Emergency Services to include services necessary to evaluate, (i.e., screen) and stabilize the Member. It is further explained that RMHP will provide the medically necessary covered care and services needed to continue to get better, referred to as "post-stabilization". Page 31 informs members that they have no copayment for emergency services provided in an emergency room. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) *Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services, page 1.* The Claims Manual states that RMHP allows (pays for) services rendered in an urgent care facility or in the emergency room and pays for all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
29. 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. *42 CFR 438.114(d)(3)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—3.5.4.1.5	*I_CM_Emergency Services* Section III provides that RMHP will cover emergency services until the attending physician or provider actually treating the member determines the member is sufficiently stabilized for transfer or discharge. *2017 Provider Manual* Page 53 provides that the attending emergency physician or provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge. *Prime Member Handbook* Page 13 informs members that the member's doctor will decide when the member receiving emergency services is ready for transfer or discharge.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
30. 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 provided to improve or resolve the member's condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—1.1.1.1.61	*I_CS_Poststabilization Services_Medicaid_CHP+* Section 4 contains the regulatory definition of poststabilization care. *Prime Member Handbook* Under "Emergency Services" on page 13, poststabilization care is explained to members, including that these are covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—3.5.4.4.1	*I_CS_Poststabilization Services_Medicaid_CHP+* RMHP does not require preauthorization for poststabilization care services. Section 3.0 provides that RMHP is financially responsible for poststabilization services obtained within or outside of the network that have been pre-approved by RMHP or its representative.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition under the following circumstances: • Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. • The Contractor does not respond to a request for pre-approval within 1 hour. • The Contractor cannot be contacted. • The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician; and	*I_CS_Poststabilization Services_Medicaid_CHP+* RMHP does not require preauthorization for poststabilization care services. Section 3.0 provides that RMHP is financially responsible for poststabilization services obtained within or outside of the network that have not been pre-approved by RMHP or its representative under all of the circumstances set forth in 42 CFR 438.114(e) and 42 CFR 422.113(c).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
the treating physician may continue with care of the patient until a plan physician is reached or the Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—3.5.4.4.1		
33. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer. • A plan representative and the treating physician reach an agreement concerning the member's care. • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—3.5.4.4.1	*I_CS_Poststabilization Services_Medicaid_CHP+* RMHP does not require preauthorization for poststabilization care services. Section 3.0 provides that RMHP's financial responsibility for poststabilization services it has not pre-approved ends when provided for in 42 CFR 438.114(e) and 42 CFR 422.113(c).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Prime Contract: Amendment 4, Exhibit A-3—3.5.4.4.1	*I_CS_Poststabilization Services_Medicaid_CHP+* Section 6.0 provides that member liability is limited to an amount no greater than what RMHP would charge the member if he or she had obtained the services through RMHP. *Prime Member Handbook* Page 13, Emergency Services, provides that member costs for poststabilization care rendered by a non-RMHP provider will be no more than what the member would have paid if treated by a RMHP provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	34	**Total Score**		=	32

Total Score ÷ Total Applicable	=	94%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services. In order for the Contractor's network to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows: • 1:2,000 primary care medical provider (PCMP)-to-members ratio. • 1:2,000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology, endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology. • Appropriate access to certified nurse practitioners and certified nurse midwives. • Physician specialists designated to practice internal medicine, gerontology, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either a PCMP or physician specialist, but not both. *42 CFR 438.206(b)(1)* *Requirement to be updated 7/2018—see appendix)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.1.2, 3.6.1.1.3, and 3.6.1.1.8	*2016 Prime Access Plan* Page 6 shows the provider to member ratio and distance/drive time requirements for primary care physicians and physician specialists. Page 2 includes nurse practitioners in the definition of primary care physician. Page 1 includes certified nurse midwives in the definition of ancillary service providers. Page 16 indicates that all providers will be included in either PCP or Specialist categories.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 healthcare 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 accepting/not accepting new Medicaid patients. • The geographic location of providers and Medicaid members, considering distance, travel time, and means of transportation ordinarily used by members. – Members have access to their choice of at least two PCMPs within their zip code or within thirty minutes' driving time from their location, whichever area is larger (excluding rural and frontier areas). • Physical access to locations for members with disabilities. *42CFR 438.206(b)(1)(i) through (v)* *Requirement to be updated 7/2018—see appendix)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.3.1, 3.6.1.3.2, 3.6.1.4.3, and 3.6.1.1.11	*2016 Prime Access Plan* Pages 2, 3, and 6 show that RMHP provides care within a reasonable travel time and distance to Members. *II_PR_2016 Availability of Practitioners Network Analysis* See page 37-38, and page 43 for Prime data and analysis. This document uses data from GeoAccess reports to monitor network adequacy to assure that providers are sufficient in number and accessibility based on current regulatory standards for distance and member/provider ratios for all provider networks. *2016 Prime Access Plan* Page 10 shows that RMHP monitors physical access for people with disabilities at PCP provider locations through office assessments. *II_QI_Annual Practice Quality Monitoring Report* This report is a summary of the activities and findings of the practice quality monitoring activity. Results of individual assessments are discussed with the medical directors when areas for improvement are identified. The results of this activity are reported annually to the Medical Advisory Council. *II_QI_Practice Quality Monitoring Template* Page 1 of this Office On-Site Evaluation Tool describes the specific elements that are reviewed at the office site where care is delivered to RMHP members to assess provider compliance with physical accessibility requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
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 healthcare services. This is in addition to the member's designated source of primary care if that source is not a women's healthcare specialist. *42 CFR 438.206(b)(2)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.1.5	*II_CM_P&P_Direct Access for OBGYN Care* This policy describes that RMHP provides for a female member to have direct access to a contracting obstetrician or gynecologist (OB/GYN) for her reproductive and gynecological care, and that the OB/GYN may serve as the woman's primary care provider. *2016 Prime Access Plan* Page 7 shows that female members have access, without referral, to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. *Prime Member Handbook* Page 6 informs Members that they may directly access women's healthcare specialists within the network.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor allows persons with special healthcare needs in need of a course of treatment or regular care monitoring to directly access a specialist as appropriate for the member's needs. • Mechanisms may include maintaining these types of specialists as PCPs or direct access/standing referrals to specialists. *42 CFR 438.208(c)(4)* Prime Contract: Amendment 4, Exhibit A-3—3.7.3.6	*2016 Prime Access Plan* Page 7 shows that persons with special healthcare needs have direct access to specialty care. *Prime Member Handbook* Page 2 describes the circumstances for direct and continuous access to doctors for Members with special health care needs.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain one outside the network if there is no other qualified health care professional within the network, at no cost to the member. *42 CFR 438.206(b)(3)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.1.7	*II_CM_Second Opinions_Out-of-Network Services 2017* Page 1, under Purpose, explains that RMHP provides for a second opinion from an in-network provider or arranges for the Member to obtain a second opinion outside the network. Page 3 describes the circumstances under which RMHP allows for and assists Members in obtaining a second opinion, and indicates that if the RMHP network is unable to provide necessary services, RMHP will adequately and timely cover these services out of network for the Member. *2017 Provider Manual* Page 17 in the Access/Availability Criteria – RMHP Prime/CHP+ section shows that RMHP covers one second opinion per medical condition without a referral and at no cost to the member. *2016 Prime Access Plan* Page 13 under Enrollee's Right to a Second Opinion shows that RMHP covers a second opinion per medical condition without a referral and at no cost to the member. *Prime Member Handbook* Page 18 informs members that second opinions are covered without cost and how to obtain one.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.2.1	*II_CM_Second Opinions_Out-of-Network Services 2017* Page 3 under Services Not Available in Network explains that if the RMHP network is unable to provide necessary covered services, RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. *2016 Prime Access Plan* Page 4 indicates that members may obtain covered services in a timely manner from out-of-network providers when RMHP has no participating providers who can provide a specific, medically-necessary covered service, or Members do not have reasonable access to a participating provider due to distance or travel time.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor coordinates with out-of-network providers 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. *42 CFR 438.206(b)(5)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.2.2	*II_CM_Second Opinions_Out-of-Network Services 2017* Page 3 under Services Not Available in Network explains that RMHP will coordinate payment with out-of-network providers to ensure that the cost to the member is no greater than it would be if the services were furnished in-network. *2016 Prime Access Plan* Page 4 shows that members may obtain covered services from out-of-network providers, subject to preauthorization, at the in-network benefit level. *II_ PR _ LOA Template2015 111315* This template shows an example of a Letter of Agreement (LOA) for out-of-network services. The provider's signature accepting the LOA indicates that there is agreement to accept RMHP's	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	reimbursement for services as payment in full for services rendered to the Member that are covered by the Member's health benefits plan, subject to the provider's right to collect applicable copayments and/or deductible from the Member.	
8. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary (e.g., emergency services). • Requires policy and procedures. *42 CFR 438.206(c)(1)(iii)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.4.3	*2016 Prime Access Plan* Page 6 shows that members have immediate access to emergency/life and limb-threatening medical and behavioral health care 24 hours a day, 7 days per week. *PR _ Physician(s) Medical Services Agreement (PMSA)* Page 13, Paragraph Y of this provider contract template shows that coverage for emergency medical services are available 24 hours per day, 7 days per week. *2017 Provider Manual* Pages and 86 inform PCPs of their obligations concerning provision of 24-hour coverage. Page 53 advises that urgent and emergent, life and limb-threatening care is available, without prior authorization, for all Members 24 hours a day, 7 days a week. *XI_Winter 2016 Member Newsletter* *II_MyDigitalMD Info for Members* These documents explain how to access MyDigitalMD to get direct access to Colorado doctors for urgent care using a computer or mobile device at no cost to the Member. MyDigitalMD is available to assist Members 365 days a year from 8:00 a.m. until midnight.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid fee-for-service if the provider serves only Medicaid members. • The Contractor's PCMP network shall provide for extended hours on evenings and weekends and alternatives for emergency room visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.4.1 and 3.6.1.4.2	*PR_ Physician(s)Medical Services Agreement (PMSA)* Page 13, Paragraph BB of this provider contract template shows that providers may not discriminate against any covered person enrolled in a publicly financed program, including limiting the hours of operation. *2017 Provider Manual* Pages 7 and 53 inform providers that they may not discriminate against any covered person enrolled in a publicly financed program, including the limiting of hours of operation in a manner which is less than is offered to Members of non-publically financed programs. *II_PR_Prime Provider Directory* Page 28 lists Urgent Care Centers throughout the state that offer care during extended hours, evenings and weekends as an alternative to emergency room treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services: • Urgently needed services are provided within 48 hours of notification of the PCMP or the Contractor. • Non-urgent, symptomatic care is scheduled within 10 days of the member's request for services.	*II_PR_Appt Wait Time Analysis 2016* This document shows that RMHP maintains an effective organizational process for monitoring appointment scheduling and wait times, analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues. *II_PR_P&P Appointment Wait Times* This document describes the process that RMHP uses to maintain an effective organizational process for monitoring appointment	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Adult, non-symptomatic well-care physical examinations are scheduled within 45 days. *42 CFR 438.206(c)(1)(i)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.5.2	scheduling and wait times, analyze data, identify areas of possible non-compliance, and formulate an action plan to address issues. *2016 Prime Access Plan* Page 6 shows that Members are offered an appointment for urgent care services, non-urgent symptomatic services, and, non-symptomatic well-care physical examinations within required timeframes. *2017 Provider Manual* Pages 18-19 show standards for timely access to care and services that providers are expected to meet for RMHP Prime and CHP+ Members.	
11. The Contractor communicates all scheduling guidelines to participating providers. Prime Contract: 3.6.1.5.4	*2017 Provider Manual* Pages 18-19 show standards for timely access to care and services that providers are expected to meet for RMHP Prime and CHP+ Members. *Fall 2016 Provider Newsletter* The 2016 Provider Newsletter, Fall edition contains a table showing Colorado Division of Insurance appointment wait time standards. These requirements are more stringent than Medicaid and CHP+ standards. The Newsletter was sent to all participating providers and was mailed September 1, 2016.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42 CFR 438.206(c)(1)(iv) through (vi)* Prime Contract: Amendment 4, Exhibit A-3—3.6.1.5.4	*II_PR_Appt Wait Time Analysis 2016* This document shows that RMHP maintains an effective organizational process for monitoring appointment scheduling and wait times, analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues. *II_PR_P&P Appointment Wait Times* This document describes the process that RMHP uses to maintain an effective organizational process for monitoring appointment scheduling and wait times, analyze data, identify areas of possible non-compliance, and formulate an action plan to address issues. *II_QI_Annual Practice Quality Monitoring Report* This report is a summary of the activities and findings of the practice quality monitoring activity. Results of individual assessments are discussed with the medical directors when areas for improvement are identified. The results of this activity are reported annually to the Medical Advisory Council. *II_QI_Practice Quality Monitoring Template* Pages 2-3 of the Office On-Site Evaluation Tool describe the specific elements that are reviewed at the office site where care is delivered to RMHP members to assess provider compliance with access to care and availability of appointment requirements. *Member Satisfaction with Primary Care Physician Survey* • *II_QI_2015_Provider Packets Sample*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *II_QI_Member Satisfaction Survey Timeline* • *II_QI_Methodology Satisfaction Survey* • *II_QI_Patient* Satisfaction Survey Sample Mbr • II_QI_Member Survey Analysis by BCat 20161115 • *Fall 2016 Provider Newsletter* Each year, Rocky Mountain Health Plans (RMHP) mails surveys to Members regarding specialist and primary care physician (PCP) visits. (PCPs and specialists are surveyed during alternate years). All of these documents together demonstrate how the Member Satisfaction survey is one of the mechanisms used to monitor Accessibility and Quality of Care provided to members by providers. The results are communicated to providers to help educate them about how members perceive things such as the timeliness of appointments. Pages 3-8 of the Member Survey Analysis by BCat illustrate results for all lines of business, including Prime (MD HMO) and CHP+ (CP HMO). Page 9 of the Member Survey Analysis by BCat summarizes the Medicaid results. Please note that this survey represents responses for both child and adult members. *II_CI_Prime Implementation Rapid Response Plan* This document sets forth RMHP's process for quickly addressing member issues, including access to care.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor participates in the State'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. (Includes policies and procedures, cultural competency training, and member communications.) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Prime Contract: Amendment 4, Exhibit A-3—3.7.4.3	*II_CM_Culturally Sensitive Services* This P&P describes RMHP's care management approach to addressing culturally sensitive and diverse Member populations. *II_QI_RMHP 2015 Annual Cultural and Linguistics Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of members and actions RMHP takes to meet those needs. Page 10 includes information about staff training that addresses Special Needs, Cultural Competency and Health Disparities and Employee Diversity Awareness Training. *II_CI_Disability Competent Care Training for Providers v4* RMHP coordinates with the Colorado Cross Disability Coalition (CCDC) to provide disability competent care training for providers across our region. Available resources are included in the resource toolkit (thumb drive) that is given to each participant. *I_CI_Disability Competent Care Training-Provider List* This is a listing of provider practices and numbers of individuals that have participated in Disability Competent Care training as of January 2017. *II_CI_Culturally_Disability Competent Resources for Providers_Screenshot*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This screenshot illustrates provider resources and information about providing culturally competent and disability competent care. *2016 Prime Access Plan* Pages 9-10 describe how RMHP addresses the needs of members with limited English proficiency, illiteracy, diverse cultural and ethnic backgrounds, and physical and mental disabilities**.** *2017 Provider Manual* Pages 93-94 describes cultural competency and provides direction to providers about where and how to complete cultural competency training. *Prime Member Handbook* Pages v-vi provides Members with RMHP's Multi-Language notice advising that language assistance services are available free of charge. Page vii provides Members with RMHP's Notice of Nondiscrimination, which explains how to obtain (1) documents in other formats, and (2) free auxiliary aids and services. All significant RMHP Member communications include notices of nondiscrimination and taglines that alert individuals with limited English proficiency and diverse backgrounds to the availability of language assistance services and documents in other languages/formats.	

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

Total Score ÷ Total Applicable	=	100%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
The Contractor must comply with the following requirements based on 42 CFR 441.50 to 441.62 effective October 1, 2015 and Code of Colorado Regulations 10 CCR 2505-10 8.280 effective April 30, 2016. Compliance References Contract: Amendment 4, Exhibit B-2—2.1.12.1 The Contractor must meet all State and federal requirements for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits under 42 CFR, Sections 441.50 through 441.61 and 10 CCR 2505-10, Section 8.280. (Services include comprehensive well-child examinations, immunizations, assessment, diagnosis and treatment, provision of benefit information, scheduling assistance, and case management.) Contract: Amendment 4, Exhibit A-3—3.7.5.2 The Contractor shall comply with all requirements of EPSDT rules at 42 CFR, Sections 441.50 through 441.61 to ensure that members have access to EPSDT benefits. Additional Resources State Medicaid Manual/Section 5: offers further detailed instructions and guidance regarding the various components of the EPSDT Program.		
1. The Contractor must have written policies and procedures for providing EPSDT services to members age 20 and under, including lead testing and immunizations. Prime Contract: Amendment 4, Exhibit B-2—2.1.12.1	*XI_CM_EPSDT Policy & Procedure* This document sets forth RMHP's policies and procedures for providing EPSDT services to eligible members, including lead testing and immunizations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor must notify members age 20 and under of the benefits and options for children and adolescents under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and is responsible for ensuring that children and their families are able to access the services appropriately. The Contractor must—	*XI_QI_Annual EPSDT Member Notification Process* This document describes RMHP's annual process for notifying eligible members and their caregivers, in clear and nontechnical language, of the Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefits.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provide a combination of written and oral methods to inform all eligible members (or their families) about the EPSDT program within 60 days of enrollment and annually thereafter. – Member communications must effectively inform those individuals who are blind or deaf or who cannot read or understand the English language. • Using clear and nontechnical language, provide information about the following— – The benefits of preventive healthcare. – The services available under the EPSDT program and where and how to obtain those services; (includes physical, mental, oral and substance abuse, as well as services that may have limits or services not covered in the state plan). – That the services under the EPSDT program are provided without cost to members 20 and under. – That necessary transportation and scheduling assistance for EPSDT services is available to members upon request, and the process to make a request. *42 CFR 441.56(a)(1)—(4)* 10 CCR 2505-10 8.280.8.D (1) Prime Contract: Amendment 4, Exhibit B-2—2.1.12.2	*XI_CI_Prime EPSDT_0-17* This letter was sent in 2016 to members with children under the age of 18 to inform them about the EPSDT program, including the services available to them without cost. The letter is sent in both English and Spanish. *XI_CI_Prime_EPSDT_18-20* This letter was sent in 2016 to members between the ages of 18-20 to inform them about the EPSDT program, including the services available to them without cost. The letter is sent in both English and Spanish. *XI_Winter 2016 Member Newsletter* *XI_Spring 2016 Member Newsletter* These issues of the Member Newsletter use clear and nontechnical language to provide information about the benefits of preventive healthcare. *XI_CS_Prime Welcome Call Script* Page 3, *Well Person* section of this script, demonstrates another oral method used to inform eligible members (or families) about EPSDT well person exams and screening and immunization services that are available at no cost. *Prime Member Handbook* Pages 23-26, "Keeping Your Child Healthy" explains the EPSDT program in clear non-technical language informing members about the benefits of preventive healthcare, what services are available and where and how to get them (including that scheduling assistance is available by contacting Family Health	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Coordinators/Healthy Communities), and that services are available at no cost. Pages ii, 4, 18 and 20 address how to obtain transportation. Pages i, iii, v, vi, and vii informs individuals who are blind or deaf or who cannot read or understand the English language how to obtain materials in alternate formats, and that RMHP provides free auxiliary aids and services to people with disabilities. The member handbook is sent to members within 60 days of enrollment. *XI_Winter 2017 Member Newsletter* Page 3 provides another written method for informing members about well child exams and that children through age 20 receive services under EPSDT. The newsletter directs members to the website and member handbook for more detailed information about EPSDT. *XI_CI_EPSDT Member Material – Website* This screenshot includes information about the EPSDT program and provides another method (electronic) to inform members about the program. *XI_CM_Process for Conducting EPSDT Gap Outreach* This document describes RMHP's process for developing and applying its method of accountability framework to EPSDT components. The document describes the measures, process, and intervention (oral and written as defined) to outreach to a population of ESPDT-eligible members.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Child Well-Care Reminders: • *XI_QI95_2016 Update_Baby Brochure* • *XI_QI96-A_2016 Update_12 Month Birthday Brochure* • *XI_QI100_2016 Update_3-6 Year Birthday Brochure* • *XI_QI108_2016 Update_18 Mos Immunization* • *XI_QI112_2016 Update_WCC Schedule New Baby* Educational flyers are sent to members throughout the year. Examples of these brochures and Member materials are included and referenced above.	
3. The Contractor must implement the American Academy of Pediatrics Bright Futures periodicity schedule. *42 CFR 441.58 (a) and (b)* 10 CCR 2505-10 8.280.4.A (1), 8.280.4.A (2) Prime Contract: Amendment 4, Exhibit A-3—3.7.5.2.2	*2017 Provider Manual* Pages 54-55 inform providers that RMHP has adopted, and providers are expected to follow, the AAP Bright Futures periodicity schedule. *Winter 2016 Provider Newsletter* Page 4 of this Provider Newsletter provides information about EPSDT and directs providers to RMHP's website that includes the recommended periodicity schedule. *XI_CI_EPSDT Provider Material – Website* Informs providers that RMHP has adopted, and providers are expected to follow, the AAP Bright Futures periodicity schedule. http://www.rmhpcommunity.org/epsdt *XI_CM_EPSDT Policy & Procedure* Page 3, Section 6.0, Paragraph I, indicates that RMHP has implemented the AAP Bright Futures periodicity schedule. *Prime Member Handbook*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	"Keeping Your Child Healthy," pages 23 and 24 inform members of the schedule for screenings set forth in the AAP Bright Futures periodicity schedule. Child Well-Care Reminders: • *XI_QI95_2016 Update_Baby Brochure* • *XI_QI96-A_2016 Update_12 Month Birthday Brochure* • *XI_QI100_2016 Update_3-6 Year Birthday Brochure* • *XI_QI108_2016 Update_18 Mos Immunization* • *XI_QI112_2016 Update_WCC Schedule New Baby* Educational flyers are mailed to members throughout the year that incorporate relevant provisions from the American Academy of Pediatrics Bright Futures periodicity schedule. Examples of these brochures and Member materials are included and referenced above.	
4. The Contractor must ensure the provision of all required components of periodic health screens to EPSDT beneficiaries who request it. Screening includes: • Comprehensive health and developmental history. • Comprehensive unclothed physical examination. • Appropriate vision testing. • Appropriate hearing testing. • Appropriate laboratory tests. – As defined in the periodicity schedule. – Lead toxicity blood screening between 36 and 72 months of age if not previously tested.	*XI_QI_EPSDT Medical Record Audit* Describes an audit of pediatric provider medical records that RMHP performed to determine the extent to which longitudinal records from the Health Information Exchange (HIE) system can assist with auditing medical record documentation to assess the completeness of EPSDT documentation. *XI_CM_EPSDT Policy & Procedure* Section 6.0, Paragraph I sets forth RMHP's procedure for preventive care and screening.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Dental screening services, including an assessment of mouth, oral cavity, and teeth; and referral to a dentist for children by 1 year of age or at the eruption of the first tooth. • Developmental screening to determine whether a child's emotional and developmental processes fall within a benchmarked range according to the child's age group and cultural background. Includes self-care skills, gross and fine motor development, communication skills or language development, social-emotional development, cognitive skills, and appropriate mental/behavioral health screening. • Health education and anticipatory guidance. • Screenings shall be performed by a provider qualified to furnish primary medical and/or mental health services. • Screenings shall be performed in a culturally and linguistically sensitive manner. • To avoid duplicate screening services, written verification that any age-appropriate screening services due under the periodicity schedule have already been provided. *42 CFR 441.56 (b)(i) through (vi) and 441.59 (b)* 10 CCR 2505-10 8.280.8.C; 8.280.4.A.3, 8.280.4.A.4 Prime Contract: Amendment 4, Exhibit A-3—3.7.5.2.2 and Exhibit B-2	*XI_CM_Process for Conducting EPSDT Gap Outreach* Page 5-6 includes the call script that asks if the child received various EPSDT components, with a care coordinator providing help as need. *2017 Provider Manual* Pages 54-55 sets forth for providers what must be included for a comprehensive screening. Page 55 informs providers that screenings should be performed by providers qualified to furnish primary medical and/or mental health services. They should be performed in a culturally and linguistically sensitive manner. If the PCMP is not equipped or licensed to provide the additional diagnosis or treatment, a referral should be made to the appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider. *PR_Physician(s) Medical Services Agreement (PMSA)* Exhibit B, page 3, Paragraph 2.K. of this provider agreement requires providers to comply with various policies and procedures, in particular, the Provider Manual. *2017 Provider Manual* Page 90 of the Provider Manual states that a PCP's responsibility is to arrange for copies of laboratory results and other health records to accompany the patients referred to specialty physicians and other service providers as appropriate in order to enhance continuity of care and to reduce the need for duplication of diagnostic procedures.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 92, under *Periodic Health Screening Examinations*, indicates that the primary care physician should make copies of pertinent tests, reports, and medical records and make them available to a consulting provider and document this in the medical record. Child Well-Care Reminders: • *XI_QI95_2016 Update_Baby Brochure* • *XI_QI96-A_2016 Update_12 Month Birthday Brochure* • *XI_QI100_2016 Update_3-6 Year Birthday Brochure* • *XI_QI108_2016 Update_18 Mos Immunization* • *XI_QI112_2016 Update_WCC Schedule New Baby* Educational flyers are mailed to members throughout the year that incorporate relevant provisions from the American Academy of Pediatrics Bright Futures periodicity schedule. Examples of these brochures and Member materials and referenced above.	
5. Results of screenings and examinations shall be recorded in the child's medical record. Documentation shall include, at a minimum, identified problems and negative findings and further diagnostic studies and/or treatments needed and the date ordered. 10 CCR 2505-10 8.280.4.A (5)	*2017 Provider Manual* Page 55 informs providers that they must record the results of screenings and examinations in the medical record and sets forth the minimum documentation requirements that comport with state regulation. *XI_QI_EPSDT Medical Record Audit* RMHP completed a baseline study to determine the extent to which longitudinal records from the Health Information Exchange (HIE) system can assist with auditing medical record documentation to assess the completeness of EPDST documentation. This document provides a summary of the findings regarding screenings and examinations that were recorded in the child's medical record.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The Contractor must provide diagnostic services in addition to treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedure—even if the services are not covered in the plan—including: • Diagnosis of and treatment for defects in vision and hearing, including eyeglasses and hearing aids. • Dental care at as early an age as necessary for relief of pain and infections, restoration of teeth, and maintenance of dental health. • Appropriate immunizations. (If determined at the time of screening that immunization is needed and appropriate to provide at the time of screening, then immunization treatment must be provided at that time.) *42 CFR 441.56 (c)* 10 CCR 2505-10 8.280.4.A (3) (e); 8.280.4.C (3) Prime Contract: Amendment 4, Exhibit A-3—3.7.5.2, 3.7.5.2.2; Exhibit B-2—2.1.12.1	*XI_CM_EPSDT Policy & Procedure* Section II.1.5, page 6 sets forth RMHP's procedure for referring members to diagnostic and treatment for all physical and mental illnesses or conditions discovered by any screening or diagnostic procedure – even if not covered in the plan – including those listed in 42 CFR 441.56(c). *2017 Provider Manual* Page 55 informs providers that medically necessary treatments for conditions discovered by any screening or diagnostic procedure – even if not covered by the plan, including appropriate vision and hearing testing and appropriate immunizations. *Winter 2016 Provider Newsletter* Page 4 of this Provider Newsletter advises providers that EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, hearing, vision, mental health, developmental, and specialty services. The article provides the RMHP website link for more detailed information, including the statement that additional health care services that are found to be medically necessary to treat, correct or ameliorate illnesses and conditions are covered regardless of whether the service is covered under the Colorado's State Medicaid Plan. *XI_CI_EPSDT Provider Material – Website* Informs providers of the obligation to provide diagnostic services in addition to treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedure – even if services are not covered in the plan, including those listed in 42 CFR 441.56(c). http://www.rmhpcommunity.org/epsdt	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. If the screening provider is not licensed or equipped to render necessary treatment or further diagnosis, the provider shall refer the individual to an appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider. 10 CCR 2505-10 8.280.4.C.2 Prime Contract: Amendment 4, Exhibit B-2—2.1.12.1	*2017 Provider Manual* Page 55 directs the provider to make a referral to the appropriate practitioner or facility or to Healthy Communities if the screening provider is not licensed or equipped to render necessary treatment or further diagnosis. *XI_CM_EPSDT_Care Coordination Activities By County* This document lists for each RMHP Prime county the entities that provide care coordination, the documentation systems used by the organization, and the activities performed. Essette is RMHP's care coordination documentation platform that allows RMHP to share assessments and care plans across Essette users.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor must employ processes to ensure timely initiation of treatment, if required, generally within an outer limit of six months after the request for screening services. *42 CFR 441.56 (e)*	*Member Satisfaction with Primary Care Physician Survey* • *II_QI_2015_Provider Packets Sample* • *II_QI_Member Satisfaction Survey Timeline* • *II_QI_Methodology Satisfaction Survey* • *II_QI_Patient* Satisfaction Survey Sample Mbr • II_QI_Member Survey Analysis by BCat 20161115 Each year, RMHP mails surveys to Members regarding specialist and primary care physician (PCP) visits. All of these documents together demonstrate how the Member Satisfaction survey is one of the mechanisms used to monitor Accessibility and Quality of Care provided to members by providers. The results are communicated to providers to help educate them about how members perceive things such as the timeliness of appointments. Pages 3-8 of the Member Survey Analysis by BCat illustrate results for all lines of business, including Prime (MD HMO) and CHP+ (CP HMO). Page 9 of the Member Survey Analysis by	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	BCat summarizes the Medicaid results. Please note that this survey represents responses for both child and adult members. *XI_QI_RMHP Child Medicaid_2016 CAHPS Survey* The CAHPS results are reviewed and analyzed annually to identify potential areas of opportunity for improving accessibility and availability of services. Pages 26-29 include the results of the Getting Needed Care and Getting Care Quickly questions. *XI_CM_Process for Conducting EPSDT Gap Outreach* Page 6, questions 7 and 8 include questions to gauge if children who have not received required EPSDT screenings have had problems getting care or have unmet needs and to provide referral assistance as necessary. *II_CI_Prime Implementation Rapid Response Plan* This document sets forth RMHP's process for quickly addressing member issues, including access to care. This process was used to ensure prompt resolution if a member indicated a problem getting care, and to monitor trends or global issues.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. A referral from the member's primary care physician may be required for care provided by anyone other than the primary care physician. • Members may self-refer for routine vision, dental, hearing, or mental health services; or family planning services. • Providers shall be responsible for obtaining prior authorization when required for identified services such as home health, orthodontia, private duty nursing, and pharmaceuticals. 10 CCR 2505-10 8.280.6 and 8.280.7 Prime Contract: Amendment 4, Exhibit B-2—2.1.12.1	*I_CM_Preauthorization Policy & Procedure* Section 6.0, page 3, Paragraph 5 provides that RMHP does not require a referral to see an in-network provider or specialist. Paragraph 7 states that preauthorization is not required for vision, dental, hearing, mental health or family planning services. Paragraph 9 indicates that it is the responsibility of the participating physician or vendor providing the service to obtain preauthorization when it is required. *2017 Provider Manual* Page 20 informs providers that RMHP does not require referral by a primary care physician for specialists, and that providers are responsible for obtaining prior authorization for those services requiring it. *Prime Member Handbook* Page 4 informs Members that they do not need a referral to see an in-network specialist. Page 5 informs Members that their PCP can arrange care when it is subject to preauthorization. Page 6 informs members that mental health services are covered by the BHO and how to contact the BHO. Page 26 informs Members that dental services are not covered by RMHP and explains how to get therm. Page 32 informs Members that they do not need a referral to obtain family planning services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor defines "Medical Necessity for EPSDT Services" as: • A service that is found to be equally effective treatment among other less conservative or more costly treatment options, and • Meets one of the following criteria: – The service is expected to prevent or diagnose the onset of an illness, condition, or disability. – The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. – The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability. – The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living. • May be a course of treatment that includes observation or no treatment at all. – The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements: o The service is medically necessary.	*XI_CM_EPSDT Policy & Procedure* Section 4.0, page 2 contains RMHP's definition of "medical necessity for EPSDT services," which comports with the definition set forth in regulation and the contract.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
o The service is in accordance with generally accepted standards of medical practice. o The service is clinically appropriate in terms of type, frequency, extent, and duration. o The service provides a safe environment or situation for the child. o The service is not for the convenience of the caregiver. o The service is not experimental and is generally accepted by the medical community for the purpose stated. *42 CFR 441.57* 10 CCR 2505-10 8.280.1, 8.280.4.D and E Prime Contract: Amendment 4, Exhibit B-2—1.1.7.8		
Findings: The EPSDT policy and the Care Management Preauthorization of Service policy included this EPSDT-specific definition and criteria. RMHP Prime should note that the definition of "medical necessity" outlined in the State Medicaid plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that RMHP Prime incorporate the definition of "medical necessity" as outlined in the Findings section of Standard I, Element 4, of this tool.		

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor must provide a case management system and coordination with other providers to ensure that members receive covered services. Prime Contract: Amendment 4, Exhibit B-2—2.1.12.3	*XI_CM_EPSDT_Care Coordination Activities By County* This document lists for each RMHP Prime county the entities that provide care coordination, the documentation systems used by the organization, and the activities performed. Essette is RMHP's care coordination documentation platform that allows RMHP to share assessments and care plans across Essette users. *XI_CM_PM Post Discharge Campaign UM Data V3(16)* This document illustrates the process for referring members discharged from the hospital to case management, when appropriate. *XI_CM_PM ER Follow Up Campaign Workflow-30 Day FU 071916* This document illustrates the process for referring members to case management when appropriate (e.g., high risk discharge, no PCP, high ER utilizers, non-acute situations).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor must provide referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • The Contractor must make appropriate use of State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Health Care Program for Children with Special needs. Further, the Contractor should make use of other public health, mental health, and education programs and related programs such as Head Start, Title XX (Social Services) programs,	*XI_CM_EPSDT Policy & Procedure* Pages 6-7, Section III, Paragraphs 2 and 3 sets forth how RMHP provides referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. *Prime Member Handbook* Page ii provides information to members about how to contact Healthy Communities EPSDT Family Health Coordinator and social services. Page 4 explains how to get help to arrange transportation. *XI_CM_Process for Conducting EPSDT Gap Outreach*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
and the Special Supplemental Food Program for Women, Infants and Children (WIC). – Includes Child Find, Early Intervention Colorado, and the Accountable Care Collaborative. • The Contractor must offer, and provide if the member/family requests, assistance with transportation and assistance with scheduling appointments for services. • The contractor must have a process to ensure that medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. – Also includes support services available through local public health departments and Healthy Communities. *42 CFR 441.61 and 441.62* 10 CCR 2505-10 8.280.8.D Prime Contract: Amendment 4, Exhibit B-2—2.1.12.1 and Exhibit A-3—3.5.4.8.2	Page 3 provides that one of the goals for this outreach process is to provide referral assistance. The data collection instrument on pages 5 and 6 includes questions to identify potential areas of need for assistance. *XI_CM_EPSDT Training* This training is for the Care Management Department to help staff understand EPSDT and its applicability to their work, including referral assistance.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor ensures provision of all required components of periodic health screens through: • Systematic communication with network providers regarding the Department's EPSDT requirements. • A proactive approach to ensure that eligible members obtain EPSDT screens. • A process to measure and ensure compliance with the EPSDT schedule. • Complying with all reporting requirements and data needs for federal reporting. 10 CCR 2505-10 8.280.8.D (2), (3), (4), and (6) Prime Contract: Amendment 4, Exhibit B-2—2.1.12.1 and Exhibit A-3—3.5.4.8.2 and 5.6.2	*2017 Provider Manual* Pages 54-55 inform providers about EPSDT program requirements. *Winter 2016 Provider Newsletter* Page 4 of this Provider Newsletter provides information about the Department's EPSDT requirements, and lists the RMHP website link for more detailed information. *XI_CI_EPSDT Provider Material – Website* Informs providers about the Department's EPSDT program requirements. http://www.rmhpcommunity.org/epsdt *XI_CS_Prime Welcome Call Script* Page 3 informs members about well-child visits available under EPSDT. *XI_CM_Process for Conducting EPSDT Gap Outreach* This document describes the process RMHP developed to establish a measurement and intervention process to outreach to children who did not receive a required EPSDT preventive medical screening in order to close gaps in EPSDT services and provide referral assistance as necessary. *XI_QI_EPSDT Medical Record Audit* This document describes a process RMHP implemented to measure and ensure compliance with the EPSDT schedule. A baseline study was completed to determine the extent to which longitudinal records from the Health Information Exchange (HIE) system can assist with auditing medical record documentation to assess the completeness of EPDST documentation. This document provides a summary of the findings regarding screenings and examinations that were recorded in the child's medical record.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Child Well-Care Reminders: • *XI_QI95_2016 Update_Baby Brochure* • *XI_QI96-A_2016 Update_12 Month Birthday Brochure* • *XI_QI100_2016 Update_3-6 Year Birthday Brochure* • *XI_QI108_2016 Update_18 Mos Immunization* • *XI_QI112_2016 Update_WCC Schedule New Baby* Educational flyers and immunization incentives are sent out to members throughout the in a proactive effort to encourage members to receive EPSDT services in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule. Examples of these brochures and incentives are included and referenced above. *XI_CMS_416_EPSDT_10012014_09302015* This report documents that RMHP complies with all reporting requirements and data needs for federal reporting. Note: RMHP will provide the report covering 2016 data onsite. It will be submitted to the Department on February 1st.	
Findings: RMHP Prime conducted the first phase of a study to identify a comprehensive and efficient mechanism to ensure compliance with the EPSDT schedule using data from the Health Information Exchange (HIE). Staff members provided reports that demonstrated RMHP Prime's compliance with federal reporting requirements. RMHP Prime proactively reached out to members using the member handbook, website, quarterly newsletters, and annual mailings to educate about the availability of EPSDT services and benefits and how to obtain them. Through use of the provider manual and website, RMHP Prime notified providers about EPSDT benefits and the requirement that providers adhere to the AAP Bright Futures periodicity schedule; however, these communication mechanisms generally prove to be stagnant resources. While RMHP Prime did include EPSDT information in a provider newsletter, this newsletter was released late in the review period.		
Required Actions: RMHP Prime must enhance and implement effective "systematic"—i.e., regular and periodic—communications with network providers regarding the Department's EPSDT requirements and provision of periodic health screens.		

Standard XI—EPSDT Services							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	13	**Total Score**		=	12

Total Score ÷ Total Applicable	=	92%

Appendix B. Record Review Tool

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Rocky Mountain Health Plans Prime

Review Period:	January 1, 2016—December 31, 2016
Date of Review:	February 28, 2017
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Sandy Dowd and Matt Cook

Requirements	File 1	File 2	File 3	File 4	File 5
Member	RE	AA	DR	AC	DBL
Date of initial request	03/22/16	10/06/16	02/06/16	04/30/16	07/27/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	CL	CL	CL	NR
Standard (S), Expedited (E), or Retrospective (R)	S	R	R	R	S
Date notice of action sent	03/25/16	10/17/16	02/09/16	—	07/28/16
Notice sent to provider and member? (C or NC)	C	C	C	NC	C
Number of days for decision/notice	3	11	3	—	1
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	NC	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	NA	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	C	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	NC	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	NA	C
Total Applicable Elements	**6**	**7**	**7**	**4**	**6**
Total Compliant Elements	**6**	**7**	**6**	**2**	**6**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**86%**	**50%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Requirements	File 6	File 7	File 8	File 9	File 10
Member	KS	SH	LC	RB	RS
Date of initial request	11/19/16	02/25/16	Omitted	05/13/16	05/21/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	CL	NR		NR	CL
Standard (S), Expedited (E), or Retrospective (R)	R	S		S	R
Date notice of action sent	11/22/16	03/03/16		05/16/16	05/24/16
Notice sent to provider and member? (C or NC)	C	C		C	C
Number of days for decision/notice	3	7		3	3
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C		C	C
Was authorization decision timeline extended? (Y or N)	N	N		N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA		NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA		NA	NA
Notice of Action includes required content? (C or NC)	C	C		C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C		C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA		NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA		NA	NC
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C		C	C
Was correspondence with the member easy to understand? (C or NC)	C	C		C	C
Total Applicable Elements	**6**	**6**		**6**	**7**
Total Compliant Elements	**6**	**6**		**6**	**6**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**		**100%**	**86%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Requirements	OS 1	OS 2	OS 3	OS 4	OS 5
Member	EM				
Date of initial request	09/10/16				
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR				
Standard (S), Expedited (E), or Retrospective (R)	S				
Date notice of action sent	—				
Notice sent to provider and member? (C or NC)	NC				
Number of days for decision/notice	—				
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	NC				
Was authorization decision timeline extended? (Y or N)	N				
If extended, extension notification sent to member? (C, NC, or NA)	NA				
If extended, extension notification includes required content? (C, NC, or NA)	NA				
Notice of Action includes required content? (C or NC)	NA				
Authorization decision made by qualified clinician? (C, NC, or NA)	C				
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA				
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA				
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C				
Was correspondence with the member easy to understand? (C or NC)	NA				
Total Applicable Elements	**4**				
Total Compliant Elements	**2**				
Score (Number Compliant / Number Applicable) = %	**50%**				

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business

Total Record Review Score	Total Applicable Elements: 59	Total Compliant Elements: 53	Total Score: 90%

Notes:

File 1 (RE): Notes indicated that after evaluating the multiple tests being requested eviCore approved some and denied others based on lack of medical necessity.

File 2 (AA): Notes indicated that eviCore (the agency RMHP Prime contracted with to determine appropriateness of genetic testing) telephoned the requesting provider and faxed a request for more information to the provider and the laboratory. eviCore denied the service after waiting 10 days for additional information.

File 3 (DR): RMHP Prime denied the claim for skilled nursing care due to it not being a covered service. No information about wraparound benefits or about how to obtain services covered by Medicaid fee-for-service was included in the notice of action. The notice of action stated that the member was responsible for the charges.

File 4(AC): RMHP Prime denied the claim because it exceeded the benefit amount. RMHP Prime provided the member with no notice of the denied claim.

File 5 (DBL): This was a request for a non-formulary medication. RMHP Prime reviewed the request and determined that the requested medication would duplicate treatment provided by other medications that the member was taking. The notice of action suggested four alternative medications.

File 6 (KS): RMHP Prime denied the claim for a vaccination because the code used is specifically listed as not a covered benefit.

File 7 (SH): RMHP Prime denied the request for continuous passive motion (CPM) machine because it is not approved for the intended use.

File 8 (LC): RMHP Prime initially denied the services and mailed the member a notice of action; however, upon further review, RMHP Prime determined that this was an administrative denial and paid the claim after the provider addressed the issue and resubmitted.

File 9 (RB): The authorization request was for two separate services. RMHP Prime approved one service and denied the second service based on its status as an experimental therapy.

File 10 (RS): RMHP Prime denied the claim for skilled nursing care due to it not being a covered service. No information about wraparound benefits or about how to obtain services covered by Medicaid fee-for-service was included in the notice of action. The notice of action stated that the member was responsible for the charges.

File OS1 (EM): RMHP Prime denied the claim for an annual wellness visit because this was the second claim for an annual visit within a span of three months. The benefits limit is one wellness exam per year. RMHP Prime provided the member with no notice of the denied claim.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **RMHP Prime**.

Table C-1—HSAG Reviewers and RMHP Prime and Department Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
RMHP Prime Participants	**Title**
Amber Davis	Claims Operations Analyst
Angela Engle	Quality Improvement Compliance Specialist
Ashleigh Gianetti	Community Health Outreach Coordinator
Carol Ann Hendrikse	Project Manager, Care Management; RCCO Clinical Manager
Christy Hunt	Claims Production Manager
Dale Renzi	Director, Provider Network Management (PNM)
Daniel Grossman	Manager, Internal Audit
David Klemm	Manager, Member Experience
Eve Presler	RCCO Colorado Opportunity Project Liaison
Greg Coren	Manager, Western Slope Provider Relations and Provider Network
Jackie Hudson	Director, Quality Improvement
Jerry Spomer	Director—Internal Audit, Member Benefit Administration and Member Enrollment, and Billing
Jessica Segrest	Care Management
Kelli Steinkirchner	PNM Project Coordinator
Kendra Peters	Coordinator, RCCO Marketing and Communications
Kila Watkins	Manager, Complete Case Management/Disease Management
Kim Nelson	Supervisor, Appeals and Grievances
Lesley Reeder	Consultant/Steadman Group
Lori Stephenson	Director, Clinical Program Development and Evaluation
Marci O'Gara	Director, Customer Service
Matt Cook	Director, Claims
Mike Huotari	Vice President, Legal and Government Affairs

RMHP Prime Participants	Title
Nicole Konkoly	Program Development Specialist, Community Integration
Nora Foster	Coordinator, Compliance/Audit
Patrick Gordon	Associate Vice President, Community Integration
Pauline Casey	Senior Program Operations Leader
Rhonda Hastings	Coordinator, Program Logistics
Sandy Dowd	Director, Care Management
Sharon Steadman	Consultant/Steadman Group
Steve Nolan	Director, Pharmacy
Sue Baker	Manager, Customer Service
Tammy Tway	Supervisor, Care Management Administrative Operations
Tara Rex	Practice Quality Monitoring, QI Team
Zach Kareus	Clinical Pharmacist
Shannon Emerick	Beacon, Clinical Services/Manager
Jennifer Coulson Hall	Beacon, Director—Long Term Services and Support
Laura Beavers	Beacon, Clinical Director
Ashley Maloney	eviCore
Craig Hightower	eviCore
Helen Yu	eviCore
RMHP Prime Department Observers	**Title**
Ben Harris	Policy Analyst, Accountable Care Collaborative
Gina Robinson	EPSDT Program Administrator
Russ Kennedy	Quality and Compliance Specialist
Patricia Connally	Quality and Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2016–2017

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

Table D-1—Corrective Action Plan Process

Step	Action
Step 1	**Corrective action plans are submitted**
	If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance site review report via email or through the file transfer protocol (FTP) site, with an email notification to HSAG and the Department. The health plan must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the health plan 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**
	Following review of the CAP, the Department or HSAG will notify the health plan via email whether: • The plan has been approved and the health plan should proceed with the interventions as outlined in the plan. • Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via email or the FTP site, with an email 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 health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Step	Action
Step 6	**Documentation substantiating implementation of the plan is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan 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 health plan must submit additional documentation. The Department or HSAG will inform each health plan in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the health plan into full compliance with all the applicable healthcare regulations and managed care contract requirements.

The CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for RMHP Prime

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. Notices of action must contain: • The action the Contractor (or its delegate) has taken or intends to take. • The reasons for the action. • The member's or provider's (on behalf of the member) right to file an appeal and procedures for filing. • The date the appeal is due. • The member's right to a State fair hearing. • The procedures for exercising the right to a State fair hearing. • The circumstances under which expedited resolution is available and how to request it. • The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. • The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42 CFR 438.404(b)* 10CCR2505–10, Sec 8.209.4.A.2 Prime Contract: Amendment 4, Exhibit A-3—4.1.1.4.2.2	RMHP Prime's Preauthorization of Services policy accurately described the content that must be included in notices of action, and on-site record reviews demonstrated compliance. However, two of ten records reviewed on-site were cases in which RMHP Prime denied payment for skilled nursing. Both denial letters stated that skilled nursing was not a covered benefit and that "the member is responsible for payment." This is incorrect information. While the health plan may deny payment to the provider, Medicaid members are not liable for payment of services. In addition, while the benefits are not covered under the RMHP Prime plan, they may be covered under Medicaid fee-for-service; and the member should be provided information on how to obtain such services. HSAG recommends that RMHP Prime modify its notice of action (when denying payment for services not covered under the RMHP Prime plan but which may be covered by Medicaid fee-for-service) to include information on how the member can obtain the service. Furthermore, RMHP Prime must remove from the denial letter information which implies that the member is liable for payment.	RMHP Prime must remove from the denial letter information which implies that the member is liable for payment.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
16. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except: – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands that service termination or reduction will occur. o The member has been admitted to an institution in	RMHP Prime's policies and procedures described the process for notifying the requesting provider and member of any decision to deny a service or to authorize less than what is requested; however, for two of the 10 denial records reviewed on-site, RMHP Prime failed to notify the member of the denied payment.	RMHP Prime must ensure that it provides members with notice of any decision to deny a payment.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
which the member is ineligible for Medicaid services. o The member's address is determined unknown based on returned mail with no forwarding address. o The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. o A change in the level of medical care is prescribed by the member's physician. o The notice involves an adverse determination with regard to preadmission screening requirements. • For denial of payment, at the time of any action affecting the claim. • For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the time frame, as expeditiously as the member's health condition requires and no later than the date the extension expires.		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
42 CFR 438.210 (d) *42 CFR 438.404(c)* *42 CFR 431.211, 431.213, and 431.214* 10CCR2505–10, Sec 8.209.4.A.3 Prime Contract: Amendment 4, Exhibit A-3—4.1.1.4.3 through 4.1.1.4.5		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the three standards and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. • HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to health plan service and claims denials and notices of action. • Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) • At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2016–2017 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the health plan and the Department for review and comment. • HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the health plan and the Department.