COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2017–2018 Site Review Report

for

Rocky Mountain Health Plans CHP+ and Rocky Mountain Health Plan Medicaid Prime

March 2018

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Code of Federal Regulations, Title 42—federal Medicaid managed care regulations, with revisions published May 6, 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. Public Law 111-3, Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, requires that each state's Children's Health Insurance Program (CHIP) apply several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. The Department of Health Care Policy and Financing (the Department) has elected to complete the requirement for periodic evaluation of Colorado's Child Health Plan *Plus* (CHP+) and Medicaid managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

In order to allow for implementation of new federal managed care regulations published May 2016, the Department determined that the review period for FY 2017–2018 was July 1, 2017, through December 31, 2017. This report documents results of the FY 2017–2018 site review activities for **Rocky Mountain Health Plans CHP+** (**RMHP CHP+**) and **Rocky Mountain Health Plans Medicaid Prime** (**RMHP Prime**). For each of the four 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 describes the background and methodology used for the 2017–2018 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2016–2017 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 appeals and grievances 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 2017–2018 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 Medicaid requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. Revisions to federal Medicaid managed care regulations published May 6, 2016, are not applicable to CHIP until July 1, 2018; therefore, HSAG assigned each **revised** federal requirement a score of *Met* or *Not Scored* for CHP+. HSAG assigned required actions for any requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* HSAG identified recommendations for those CHP+ requirements that do not become effective until July 2018.

CHP+ Results

Table 1-1 presents the scores for **RMHP CHP+** 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 RMHP CHP+ Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information	24	12	12	0	0	12	100%
VI. Grievance System	35	22	18	0	4	13	82%
VII. Provider Participation and Program Integrity	16	14	13	1	0	2	93%
IX. Subcontracts and Delegation	4	0	0	0	0	4	NA
Totals	**79**	**48**	**43**	**1**	**4**	**31**	**90%**

Note: While the scoring of individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results as new federal requirements do not apply to CHP+ until July 1, 2018.

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements. (All elements representing revised requirements effective July 2018 were considered *Not Applicable*.)

Table 1-2 presents the scores for **RMHP CHP+** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	30	29	24	5	1	83%
Grievances	60	33	28	5	27	85%
Totals	**90**	**62**	**52**	**10**	**28**	**84%**

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

Medicaid Results

Table 1-3 presents the scores for **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 1-3—Summary of RMHP Prime Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
V. Member Information	25	14	14	0	0	11	100%
VI. Grievance System	35	35	31	0	4	0	89%
VII. Provider Participation and Program Integrity	16	14	13	1	0	2	93%
IX. Subcontracts and Delegation	4	4	4	0	0	0	100%
Totals	**80**	**67**	**62**	**1**	**4**	**13**	**93%**

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

Table 1-4 presents the scores for **RMHP Prime** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tool.

Table 1-4—Summary of RMHP Prime Scores for the Record Reviews

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Appeals	60	59	52	7	1	88%
Grievances	60	35	33	2	25	94%
Totals	**120**	**94**	**85**	**9**	**26**	**90%**

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

Standard V—Member Information

The following sections summarize the findings applicable to both CHP+ and Prime managed care. Any notable differences in compliance between the CHP+ and Prime lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

RMHP implemented several strategies to ensure that its CHP+ and Prime members understand the requirements and benefits of the plans. **RMHP** mails member handbooks and welcome letters to all new members within 30 days of receiving notice of enrollment. Additionally, RMHP's customer service staff members call new members to welcome them to the health plan, verify mailing address, confirm receipt of member handbook, review the process for and importance of selecting a primary care provider and attending regular well-person exams, describe the availability of care coordinators and support services for persons with special healthcare needs and chronic medical conditions, and inform of what to do in case of a medical emergency. **RMHP CHP+**'s and **RMHP Prime**'s member informational materials were written using easy-to-understand language and format and included required tag lines describing the availability of interpreter services and alternative formats and languages free of charge, and how to request them. Members materials repeatedly remind members to contact customer service representatives with any questions, and the RMHP.org website offers those who use it the option of "chatting" with a customer service representative.

RMHP CHP+ and **RMHP Prime** member handbooks, provider directories, and formulary drug lists included the required content and were available online and upon request in both English and Spanish. Documents available on **RMHP CHP+** and **RMHP Prime** websites were prominently located, in machine-readable format, and could be electronically retained and printed.

RMHP demonstrated great commitment to serving its members with physical disabilities and those who are deaf or hard of hearing. **RMHP**, in partnership with the Colorado Cross-Disability Coalition (CCDC), formed the Western Slope Member Advisory Council. The Council exists to advise **RMHP** about member needs, provide information to members via a peer network, and involve members in evaluating and designing healthcare programs and services. **RMHP** has also been engaged with Bridging Communications, a Western Slope group of deaf and hard-of-hearing community members. **RMHP** partnered with the Center for Independence to hire a deaf services coordinator who is working to recruit interpreters and to expand services for the deaf in the western Colorado service area. With **RMHP**'s support and assistance, the group organized for healthcare providers a training about effective communication strategies that can be used with their deaf and hard-of-hearing patients. Fostering these relationships serves as a best practice for ensuring comprehensive care for members with disabilities.

Summary of Findings Resulting in Opportunities for Improvement

RMHP CHP+ and **RMHP Prime** provider directories designated provider locations that self-reported accommodations for people with physical disabilities. HSAG encouraged **RMHP CHP+** and **RMHP Prime** to require that providers specify which locations have accessible equipment such as adjustable exam tables and wheelchair-accessible scales.

RMHP provided ample evidence to demonstrate compliance with Section 508 Standards guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines. HSAG suggested that **RMHP** develop a policy that delineates the requirements and processes to ensure ongoing compliance.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VI—Grievance System

The following sections summarize the findings applicable to both CHP+ and Prime managed care. Any notable differences in compliance between the CHP+ and Prime lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

RMHP's grievance system included policies and procedures that addressed State and federal requirements pertaining to member grievance, appeal, and State fair hearing processes. The documented procedures within the Member Appeals Process policy and the Grievance Policy and Process document reflected current Code of Federal Regulations (CFR) Part 438—Managed Care processing requirements and time frames for receiving, acknowledging, and resolving grievances and appeals and adhered to member notice requirements. Grievance system information was also provided to all **RMHP**-contracted providers and subcontractors through provider contracts and the **RMHP** provider manual. **RMHP** had an effective health information system for documenting and tracking information related to the grievance system and demonstrated mechanisms for ensuring appeal and grievance timeliness compliance. Additionally, **RMHP** maintained an effective expedited appeal review process.

The on-site record review demonstrated that **RMHP** staff making decisions on appeals and grievances have the appropriate clinical expertise, when applicable, and consider when making decisions all documentation submitted by the member or the member's designated representatives. Additionally, through the on-site record review, HSAG confirmed that resolution letters were member-centric and easy to understand.

Summary of Findings Resulting in Opportunities for Improvement

RMHP had established processes and procedures for the grievance system; however, the Member Appeals Process policy and Grievance policy and process document applied to all lines of business and, in some instances, did not clearly delineate Medicaid and CHP+ requirements. **RMHP** should consider updating its policies to reflect this delineation.

During the on-site file review, **RMHP** had one case noncompliant with appeal resolution time frames due to internal staff not forwarding the appeal to the Appeals and Grievances Department timely. Another instance occurred in which a member grievance was forwarded three days after receipt. **RMHP** should educate all staff and enhance mechanisms for ensuring the timely processing of appeals and grievances.

Summary of Required Actions

RMHP must have mechanisms in place to ensure that members receive written acknowledgement of each grievance within two working days of receipt. **RMHP**'s Grievance Policy and Process document supported members receiving written acknowledgement of grievances within two working days. Through the on-site file review, however, **RMHP** did not consistently demonstrate that members receive written acknowledgement of each grievance timely. Specifically, for CHP +, the plan either did not send an acknowledgement letter or sent the acknowledgement to the member untimely in three of 10 cases reviewed. For Medicaid grievances, two of 10 cases reviewed indicated that those members did not receive written acknowledgement letters.

RMHP must resolve each grievance and provide notice as expeditiously as the member's health condition requires, but no later than 15 working days of when the member files the grievance. **RMHP**'s Grievance policy specified that, for Medicaid members, any grievance must be resolved and notice sent to the member within 15 working days or as expeditiously as the member's health condition requires. During the on-site file review, all Medicaid cases reviewed demonstrated that the health plan was compliant with resolving and sending resolution notices timely. However, one CHP+ grievance reviewed was not resolved timely, and the resolution notice for that grievance was not sent to the member within 15 working days.

RMHP must have mechanisms in place to ensure that written acknowledgement of each appeal is sent to members within two working days of receipt, unless the member or designated client representative requests an expedited resolution. **RMHP**'s Member Appeals Time Grid specified that written acknowledgement of appeals must be sent to Medicaid and CHP+ members within two working days of receipt of the appeal. During the on-site file review; however, one of four applicable CHP+ appeals and six of nine applicable Medicaid appeals revealed that the plan was not sending acknowledgement letters to members as required.

RMHP must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires, but not to exceed 10 working days from receipt for standard resolution of appeals. **RMHP**'s Appeals policy, Member Appeals Time Grid, and Notice of Appeal

Resolution template supported that appeals are resolved and members receive written notice of appeal resolution within 10 working days from date of receipt. During the on-site file review, two CHP+ member appeals were not resolved within the 10 working days-time frame.

RMHP's written notice of appeal resolution must include the date that the resolution process was completed. For appeals not resolved wholly in favor of the member, the written notice of appeal resolution must also include the right to request a State fair hearing, and how to request the hearing. **RMPH**'s Member Appeals Process policy complied with written notice of appeal resolution requirements. During the on-site file review; however, four of 10 Medicaid resolution letters contained inaccurate time frame requirements for requesting a State fair hearing and/or the notice did not include the date that the resolution process was completed.

RMHP must ensure that all documentation—including notice of resolution template letters—support that, for adverse benefit determinations, members may request State fair hearings within 120 calendar days from the date of the notices of resolution. **RMHP**'s appeals policy and handbooks indicated that members could request State fair hearings within 120 calendar days from the date of notices of resolution. During the on-site file review; however, four resolution letters sent to Medicaid members did not indicate that members may request State fair hearings within 120 calendar days from the date of the notices of resolution. Instead, these letters inaccurately indicated that members had 30 days from the date of the notice of resolution to request State fair hearings.

Standard VII—Provider Participation and Program Integrity

The following sections summarize the findings applicable to both CHP+ and Prime managed care. Any notable differences in compliance between the CHP+ and Prime lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

RMHP demonstrated effective mechanisms, including detailed policies and procedures, to support the appropriate retention and selection of healthcare providers. **RMHP** also exhibited a documented process for complying with the State's credentialing and recredentialing requirements. Additionally, **RMHP** had a monitoring and tracking system for ensuring that no employees, providers, consultants, subcontractors, board of directors, or other applicable individuals or entities were excluded from participating in the Medicaid program. **RMHP** demonstrated a robust process for monitoring and preventing discriminatory credentialing practices. Specifically, **RMHP**'s Credentialing Committee and Medical Practice Review Committee members sign an agreement to comply with all laws pertaining to discrimination; and, to ensure that decisions to deny were not discriminatory in nature, **RMHP**'s Internal Audit team annually assesses all providers who were denied participation during the credentialing process.

RMHP demonstrated a satisfactory compliance program which includes written policies and procedures, designated staff to conduct internal audits and fraud and abuse investigation, tasked a compliance committee with overseeing the compliance program, included effective lines of communication for staff to report compliance-related issues and suspected fraud and abuse, and offered

provisions for taking action when noncompliance is identified. Additionally, **RMHP** demonstrated efforts to ensure an effective compliance program through a documented audit plan and an annual risk assessment of potentially high-risk program areas.

Summary of Findings Resulting in Opportunities for Improvement

While **RMHP** demonstrated an adequate compliance program through individual documents, including the compliance plan, annual audit plan, and annual risk assessment analysis, **RMHP** did not present a comprehensive document to delineate all annual compliance-related activities and their statuses. HSAG recommends developing an annual compliance work plan that includes all compliance-focused activities—training and education efforts, ongoing monitoring efforts, risk assessment and auditing initiatives, and policy and procedure reviews. Additionally, HSAG recommends that **RMHP** designate the compliance officer position and the name of the person assigned to this role on its organizational chart and in compliance-related documentation.

Summary of Required Actions

RMHP must have a method to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. **RMHP** was unable to demonstrate an existing process to regularly verify that services billed by network providers were actually received by members.

Standard IX—Subcontracts and Delegation

The following sections summarize the findings applicable to both CHP+ and Prime managed care. Any notable differences in compliance between the CHP+ and Prime lines of business are identified.

Summary of Strengths and Findings as Evidence of Compliance

RMHP's policies and procedures described the processes for evaluating a prospective subcontractor's ability to perform activities to be delegated, for monitoring subcontractors' performance ongoing and annually, and for requiring corrective actions for any identified deficiencies or areas for improvement. **RMHP** had written agreements with its subcontractors that specified the delegated activities and reporting requirements and that delineated sanctions (including revocation) available to **RMHP** if the subcontractor failed to meet performance standards. Written agreements required subcontractors to comply with all applicable federal and State laws. **RMHP** provided evidence of collecting and reviewing ongoing reports from its subcontractors and of performing annual formal reviews. All subcontractor performance review results are presented to the Medical Advisory Council (MAC).

Summary of Findings Resulting in Opportunities for Improvement

RMHP's written agreements required that, for audit purposes, subcontractors make their premises, equipment, books, records, and contracts available to State, CMS, the Department of Health and Human Services (HHS) Inspector General, Comptroller General, or their designees. The time frame specified for the right to audit varied by contract, but included the phrase "…or period required by law." HSAG strongly encouraged **RMHP** to implement a mechanism to proactively inform its subcontractors about any changes in laws related to the duration of the right to audit.

Summary of Required Actions

HSAG identified no required actions for this standard.

2. Overview and Background

Overview of FY 2017–2018 Compliance Monitoring Activities

For the fiscal year (FY) 2017–2018 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements and regulations specified by the federal Medicaid/CHP+ managed care regulations published 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 CHP+ and Medicaid appeals and grievances.

HSAG reviewed a sample of the health plan's administrative records related to Medicaid appeals and grievances to evaluate implementation of federal healthcare regulations and managed care contract requirements as specified in 42 CFR 438 Subpart F and 10 CCR 2505-10, Section 8.209. Additionally, HSAG reviewed a sample of the health plan's administrative records related to CHP+ appeals and grievances to evaluate implementation of managed care contract requirements for processing grievances and appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records—to the extent available—for each of Medicaid and CHP+. Using a random sampling technique, HSAG selected the samples from all applicable Medicaid and CHP+ appeals and grievances that occurred between July 1, 2017, and December 31, 2017. For the record review, the health plan received a score of *M* (met), *NM* (not met), or *NA* (not applicable) for each required element. Results of record reviews were considered in the review of applicable requirements in Standard VI—Grievance System. HSAG also separately calculated a grievances record review score, an appeals record review score, and an overall record review score for **RMHP CHP+** and **RMHP Prime**.

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.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2017–2018 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

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

[2-1] 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)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2017.

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

FY 2016–2017 Corrective Action Methodology

As a follow-up to the FY 2016–2017 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 CHP+** and **RMHP Prime** until they completed each of the required actions from the FY 2016–2017 compliance monitoring site review.

Summary of FY 2016–2017 Required Actions

For the FY 2016–2017, HSAG reviewed for **RMHP CHP+** and **RMHP Prime** Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. HSAG reviewed for **RMHP Prime** only Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services. Resulting from this review, both **RMHP CHP+** and **RMHP Prime** were required to ensure that they provide members with notice of any decision to deny payment. Additionally, **RMHP Prime** was required to remove from the denial letter information which implies that the member is liable for payment for services covered under the State plan but not covered under the **RMHP Prime** contract. **RMHP Prime** was also required to 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.

Summary of Corrective Action/Document Review

RMHP CHP+ and **RMHP Prime** submitted their proposed plans of corrective actions in July 2017. HSAG and the Department reviewed and approved the proposed plan. **RMHP CHP+** and **RMHP Prime** were allowed until December 30, 2017, to submit evidence of having implemented corrective actions.

In September 2017, **RMHP CHP+** submitted evidence that it had implemented its plan to ensure having mailed members notice of any decision to deny payment. After careful review, HSAG and the Department determined that **RMHP CHP+** had successfully addressed all required actions.

HSAG completed this 2017–2018 compliance monitoring report prior to receiving and processing **RMHP Prime**'s 2016–2017 CAP submission and is unable to comment on the completeness of the corrective actions.

Summary of Continued Required Actions

HSAG will review **RMHP Prime**'s CAP submission with the Department when received and work with **RMHP Prime** to ensure full implementation of all corrective actions.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor provides all required member information to members in a manner and format that may be easily understood **and is readily accessible by members.** *(Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.)* *42 CFR 438.10(b)(1)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—3.4.2.1.5, 4.1.1.3.3.1	*See Element #6 for evidence that information is readily accessible by members.* *V_CI_Prep_Maintain_ Distribute_Medicaid_CHP+_Member Materials_PP_101317* This Policy and Procedure is written to assure that all materials intended for distribution to RMHP Medicaid and CHP+ members are reviewed and edited to promote ease of use for RMHP enrollees, and to assure that they are readily accessible. Page 1 also indicates that RMHP will accommodate members with vision or other impairments by providing member materials in alternative formats. Examples of member materials: *RMHP CHP+ Benefits Booklet 0717_508* *V_CS_CHP+ Welcome Ltr_Eng_Span* *V_CI_CHP+_Copay Notices* *V_CHP+ ID Card Layout 03* *V_PH_Prime_CHP+ Good Health Formulary English 100117* *Prime Member Handbook 0717_508* *V_CS_Prime Welcome Ltr_Eng_Span* *V_CI_Prime OE Letter English_Spanish 051717* *V_CI_Prime ID Card Layout 06*	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* CHP+ Contract: Exhibit B—6.3.1.15 Prime Contract: Exhibit K—1.1.2.5	*RMHP CHP+ Benefits Booklet 0717_508* The CHP+ Benefits Booklet includes information to help members understand the requirements and benefits of the plan. The RMHP Customer service number is listed in the footer of the handbook. *V_CI_CHP+_Copay Notices* CHP+ copay notices are sent with the CHP+ Benefits Booklet, and present copays based on member income. The following documents are all designed to assist members to understand the requirements and benefits of the plan. *V_CS_CHP+ Welcome Ltr_Eng_Span* *V_CS_CHP+ Child Welcome Call Script* *V_CS_CHP+ Adult Welcome Call Script* *V_CI_CHP+ ID Card Layout 03*	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
3. **For consistency in the information provided to members, the Contractor uses the following as developed by the State:** • **Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan,**	Advised by HSAG via email 9-18-17: None of this requirement is yet applicable to CHP+, as indicated in the CHP+ scoring. For Prime—HSAG has confirmed with the Department that a consensus definition has not been completed by the State for all of these terms, and that model member notices (other than the Medicaid member handbook) have not yet been implemented. The Department agreed that it is premature to score	**CHP+:** ☐ Met ☒ Not Scored **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • **Model member handbooks and member notices.** *42 CFR 438.10(c)(4)* CHP+ Contract: N/A Prime Contract: (Not found)	the health plans on this element until the Department has completed a list of State definitions and implemented model notices. The requirement will remain on the tool for educational purposes—i.e. the health plans will need to meet this requirement at an appropriate future time-- but score it as *Not Applicable* for all Medicaid health plans for this review cycle.	
Findings: HSAG is aware and the Department acknowledges that, for the 2017–2018 compliance review period, the State has not completed nor communicated to health plan contractors a consensus list of managed care definitions to be used in information provided to members. HSAG has therefore scored this element as *Not Applicable*. HSAG recommends that all Contractors maintain awareness of this requirement and, when received, incorporate State-defined managed care definitions into all applicable member communications, as directed by the Department.		
4. The Contractor makes written information available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. • Written materials must use easily understood language and format. *42 CFR 438.10(d)(3) and (d)(6)(i)* CHP+ Contract: Exhibit B—10.8.2.5 Prime Contract: Exhibit A-5—3.7.4.3.7	*Prime Member Handbook 0717_Spanish* *V_CS_Prime Welcome Ltr_Eng_Span* *V_CI_Prime OE Letter English_Spanish 051717* *RMHP CHP+ Benefits Booklet 0717_Spanish* *V_CS_CHP+ Welcome Ltr_Eng_Span* *ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination SP 081517* *V_PH_Prime_CHP+ Good Health Formulary Spanish 100117* *V_CM_Medicaid_CHP Appeal Rights 070117_SP* The documents listed above are examples of documents that are available to members in	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Spanish. Spanish is the prevalent non-English language in the RMHP Prime/CHP+ service-area. *Prime Member Handbook 0717_508* Page vii and page 1 of the Prime Member Handbook explains how members can access materials in other languages and formats. *RMHP CHP+ Benefits Booklet 0717_508* Page 114 of the CHP+ Benefits Booklet tells members how to access the information in alternative formats. *ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 081517* This document indicates in 17 different languages that language assistance services are available to members free of charge. This notice is inserted in all written materials that are critical to obtaining services. *V_CI_Prep_Maintain_ Distribute_Medicaid_CHP+_Member Materials_PP_101317* Page 1 indicates that RMHP will create member material that is easy to use and understand, and that RMHP will make materials available in non-English languages and alternative formats without charge.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_CS_Process for Large Print Document Request *V_CS_Process for Alternate Language Document Request* These Customer Service processes explain RMHP's process for making written information available in other formats.	
5. **Written materials that are critical to obtaining services include: provider directories, member handbooks, appeal and grievance notices, and denial and termination notices.** **All written materials for members must:** • **Use a font size no smaller than 12 point.** • Be available in alternative formats **and through provision of auxiliary aids and service** that takes into consideration the special needs of members **with disabilities** or limited English proficiency. • **Include taglines in large print (18 point) and prevalent non-English languages describing how to request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service number, and availability of materials in alternative formats.** *42 CFR 438.10(d)(3) and (d)(6)(ii–iv)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.1.3.3.3	*V_CI_Prep_Maintain_ Distribute_Medicaid_CHP+_Member Materials_PP_101317* Page 1explains that RMHP will include in large print (18 point font) (1) taglines in non-English languages indicating the availability of language services for individuals who are limited English proficient, and (2) information about how to request auxiliary aids and services. This information will be sent with all member materials that are considered critical to obtaining services. This document also states that RMHP will use font size no smaller than 12 point. The following documents are examples of materials critical to obtaining services: *Prime Member Handbook 0717_508* *RMHP CHP+ Benefits Booklet 0717_508* *V_PH_Prime_CHP+ Good Health Formulary English 100117* *2017 Prime Directory 102517_508* *2017 CHP+ Directory 102517_508* *VI_CM_Medicaid CHP Appeal Rights 070117*	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 081517 This document is inserted with all member materials that are considered to be critical to obtaining services. It includes taglines in large print (18 point font) and how to obtain free auxiliary aids and services in large print (18 point font). *V_LRA_Tagline Grid* This document illustrates the written materials that are critical to obtaining services that will include the Multi Language Insert Tagline and Notice of Nondiscrimination.	
6. **If the Contractor makes information available electronically—Information provided electronically must meet the following requirements:** • **The format is readily accessible (see definition of readily accessible above).** • **The information is placed in a Web site location that is prominent and readily accessible.** • **The information can be electronically retained and printed.** • **The information complies with content and language requirements.** • **The member is informed that the information is available in paper form without charge upon request, and is provided within five (5) business days.**	*V_PH_PBM Message Confirming 508 Compliance of Formulary* This message from the RMHP Pharmacy Benefit Manager confirms that the Good Health Formulary (used for Prime and CHP+) is 508 compliant. *V_IT_Message Confirming 508 Compliance of Prime_CHP Sections* This message from RMHP IT staff verifies that the Medicaid Prime and CHP+ sections on the rmhp.org website are 508 compliant *V_H2R_Message Confirming 508 Compliance of rmhpcommunity.org* This message from Health2 Resources confirms that the website at www.rmhpcommunity.org is 508	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.10(c)(6) CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.1.3.8	compliant with no errors, according to the WAVE web accessibility evaluation tool recommended by the GSA. *Accessibility Report Prime Handbook 0717* *Accessibility Report CHP Benefits Booklet 0717* *Accessibility Report Prime Directory 102517* *Accessibility Report CHP+ Directory 102517* *V_CI_Screenshot of Links to Prime Member Handbook* *V_CI_Screenshot of Links to CHP+ Benefits Booklet* *Prime Member Handbook 0717_508* Page iv indicates that the Member Handbook and the Provider Directory are at rmhp.org and rmhpcommunity.org where the member can view or print these documents. Members are informed that they can also ask RMHP to mail a copy at any time at no cost. *RMHP CHP+ Benefits Booklet 0717_508* Page 4 explains to members that they can get a new CHP+ Benefits booklet each year or any time they want it – they can ask RMHP to mail it or it is accessible online at rmhp.org.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_CI_Prep_Maintain_ Distribute_Medicaid_CHP+_Member Materials_PP_101317 Page 1 of this P&P describes the process that RMHP uses to prepare member materials that comply with content and language requirements, and that RMHP will make information available to an enrollee in paper form and without charge within 5 days of request.	
7. **The Contractor makes available to members in electronic or paper form information about its formulary:** • **Which medications are covered (both generic and name brand).** • **What tier each medication is on.** • **Formulary drug list must be available on the Contractor's Web site in a machine readable file and format.** *42 CFR 438.10(i)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—3.5.4.6.2.1	*V_PH_Prime_CHP+ Good Health Formulary English 100117* This formulary indicates which medications are covered (both generic and brand) and indicates what tier each medication is on. *V_PH_PBM Message Confirming 508 Compliance of Formulary* This message from the RMHP Pharmacy Benefit Manager confirms that the Good Health Formulary (used for Prime and CHP+) is 508 compliant. *V_CI_Screenshot of Link to Prime and CHP+ Formulary*	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* CHP+ Contract: Exhibit B—7.5, 14.1.3.4, 14.1.7.4–6 Prime Contract: Exhibit A-5—3.7.4.3.4–5, 3.7.4.3.7	*V_CS_Accommodations for Mem w Disabilities_PP* This Customer Service P&P indicates that for non-English speaking members, CS employs bilingual representatives and utilizes Certified Language International (CLI) to interpret for the member. *Prime Member Handbook 0717_508* Page 1 explains that for callers who do not speak English or Spanish, RMHP uses Certified Language International (CLI) interpreters. RMHP provides interpretation services at no cost to members, and advises members to tell Customer Service if they need interpreter services or help in other languages. *RMHP CHP+ Benefits Booklet 0717_508* Page 4 indicates that for callers who do not speak English or Spanish, RMHP uses Certified Languages International interpreters. RMHP provides interpretation services at no cost to members. Members are advised to tell RMHP if they need interpreter services or help in other languages. *V_CI_Prep_Maintain_ Distribute_Medicaid_CHP+_Member Materials_PP_101317* Page 1 and 2 indicate that RMHP will translate documents into prevalent non-English languages.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 081517 This document indicates in 17 different languages that language assistance services are available to members free of charge. This notice is inserted in all written materials that are critical to obtaining services.	
9. **Interpretation service includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language.** • The Contractor notifies members that **auxiliary aids and services are available upon request and at no cost for members with disabilities**, and how to access them. *42 CFR 438.10(d)(4) and (d)(5)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.1.3.3.3	*ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 081517* The Notice of Nondiscrimination indicates that RMHP provides: • Free auxiliary aids and services to people with disabilities such as qualified sign language interpreters (remote interpreting service or on-site appearance), and written information in other formats (large print, audio, accessible electronic formats, other formats) • Free language assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages. This document is inserted in all member material that is considered critical to the Member receiving services. It is found in the Prime Member Handbook on page vii, and in the CHP+ Benefits Booklet on page 114. Members are told that they may access these services by calling RMHP.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. **The Contractor provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment.** *Note: The State generally defines "a reasonable time" as 30 days.* *42 CFR 438.10(g)(1)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.1.3.2	*V_CI_Prep_Maintain_ Distribute_Medicaid_CHP+_Member Materials_PP_101317* The Prime Member Handbook and CHP+ Benefits Booklet are mailed as part of the initial enrollment packet. Page 2 of the P&P explains how the new member packet is mailed within a reasonable timeframe after notification of the member's enrollment. RMHP strives to send these materials within the first few weeks of a member's initial enrollment.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
11. The Contractor gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* CHP+ Contract: Exhibit B—14.1.3.13 Prime Contract: Exhibit A-5—4.1.1.4.1	*V_CI_Prep_Maintain_ Distribute_Medicaid_CHP+_Member Materials_PP_101317* Page 1 indicates that RMHP will provide enrollees at least a 30-day notice of any change in the information that the State defines as significant. *V_ Prime_CHP+ Member Newsletter_Fall 2017* Page 2 of this Newsletter provides an Important Pharmacy Update that describes pharmacy changes effective January 1, 2018. This Newsletter was mailed the week of October 16, 2017. Additional targeted notices to Members to be mailed in November will be provided on site.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* CHP+ Contract: Exhibit B—7.12.2, 14.1.8.1 Prime Contract: Exhibit A-5—4.1.5.1	*V_CM_Prov Term Cross Dept_PP* It is the policy of RMHP to ensure that all members assigned to a Primary Care Physician (PCP) with at least one visit with a PCP within the previous twelve months, are notified when the PCP is no longer contracted with RMHP. This document outlines, at a high level, the cross departmental workflow of the PCP termination process. *V_CS_Prov Term Notif_PP* Details the process for letting members know that their provider is no longer contracted with RMHP. *V_CS_PCP Term Ltr MD_CHP* *V_CH_Spec Term Facility MD_CHP* *V_CS_Spec Term MD_CHP* These provider termination notice templates are used when RMHP provides written notice of the termination of a participating PCP, specialist or pharmacy.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals**, pharmacies, and behavioral health providers, and long-term services and supports (LTSS) providers:** • The provider's name and **group affiliation**, street address(es), telephone number(s), **Web site URL, specialty (as appropriate),** and whether the providers will accept new members.	*2017 Prime Directory 102517_508* *2017 CHP+ Directory 102517_508* The Prime and CHP+ Provider Directories are available on the RMHP website in both electronic and paper form. The paper directory includes the provider's name, group affiliation, street address, and specialty. In addition, the paper provider directory indicates: • Languages offered	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• **The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training.** • **Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.** *(Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the Contractor receives updated provider information.)* *42 CFR 438.10(h)(1–3)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—3.8.2.3.1.2	• If the provider accepts established patients only through use of an icon showing a circle with strike mark • PCPs through use of an icon showing the letter "P" within a circle • Handicap accessibility through use of a wheelchair icon. Page 11 (Prime) and page 10 (CHP+) indicates providers who have completed RMHP's Disability Competent Care Training Program. Information about the electronic provider directory can be found at www.rmhp.org. It indicates that practitioners and hospitals may self-report, or update upon RMHP's request, the demographic information displayed in the directory, including name, address, phone number, gender, languages spoken, medical group affiliation, hospital affiliation, and accepting current patients. This data is updated weekly to maintain accuracy. The Directory is current as of Wednesday of each week. (Provider website URLs are not available at this time). *V_PR_Directory Procedures 101617* For Prime and CHP+ Directories, page 2 indicates that information included in a paper provider directory is updated at least monthly, and electronic	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	provider directories are updated no later than 30 calendar days after RMHP receives updated provider information.	
14. **Provider directories are made available on the Contractor's web site in a machine readable file and format.** *42 CFR 438.10(h)(4)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—3.8.2.3.1.2, 4.1.1.3.7	*2017 Prime Directory 102517_508* *2017 CHP+ Directory 102517_508* *V_CI_Screenshot of Links to Prime and CHP+ Directories*	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. **Prime only—** For any information provided to members by the Contractor, the Contractor ensures that information is consistent with federal requirements in 42 CFR 438.10. *42 CFR 438.10 (b)*	*V_CI_Prep_Maintain_ Distribute_Medicaid_CHP+_Member Materials_PP_101317* Pages 1-2 indicate how RMHP prepares member materials so that all information is consistent with federal requirements.	**Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The member handbook provided to members following enrollment includes: • The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. • Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider.	*RMHP CHP+ Benefits Booklet 0717_508* The amount, duration and scope of benefits available are described in Section 5, Covered Services, and pages 30-72. "Summary of Covered Benefits" pages 11-12 Procedures for obtaining benefits are explained as follows: • Section 1, page 16, Getting Care, • "Pre-authorization" explains pre-authorization requirements.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Any restrictions on the member's freedom of choice among network providers. • In the case of a counseling or referral service that the Contractor does not cover due to moral or religious objections, the Contractor informs the member that the service is not covered and how the member can obtain information from the State about how to access such services. *42 CFR 438.10(g)(2)(iii, iv, vi) and (g)(ii)(A–B)* CHP+ Contract: Exhibit B—14.1.3.13.1–3, 14.1.3.14.4 and Exhibit K—1.1.4.1–3, 1.1.7, 1.1.16.3.11, 1.1.28 Prime Contract: Exhibit K—1.1.2.2, 1.1.2.5–6, 1.1.2.10, 1.1.2.12.1, 1.1.2.12.1	• Page 14, "Specialty Care" explains that referrals are not needed to see a specialist that works with RMHP. • Page 15 explains how to get hospital care, pregnancy care, prescription drugs. Restriction of choice among network providers: RMHP does not restrict choice among network providers. RMHP does not exclude any counseling or referral services due to moral or religious objections.	
17. The member handbook provided to members following enrollment includes: • The extent to which and how members may obtain benefits, including family planning services, from out-of-network providers. **This includes an explanation that the Contractor cannot require the member to obtain a referral before choosing family planning provider.** • **The process of selecting and changing the member's primary care provider.** *42 CFR 438.10(g)(2)(vii, x)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—2.1.14, 4.1.1.4.1.3 and Exhibit K—1.1.2.7	*RMHP CHP+ Benefits Booklet 0717_508* Section 2, Member's Rights & Responsibilities, page 18 indicates the right to get family planning services from any Health First Colorado provider in or out of RMHP's network, with no referral. Section 5, Covered Services, "Family Planning/Reproductive Health", pages 36-37 indicates that family planning/reproductive health services do not require pre-authorization or referral for any provider regardless of whether they are in-network or not. This could be a PCP or an OB/GYN.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	"Doctors that do not work with RMHP", page 16 explains that in general members must obtain services from network providers, but that this requirement does not apply to emergency or urgent care. The section goes on to instruct the member to call RMHP if they need care from a doctor that does not work with RMHP. In this case, RMHP may give permission to see the OON doctor and the member will not have to pay for the care. Information for New Members- • "I am a New Member. What do I do Now," page 7 explains how to pick a primary care provider. • Information for New Members, "How to Change your PCP," page 9 explains how a member may change their primary care provider.	
18. The member handbook provided to members following enrollment includes the following member rights and protections as specified in 42 CFR 438.100. Each member has the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy.	*RMHP CHP+ Benefits Booklet 0717_508* Section 2-Member Rights & Responsibilities, pages 18-19 enumerate the member rights and protections set forth in 42 CFR 438.100. This information is set forth in the member handbook in accordance with the information requirements set forth in 42 CFR 438.10 (e.g., in a manner and format that is easily understood and readily accessible).	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her healthcare, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished healthcare services in accordance with requirements for access, coverage, and coordination of medically necessary services. • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its network providers, or the State agency treats the member. *42 CFR 438.10(g)(2)(ix)* CHP+ Contract: Exhibit B—14.1.3.6.1 and Exhibit K—1.1.2 Prime Contract: Exhibit A-5—4.1.1.1, 4.1.1.3.3.1		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and fair hearing procedures and timeframes: • The right to file grievances and appeals. • The requirements and timeframes for filing a grievance or appeal. • The right to a request a State fair hearing after the Contractor has made a determination on a member's appeal which is adverse to the member. • The availability of assistance in the filing process. • The fact that, when requested by the member: – Benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or if a request for State fair hearing is filed within the time frames specified for filing. – If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending if the final decision is adverse to the member. *42 CFR 438.10(g)(2)(xi)* CHP+ Contract: Exhibit B—1.1.16.6, 1.1.16.6.1, 1.1.16.6.3 Prime Contract: Exhibit A-5—Exhibit K—1.1.2.13.1.1, 1.1.2.13.2–4, 1.1.2.13.6	*RMHP CHP+ Benefits Booklet 0717_508* Section 9, "Complaints, Appeals & Grievances, pages 91-95 explains the process for filing grievances and appeals, including timeframes for filing, the right to request a State fair hearing, assistance that is available and the rules around continuing benefits during while the appeal/hearing is pending.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
20. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: • What constitutes an emergency medical condition and emergency services. • The fact that prior-authorization is not required for emergency services. • The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR 438.10(g)(2)(v)* CHP+ Contract: Exhibit K—1.1.10.1, 1.1.10.1.1–2, 1.1.10.1.5 Prime Contract: Exhibit K—1.1.2.8	*RMHP CHP+ Benefits Booklet 0717_508* Section 5, Covered Services, "Emergency and Urgent/After-Hours Care", pages 33-36 explains how after-hours and emergency coverage are provided. Emergency medical condition (including examples) is described at pages 34-35. Emergency services that are covered are discussed at pages 35-36. The fact that prior authorization is not required for emergency services is explained at page 34. Page 34 explains that a member can get emergency care anywhere in the United States and that permission from RMHP is not required.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
21. The member handbook provided to members following enrollment includes: • That cost-sharing, if any, is imposed under the State plan. • How and where to access any benefits that are available under the State plan but not covered under the CHP+ managed care contract. • How transportation is provided. *42 CFR 438.10(g)(2)(ii, viii)* CHP+ Contract: Exhibit K—1.1.3 Prime Contract: Exhibit K—1.1.2.11–12	*RMHP CHP+ Benefits Booklet 0717_508* Section 3, "What you Pay for Enrollment & Service," pages 21-24, explains all cost sharing (enrollment fees and co-payments) imposed at all income levels on services under the CHP+ State plan. Section 5, Covered Services, pages 71-72 provides an explanation of emergency ambulance services that are covered. No other transportation (including non-emergency medical transportation) is a covered benefit under the CHP+ State plan or RMHP's contract.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_CI_CHP+_Copay Notices A CHP+ copay notice is included in the welcome packet with the Benefits Booklet. It illustrates the amount of member copays (varies based on member income). RMHP covers all benefits that are covered under the CHP+ State plan.	
22. The member handbook provided to members following enrollment includes: • **The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.** • **Information on how to report suspected fraud or abuse.** • **How to access auxiliary aids and services, including information in alternative formats or languages.** *42 CFR 438.10(g)(2)(xiii, xiv, xv)* CHP+ Contract: N/A Prime Contract: (Not found)	*RMHP CHP+ Benefits Booklet 0717_508* The toll-free telephone number for member services is found on the cover of the benefits booklet, at the bottom of every page and on page 4 "How to Contact Rocky Mountain Health Plans." On page 18, under "How to Contact RMHP Care Coordination," a telephone number for customer service is provided that a member may use to ask from help with care coordination. Section 7, Administrative Information and Additional Information, "Fraud Activity," pages 81-82, provides information to members about how to report suspected fraud or abuse. Notice of Non-Discrimination, page 114 provides information about how to access auxiliary aids and services, including alternative formats and languages.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
23. The member handbook provided to members following enrollment includes **how to exercise** an advance directive as required in 438.3 (j): • The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. • The Contractor's policies and procedures respecting implementation of advance directives, with a clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • Instructions that complaints concerning noncompliance with advance directives requirements may be filed with the Colorado Department of Public Health and Environment. *42 CFR 438.10(g)(2)(xii)* CHP+ Contract: Exhibit B—14.1.1.2.7, 14.1.1.2.7.1, 14.1.9 Prime Contract: Exhibit A-5—4.1.6.1 and Exhibit K—1.1.2.13.8	*RMHP CHP+ Benefits Booklet 0717_508* Section 2-Member Rights & Responsibilities-"Your Right to Make Health Care Decisions-Advance Directives. What is an Advance Directive," page 19-20 describes the three kinds of Advance Directives. RMHP does not have any limitations regarding implementation of Advance Directives as a matter of conscience; therefore, a statement of limitation is not made. *V_PR_Advance Directives_PP* Page 2 describes provider requirements related to Advance Directives, including the need for a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. *V_PR_Summer 2017 Provider Newsletter* Page 5 delineates RMHP expectations of providers if they object to an advance directive on the basis of conscience.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. **The Contractor provides member information by any of:** • **Mailing a printed copy of the information to the member's mailing address.** • **Providing the information by email after obtaining the member's agreement to receive the information by email.** • **Posting the information on the web site of the MCO and advising the member in paper or electronic form that the information is available on the Internet and including the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.** • **Providing the information by any other method that can reasonably be expected to result in the member receiving that information.** *42 CFR 438.10(g)(3)* CHP+ Contract: N/A Prime Contract: (Not found)	*V_CI_Prep_Maintain_ Distribute_Medicaid_CHP+_Member Materials_PP_101317* Page 1 states that RMHP will make materials available to a member in paper form via U.S. mail and without charge within 5 days of request. Page 3 describes the process for sending member materials upon request by mail or by e-mail, including the timeframe for response to the request. Customer Service Reps will document if the member agrees to receive the information by e-mail. *Prime Member Handbook 0717_508* Page iv advises members that the Handbook and the Provider Directory are at rmhp.org and rmhpcommunity.org where they can view or print these documents. They can also ask Rocky Mountain Health Plans to mail a copy at any time at no cost. Page 16 tells members that they can see the prescription drugs covered by RMHP and learn about RMHP medication management by going to RMHP's website, rmhp.org, and look for formularies. *RMHP CHP+ Benefits Booklet 0717_508* Page 4 informs members that they can get a CHP+ Benefits Booklet at any time, and that they can ask RMHP to mail a copy or they can access it online.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 6 lists the RMHP website URL under Important Websites, and informs members that they can go to the website for information about providers, for a copy of the Benefits Booklet and more. Page 7 tells members that the Benefits Booklet and Provider Directory are at rmhp.org where they can view or print these documents. They can also ask Rocky Mountain Health Plans Customer Service to mail a copy at any time at no cost. Page 61 tells members that the most up-to-date list of prescription medications covered under the CHP+ plan is on RMHP's website at www.rmhp.org. A paper copy is available by calling RMHP Customer Service. *V_Prime_CHP Member Newsletter Fall 2017* Page 3, the *Learn your Member rights and responsibilities* section informs members that they can obtain a Prime Handbook or CHP+ Benefits Booklet at any time by calling RMHP, or they can see the handbooks online at the website.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. The Contractor must make available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* CHP+ Contract: (Not found) Prime Contract: Exhibit K—1.1.2.13.10	*Prime Member Handbook 0717_508* See page 37, section "How Rocky Mountain Health Plans Works" for statement that member can get more information about how RMHP works, including how RMHP is arranged, and information on RMHP's physician incentive plans. *RMHP CHP+ Benefits Booklet 0717_508* Page 83, "No Withholding of Coverage of Necessary Care" states that members can ask Customer Service to receive information on RMHP's physician incentive plans.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

CHP+ Results for Standard V—Member Information							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	12	X	NA	=	NA
Total Applicable		=	12	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	100%

Medicaid Prime Results for Standard V—Member Information							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	11	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	14
				Total Score ÷ Total Applicable		=	100%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. **The Contractor has established internal grievance procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The Contractor must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them.** • **The Contractor may have only one level of appeal for members (or providers acting on their behalf).** • **A member may request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination has been upheld.** • **If the Contractor fails to adhere to required timeframes for processing appeals, the member is deemed to have exhausted the Contractor's appeal process and the member may initiate a State fair hearing.** *42 CFR 438.400(a)(3)* *42 CFR 438.402(a-c)* *42 CFR 438.400 (b)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.6.2 10 CCR 2505-10—8.209.3.A, 8.209.4.A.2.c, 8.208.4.N, 8.209.4.O	*VI_CM_Appeals Policy and Procedure* *VI_CM_Grievance Policy and Procedure* *VI_CM_Member Appeals Time Grid* *VI_CM_Process Designation of Representatives* *VI_CM_Verbal Appeal Acknowledgment Template* *VI_CM_Written Appeal Acknowledgment Template* *VI_CM_Notice of Appeal Resolution* *VI_CM_Medicaid CHP Appeal Rights 070117* *VI_CS_Process for Accepting Appeal or Grievance* The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. The documents indicate that there is only one level of appeal with the health plan for Prime and CHP+ members. Members are provided clear instructions about how to request a State Fair Hearing after exhausting RMHP's appeal process, or if RMHP fails to adhere to the required timeframes for processing appeals.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The Contractor defines **adverse benefit determination** as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service. • The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • For a resident of a rural area with only one managed care plan, the denial of a member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: – The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. – The provider is not part of the network, but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be	*VI_CM_Appeals Policy and Procedure* Section VII, A-F, page 16 defines "adverse benefit determination."	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: Exhibit B—1.1.1 Prime Contract: Exhibit A-5—1.1.1.4 10 CCR 2505-10—8.209.2.A		
3. The Contractor also defines **adverse benefit determination** as: • **The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).** *42 CFR 438.400(b)* *42 CFR 438.52(b)(2)(ii)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.6.2 10 CCR 2505-10—8.209.2.A.7	*VI_CM_Appeals Policy and Procedure* Section VII, G, page 16 further defines "adverse benefit determination" as the denial of a member's request to dispute a member financial liability, including cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor defines "Appeal" as "a review by the Contractor of an **adverse benefit determination**." *42 CFR 438.400(b)* CHP+ Contract: Exhibit B—1.1.4 Prime Contract: Exhibit A-5—1.1.1.5, 4.1.2.6.3.1 10 CCR 2505-10—8.209.2.B	*VI_CM_Appeals Policy and Procedure* Section VI, page 16 defines "appeal" as a review by RMHP of an adverse benefit determination.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor defines "grievance" as "an expression of dissatisfaction about any matter other than an **adverse benefit determination.**" Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights **regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision.** *42 CFR 438.400(b)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—1.1.1.37 and 4.1.2.5.1 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.i	*VI_CM_Appeals Policy and Procedure* Section V, pages 16 *VI_CM_Grievance Policy and Procedure* Section I, page 6 Grievance is defined as a verbal or written expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to quality of care or services provided, aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by RMHP to make an authorization decision.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *42 CFR 438.402(c)* CHP+ Contract: Exhibit B—14.1.4.5, 14.1.5.1 Prime Contract: Exhibit A-5—4.1.2.5.3, 4.1.2.6.3.1 10 CCR 2505-10—8.209.3.B.1, 8.209.3.B.2, 8.209.2.C	*VI_CM_Grievance Policy and Procedure* Section II, page 1 indicates that a member or their designated representative may file grievances. Section IV, page 2 states that RMHP must obtain authorization in writing from the member or his/her designated client representative (DCR), including a treating health care professional, to represent his or her interests related to grievances. *VI_CM_Appeals Policy and Procedure* Section XI, page 11 states that the member or their DCR may request a State Fair Hearing. Section I.C, page 2 indicates that procedures for authorized representatives to appeal on a member's	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	behalf are outlined in the "Designation of Representatives" Process. *VI_CM_Process Designation of Representatives* Section 2, page 1 states that a member, or a designated client representative acting on behalf of a member with the member's written consent, or the legal representative of a deceased member's estate, may file a grievance, a health plan-level appeal, and may request a State Fair hearing.	
7. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* CHP+ Contract: Exhibit B—14.1.5.6 Prime Contract: Exhibit A-5—4.1.2.5.3 10 CCR 2505-10—8.209.5.D	*VI_CM_Grievance Policy and Procedure* Section I, page 2 lists the ways that RMHP accepts grievances, both orally and in writing. *VI_CS_Process for Accepting Appeal or Grievance* This document describes the process that Customer Service Representatives follow to accept member grievances orally by phone. *VI_CS_Complaints and Appeals Routing* Section 6.0, page 2 explains that Customer Service Representatives receive grievances by phone or email.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. Members may file a grievance **at any time.** *42 CFR 438.402(c)(2)(i)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.6.2 10 CCR 2505-10—8.209.5.A	*VI_CM_Grievance Policy and Procedure* Section I, page 2 states that members or their designated representative can file grievances at any time.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—14.1.5.5 Prime Contract: Exhibit A-5—4.1.2.5.3, 4.1.2.6.2 10 CCR 2505-10—8.209.5.A	*VI_CM_Grievance Policy and Procedure* Section V, page 2 states that acknowledgment letters are sent to members within two working days.	**CHP+:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The Grievance Policy and Process document supported that members receive written acknowledgement of the grievance within two working days. Through the on-site file review; however, RMHP did not consistently demonstrate that members receive written acknowledgement of each grievance timely. Specifically, for CHP +, the health plan did not send an acknowledgement letter or sent the acknowledgement to the member untimely in three of 10 cases reviewed. For Medicaid grievances, two of 10 cases reviewed indicated that members did not receive a written acknowledgement letter.		
Required Actions: RMHP CHP+ and RMHP Prime must have mechanisms in place to ensure that members receive written acknowledgement of each grievance within two working days of the health plan's receipt of the grievance.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
10. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and **within 15 working days of when the member files the grievance.** • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* CHP+ Contract: Exhibit B—14.1.5.7, 14.1.5.9 Prime Contract: Exhibit A-5—4.1.2.5.5 10 CCR 2505-10—8.209.5.B	*VI_CM_Grievance Policy and Procedure* Section I, page 4 states that RMHP must respond to a grievance within 15 working days from the date of receipt, or as expeditiously as the member's health condition requires. *VI_CM_CHP+ Grievance Resolution Template* *VI_CM_Prime Grievance Resolution Template* These templates are used to provide notice to the member of the disposition/resolution of their grievance. They are in a format and include standard language that can be easily understood by members.	**CHP+:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: RMHP's Grievance Policy specified that, for Medicaid members, any grievance must be resolved and notice sent to the member within 15 working days, or as expeditiously as the member's health condition requires. During the on-site file review, all Medicaid cases reviewed demonstrated that the health plan was compliant with resolving and sending resolution notices timely. However, one CHP+ grievance reviewed was not resolved timely, and resolution notice for that grievance was not sent to the member within 15 working days.		
Required Actions: RMHP CHP+ must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. CHP+ Contract: Exhibit B—14.1.5.1.1 Prime Contract: Exhibit A-5—4.1.2.5.5.1 10 CCR 2505-10—8.209.5.G	*VI_CM_CHP+ Grievance Resolution Template* *VI_CM_Prime Grievance Resolution Template* These templates include the disposition /resolution process and the date it was completed.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, **auxiliary aids and services upon request**, as well as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR 438.406(a)(1)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.2 10 CCR 2505-10—8.209.4.C	*VI_CM_Appeals Policy and Procedure* Section I.B, page 2 explains how RMHP assists members in completing any forms required, putting verbal requests, including requests for a State fair hearing, into writing and taking other procedural steps. *VI_CM_Grievance Policy and Procedure* Section I, General Information, page 2, explains how RMHP assists members with completing any forms or completing other procedural steps. *ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 081517* This document is sent with all significant member communications, including with all appeals and grievances member mailings. The Notice of Nondiscrimination on page 3 states that RMHP	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge, including auxiliary aids and services, free language assistance services, qualified interpreters and more.	
13. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* CHP+ Contract: Exhibit B—14.1.5.8 Prime Contract: Exhibit A-5—4.1.2.5.4 10 CCR 2505-10—8.209.4.E, 8.209.5.C	*VI_CM_Appeals Policy and Procedure* Section IV.C, page 4 describes the requirements for the reviewers/decision-makers. The Medical Director and the clinical consultant must not have been involved in the initial decision or be the subordinate of the medical director involved in the initial review. The reviewer or consultant must have the appropriate clinical expertise in treating the member's condition or disease *VI_CM_Grievance Policy and Procedure* Section I, page 4 indicates that RMHP ensures that individuals who make decisions on grievances are individuals who were not involved in any aspect of the circumstances or decision-making that led to the grievance nor a subordinate of any individual who was involved, and have the appropriate clinical expertise in treating the member's condition or disease.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. Contractor ensures that the individuals who make decisions on grievances and appeals: • **Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.** *42 CFR 438.406(b)(2)* CHP+ Contract: N/A Prime Contract: (Not found)	*VI_CM_Appeals Policy and Procedure* Section IV.C.4, page 4 provides that the individuals who make decisions on grievance and appeals take into account all comments, documents records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. A member may file an appeal with the Contractor **within 60 calendar days** from the date on the adverse benefit determination notice. *42 CFR 438.402(c)(2)(ii)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.6.9.1 10 CCR 2505-10—8.209.4.B	*VI_CM_Member Appeals Time Grid* Indicates the 60 calendar day time frame members have to submit an appeal.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* *42 CFR 438.406(b)(3)* Contract: Exhibit B—14.1.4.6, 14.1.4.16.1 Prime Contract: Exhibit A-5—4.1.2.6.3.2, 4.1.2.6.3.2.1 10 CCR 2505-10—8.209.4.F	*VI_CM_Appeals Policy and Procedure* Section I.A.4. page 2 indicates that appeals will be accepted verbally. Section II, page 3 explains how verbal appeals are acknowledged and describes the process for obtaining a written, signed appeal of an oral request. *VI_ CM_Verbal Appeal Acknowledgment Template* This template explains to members what RMHP believes to be the reason for the appeal, and indicates that the member can sign and return the letter if they agree that RMHP understands what they are appealing. This notice also explains that the member must sign and return the letter.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—14.1.4.7 Prime Contract: Exhibit A-5—4.1.2.6.4 10 CCR 2505-10—8.209.4.D	*VI_CM_Member Appeals Time Grid* This document indicates the time frame to acknowledge receipt of a standard appeal. *VI_CM_Verbal Appeal Acknowledgment Template* *VI_CM_Written Appeal Acknowledgment Template* These letter templates are used to provide written acknowledgement of verbal and written appeals and are sent within two working days of receipt of standard appeals.	**CHP+:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: RMHP's Member Appeals Time Grid specified that written acknowledgement of appeals must be sent to Medicaid and CHP+ members within two working days of receipt of the appeal. During the on-site file review; however, one of four applicable CHP+ appeals and six of nine applicable Medicaid appeals revealed that the health plan was not sending acknowledgement letters to members as required.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: RMHP CHP+ and RMHP Prime must have mechanisms in place to ensure that written acknowledgement of each appeal is sent to members within two working days of receipt, unless the member or designated client representative requests an expedited resolution.		
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date), and must be confirmed in writing unless the member or provider requests expedited resolution. • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* CHP+ Contract: Exhibit B—14.1.4.9.3 Prime Contract: Exhibit A-5—4.1.2.6.6.1, 4.1.2.7.1.1, 4.1.2.6.6.4 10 CCR 2505-10—8.209.4.F, 8.209.4.I	*VI_CM_Appeals Policy and Procedure* Section II.A. page 3 explains that verbal inquiries are treated as appeals. Paragraph A.1. describes the procedure for confirming a standard appeal in writing and that written confirmation is not required for an expedited appeal. *VI_CM_Process Designation of Representatives_PP* Paragraph 2 pages 1-2 explains that the member, his representative or the legal representative of a deceased member's estate are the parties to the appeal	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence **and testimony** and make legal and factual arguments. (**The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe in the case of expedited resolution.**) • The member and his or her representative the member's case file, including medical records, other documents and records, and **any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution timeframe.** *42 CFR 438.406(b)(4-5)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.6.6.2–3 10 CCR 2505-10—8.209.4.G, 8.209.4.H	*VI_CM_Appeals Policy and Procedure* Section II.A.2, page 3 explains how RMHP gives members an opportunity to submit further evidence, including in cases of expedited resolution where time is limited. *RMHP CHP+ Benefits Booklet* Page 92 under First Level Review, members are informed how they will receive information about how to access their appeal file and that they may provide more information about their appeal to RMHP either in person, by telephone, or in writing. *Prime Member Handbook* Page 33 under First Level Review, members are informed how they will receive information about how to access their appeal file and that they may provide more information about their appeal to RMHP either in person, by telephone, or in writing. *VI_CM_Verbal Appeal Acknowledgment Template* *VI_CM_Written Appeal Acknowledgment Template* These letter templates explain that members may have a reasonable opportunity before a decision is made to provide evidence in person or in writing. The letter also explains that the member may obtain a copy of their whole appeal file free of charge. *VI_CM_Appeals Policy and Procedure*	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Section IV.F, page 5 indicates that members are notified that they may obtain, upon request and free of charge, access to and copies of all documents relevant to the appeal decision including any new or additional evidence; relevant documents or records relied upon and documents and records submitted in the course of making the appeal decision. Section XX.A page 15 provides that upon request, a member or his/her representative can access the member's file at no cost.	
20. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10*	*VI_CM_Member Appeals Time Grid* Provides timeframes for appeals process and decisions. *VI_CM_Appeals Policy and Procedure* Section IV.D page 4 and IV.M page 5 describe the content of appeal resolution letters, including that they must be in a format and language that is easily understood by the member. *VI_CM_Notice of Appeal Resolution* This template provides the standard text contained in a notice of appeal resolution and demonstrates that the content is in a format and language that may be easily understood by the member.	**CHP+:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—14.1.4.8 and 14.1.3.1 Prime Contract: Exhibit A-5—4.1.2.6.2, 4.1.2.6.8, and 4.1.1.3.3.1 10 CCR 2505-10—8.209.4.J(1), 8.209.4.L		
Findings: RMHP's Appeals policy, Member Appeals Time Grid, and Notice of Appeal Resolution template supported that appeals are resolved and members receive written notice of appeal resolution within 10 working days from date of receipt and the written notice of the appeal is in a format and language that is easily understood by the member. During the on-site file review, two CHP+ member appeals were not resolved within the 10 working days' time frame.		
Required Actions: RMHP CHP+ must have mechanisms in place to ensure that appeals are resolved and members receive written notice of appeal resolution within 10 working days from date of receipt.		
21. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties **within 72 hours** after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.7.2.1, 4.1.2.7.2.1.3 10 CCR 2505-10—8.209.4.J.(2), 8.209.4.L	*VI_CM_Member Appeals Time Grid* Provides that the timeframe for resolving an expedited appeal is within 72 hours of receipt. *VI_CM_Appeals Policy and Procedure* Section V.B.2 page 6 provides that RMHP will make reasonable efforts to provide oral notice to the member of the expedited resolution.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
22. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* CHP+ Contract: Exhibit B—14.1.5.10 Prime Contract: Exhibit A-5—4.1.2.6.5.1, 4.1.2.7.2.1.1 10 CCR 2505-10—8.209.4.K	*VI_CM_Appeals Policy and Procedure* Section VI.H.1, pages 7-8 explains the circumstances under which RMHP will extend the time frames for resolution of both expedited and standard appeals. *VI_CM_Grievance Policy and Procedure* Process, Section I, page 5, explains the circumstances under which RMHP will extend the time frame for resolution of a grievance.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. If the Contractor extends the timeframes, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • **Within two (2) calendar days**, give the member written notice of the reason for the delay **and inform the member of the right to file a grievance if he or she disagrees with that decision.** • Resolve the appeal as expeditiously as the enollee's health condition requires and no later than the date that the extension expires. *42 CFR 438.408(c)(2)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.6.5.2 10 CCR 2505-10—8.209.4.K (2)	*VI_CM_Appeals Policy and Procedure* Section VI.H.1, pages 7-8 explains that RMHP will make reasonable efforts to give the member prompt oral notice of its decision to delay its decision due to an extension, that it will provide the member written notice of the reason for the delay within two calendar days, informing the member they may file a grievance if they disagree. Further, this P&P explains that the appeal will be resolved as expeditiously as the member's health condition requires and no later than the date the extension requires.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend or reduce.* *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—14.1.4.10 Prime Contract: Exhibit A-5—4.1.2.6.8.1–2 10 CCR 2505-10—8.209.4.M	*VI_CM_Appeals Policy and Procedure* Section IV.M, page 5 describes the information that must be included in the notice of appeal resolution. *VI_CM_Notice of Appeal Resolution* This template illustrates that the notices of appeal resolution contain the required language.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: RMHP's Member Appeals Process policy complied with written notice of appeal resolution requirements. During the on-site file review; however, four of 10 Medicaid resolution letters contained inaccurate State fair hearing time frame requirements and/or did not include the date that the resolution process was completed.		
Required Actions: RMHP must ensure that the written notice of appeal resolution letter includes the date that the resolution process was completed and accurate State fair hearing time frame requirements.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.8.1 10 CCR 2505-10—8.209.4.N, 8.209.4.O	*VI_CM_Appeals Policy and Procedure* Section IX.A., page 11 Explains that the Member or their DCR may request a State fair hearing within 120 days from the date of the notice of resolution. The P&P also explains that a member is deemed to have exhausted the appeal process and may request a State fair hearing if RMHP does not adhere to the notice and timing requirements. *RMHP CHP+ Benefits Booklet* Page 92 under Second Level Review, members are informed they may request a State fair hearing within 120 calendar days from the date of the notice of resolution and that if RMHP does not adhere to the notice and timing requirements, the member may request a State fair hearing. *Prime Member Handbook* Page 33 under Second Level Review, members are informed they may request a State fair hearing within 120 calendar days from the date of the notice of resolution and that if RMHP does not adhere to the notice and timing requirements, the member may request a State fair hearing.	**CHP+:** ☐ Met ☒ Not Scored **Prime:** ☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: RMHP's appeals policy and handbooks indicated that members could request a State fair hearing within 120 calendar days from the date of notice of resolution. During the on-site file review, four resolution letters sent to Medicaid members did not indicate that members may request State fair hearings within 120 calendar days from the dates of the notices of resolution. Instead, these letters inaccurately indicated that members had 30 days from the dates of the notices of resolution to request State fair hearings.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Recommendations: RMHP CHP+ should update documentation, including notice of resolution template letters, to support that, for adverse benefit determinations, members may request State fair hearings within 120 calendar days from the dates of the notices of resolution.		
Prime Required Actions: RMHP Prime must ensure that all documentation, including notice of resolution template letters, support that, for adverse benefit determinations, members may request State fair hearings within 120 calendar days from the dates of the notices of resolution.		
26. The parties to the State fair hearing include the Contractor, as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* CHP+ Contract: Exhibit B—14.1.4.17.5 Prime Contract: Exhibit A-5—4.1.2.8.3 10 CCR 2505-10—8.209.4.H	*VI_CM_Appeals Policy and Procedure* Section XI.D. states that the member and his or her representative participate in the state fair hearing.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a-b)* CHP+ Contract: Exhibit B—14.1.4.16, 14.1.4.16.4	*VI_CM_Appeals Policy and Procedure* Section V. pages 5-6, describes the expedited review process. Section V.B.3. page 6 states that punitive action will not be taken against a provider for requesting an expedited appeal or supporting a member's appeal. *VII_PNM._Physician(s) Medical Services Agreement* Section 7, Paragraph G. Limitations on Adverse Actions, pages 21-22	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Prime Contract: Exhibit A-5—4.1.2.7.1, 4.1.2.7.3 10 CCR 2505-10—8.209.4.Q, 8.209.4.R	RMHP will not take an adverse action against a provider for assisting a member in seeking reconsideration of a coverage decision. *VII_PNM_Professional Services Agreement* Section 7, Paragraph G. Limitations on Adverse Actions, pages 22-23 RMHP will not take an adverse action against a provider for assisting a member in seeking reconsideration of a coverage decision. *VII_PNM_Hospital Services Agreement* Section 8, Paragraph G. Limitations on Adverse Actions, pages 24-25 RMHP will not take an adverse action against a provider for assisting a member in seeking reconsideration of a coverage decision.	
28. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • **Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.** *42 CFR 438.410(c)*	*VI_CM_Appeals Policy and Procedure* Section V.B.1, page 6, provides that if RMHP denies a request for expedited resolution, it will transfer the decision to the standard time frame and will make reasonable efforts to give the member verbal notice followed by written notice of the denial within two calendar days. *VI_CM_Appeals Policy and Procedure* Section V.B.4., page 6 provides that the member has the right to file a grievance if he or she disagrees with the decision not to expedite the appeal.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—15.1.4.16.5 Prime Contract: Exhibit A-5—4.1.2.7.1.3 10 CCR 2505-10—8.209.4.S		
29. The Contractor provides for continuation of benefits/services while the Contractor-level appeal and the State fair hearing are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required timeframes. ** This definition of "timely filing" only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)*	*VI_CM_Appeals Policy and Procedure* Section XII. page 12, describes the policy for continuation of benefits *VI_CM_Notice of Appeal Resolution* This notice describe the continuation of benefits policy while RMHP appeal and State fair hearing are pending.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—14.1.4.11 Prime Contract: Exhibit A-5—4.1.2.6.9 10 CCR 2505-10—8.209.4.T		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* CHP+ Contract: Exhibit B—14.1.4.12 Prime Contract: Exhibit A-5—4.1.2.6.10 10 CCR 2505-10—8.209.4.U	*VI_CM_Appeals Policy and Procedure* Section XII.F., page 12 describes how long benefits are continued and the events that must occur before benefits can be discontinued.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* CHP+ Contract: Exhibit B—14.1.4.13 Prime Contract: Exhibit A-5—4.1.2.6.11 10 CCR 2505-10—8.209.4.V	*VI_CM_Appeals Policy and Procedure* XII.G.1, page 12 describes the member's responsibility for the cost of continued services if the appeal decision is adverse to the member.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than **72 hours** from the date it receives notice reversing the determination. *42 CFR 438.424(a)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.6.12 10 CCR 2505-10—8.209.W	*VI_CM_Appeals Policy and Procedure* XII.G.3, pages 13 describes RMHP's responsibility for effectuating the State hearing decision if it reverses RMHP's decision to deny, limit or delay services that were not furnished while the appeal was pending.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the MCO or the State must pay for those services, in accordance with State policy and regulations. *42 CFR 438.424(b)* CHP+ Contract: Exhibit B—14.1.4.15 Prime Contract: Exhibit A-5—4.1.2.6.13 10 CCR 2505-10—8.209.4.X	*VI_CM_Appeals Policy and Procedure* XII.G.2, page 13, provides that RMHP must pay for services when the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
34. The Contractor maintains records of all grievances and appeals. **The records must be accurately maintained in a manner accessible to the State and available on request to CMS. The record of each grievance and appeal must contain, at a minimum, all of the following information:** • **A general description of the reason for the grievance or appeal.** • **The date received.** • **The date of each review or, if applicable, review meeting.** • **Resolution at each level of the appeal or grievance.** • **Date of resolution at each level, if applicable.** • **Name of the person for whom the appeal or grievance was filed.** *42 CFR 438.416* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.6.2 10 CCR 2505-10—8.209.3.C	*VI_CM_Appeals Policy and Procedure* Section I.G., page 2 describes the records of appeals that RMHP maintains. *VI_CM_Grievance Policy and Procedure* Section XIII, page 4 describes the records of grievances that RMHP maintains.	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
35. The Contractor provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* CHP+ Contract: Exhibit B—11.1.12 Prime Contract: Exhibit A-5—4.1.2.3.6 10 CCR 2505-10—8.209.3.B	*VII_PNM._Physician(s) Medical Services Agreement* Section 2, Paragraph R. Expressing Disagreement, page 12 Informs providers that RMHP has a process for submitting grievances and appeals for members that is described in the provider manual that can be accessed online or can be requested in written form. *VII_PNM_Professional Services Agreement* Section 2 Paragraph O. Expressing Disagreement, page 12 Informs providers that RMHP has a process for submitting grievances and appeals for members that is described in the provider manual that can be accessed online or can be requested in written form. *VII_PNM_Hospital Services Agreement* Section 2, Paragraph U. Expressing Disagreement, page 15 Informs providers that RMHP has a process for submitting grievances and appeals for members that is described in the provider manual that can be accessed online or can be requested in written form. *VII_PNM_Addendum to PMSA for ACC Medicaid* Page 3, paragraph 3 states that RMHP will make a Provider Manual available to contracted providers. *2017 Provider Manual* Pages 50-53 describe the Appeal and Grievance Processes for Prime and CHP+	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

CHP+ Results for Standard VI—Grievance System							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	0	X	.00	=	0
	Not Met	=	4	X	.00	=	0
	Not Applicable	=	13	X	NA	=	0
Total Applicable		=	22	**Total Score**		=	18
				Total Score ÷ Total Applicable		=	82%

Medicaid Prime Results for Standard VI—Grievance System							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	0	X	.00	=	0
	Not Met	=	4	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	35	**Total Score**		=	31
				Total Score ÷ Total Applicable		=	89%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor implements written policies and procedures for selection and retention of providers. *42 CFR 438.214(a)* CHP+ Contract: Exhibit B—14.2.1.1 Prime Contract: Exhibit A-5—4.2.2.1	*VII_QI_Cred Criteria and Process CR1.16* This policy defines a consistent credentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for credentialing of its providers. Pgs. 1-13 *VII QI Recred Process RC1.16* This policy defines a consistent recredentialing process for practitioners applying to the RMHP panel in compliance with federal regulation and NCQA standards for recredentialing of its providers. Pgs. 1-13	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor follows a documented process for credentialing and recredentialing that complies with the State's policies for credentialing. • The Contractor's credentialing program shall comply with the standards of the National Committee for Quality Assurance (NCQA). • The Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. *42 CFR 438.214(b)* CHP+ Contract: Exhibit B—14.2.1.3 Prime Contract: Exhibit A-5—4.2.2.3	*VII_QI_Cred Criteria and Process CR1.16* The Contractor complies with NCQA standards and guidelines for credentialing and recredentialing its providers. *VII_QI Health Delivery Org Credentialing HDO.1.16* Contractor ensures that all laboratory-testing sites providing services under the Contract shall have either a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver or a Certificate of Registration along with a CLIA registration number. Page 2.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: • Discriminate against particular providers for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. • Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42 CFR 438.12(a)(1) and (2)* *42 CFR 438.214(c)* CHP+ Contract: Exhibit B—14.4.1 and 14.2.1.6 Prime Contract: Exhibit A-5—4.2.2.5 and 4.2.9.1	*VII_QI_Non Discriminatory Credentialing CR14.16* This policy describes the process used to monitor for and prevent against discriminatory Credentialing practices.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This is not construed to: • Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members. • Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. • Preclude the Contractor from establishing measures that are designed to maintain quality of services and control	*VII_QI_Cred Criteria and Process CR1.16* See Pgs. 11-12 –Section II. E. Final Decision and Notifications, which sets for the notification procedure for practitioners applying to the RMHP panel. *VII QI Recred Process RC1.16* See page 12, Section II.E. Final Decision and Notification, which sets forth the notification procedure for practitioners applying to the RMHP panel.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
costs and are consistent with its responsibilities to members. *42 CFR 438.12(a–b)* CHP+ Contract: Exhibit B—14.4.1, 14.4.1.1–3 Prime Contract: Exhibit A-5—4.2.9.1	*VII_QI_Reduction, Suspension or Termination Practices RC4.16* See pages 2-5, Section 1. This policy outlines the process for notifying a provider of the reduction, suspension or termination of a health care provider's contracting status.	
5. The Contractor has a signed contract or participation agreement with each provider. *42 CFR 438.206(b)(1)* CHP+ Contract: Exhibit B—10.1 Prime Contract: (Not found)	*VII_PNM._Physician(s) Medical Services Agreement* Section 1 Paragraph FF. "Participating Physician," page 5 provides that the term "participating physician" means a person who holds a degree of Doctor of Medicine or Doctor of Osteopathy, is licensed by the State of Colorado to practice medicine, has a written agreement directly with RMHP.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor does not employ or contract with providers or other individuals or entities excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act. *42 CFR 438.214(d)* *42 CFR 438.610* CHP+ Contract: Exhibit B—19.1.1.1 Prime Contract: Exhibit A-5—7.1.3	*VII_QI_Cred Criteria and Process CR1.16* This policy defines the credentialing process for Practitioners applying to the RMHP panel. On page 7 the policy states that if a provider is on the OIG's list of debarred providers, credentialing/contracting will not be initiated. Pages 8-9: RMHP's credentialing verification sources include license sanction status (#8), and Medicare/Medicaid sanction Status (#9). *VII_PNM_ Process to Initiate Credentialing PP*	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Provides that before credentialing can begin, SAM, OFAC and OIG websites must be checked to ensure provider is not excluded from participation in federal healthcare programs. *VII_QI_National Practitioner Data Bank CR.05.16* Describes RMHP's process for accessing the NPDB for all new practitioners and all currently contracted practitioners. This serves as primary source verification of sanctions against or limitations on licensure, sanction activity by Medicare and Medicaid, and malpractice history.	
7. The Contractor may not knowingly have a director, officer, partner, employee, consultant, provider, subcontractor, or owner (owning 5 percent or more of the Contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42 CFR 438.610* CHP+ Contract: Exhibit B—19.1.1 and 19.1.2 Prime Contract: Exhibit A-5—7.1.1.1	*VII_LRA_Compliance Plan_101017* pages 28-30: *Sanctioned/ Excluded Parties* – all individuals affiliated with the company must be screened to ensure they are not debarred, suspended or excluded from participating in federally-funded health care programs or procurement. *VII_HR_OIG OFAC SAM_Process 071617* RMHMC Human Resource (HR) process for checking the OIG, OFAC & SAM lists of Excluded Individuals/Entities prior to hiring or contracting with individuals or entities or appointing Board Members. HR periodically checks the OIG, OFAC and SAM web sites for determining the participation/exclusion status of current employees or entities contracted by RMHMC. Page 4 describes the process followed for current employees, Board members, RMHMC contractors and independent contractors.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor does not prohibit, or otherwise restrict healthcare professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: • The member's health status, medical care, or treatment options—including any alternative treatments that may be self-administered. • Any information the member needs in order to decide among all relevant treatment options. • The risks, benefits, and consequences of treatment or non-treatment. • The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions. *42 CFR 438.102(a)(1)* CHP+ Contract: Exhibit B—10.4.3 Prime Contract: Exhibit A-5—3.6.3.2	*VII_PNM._Physician(s) Medical Services Agreement* Section 2, Paragraph R. *Expressing Disagreement*, page 12 RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation, and that RMHP has a process for submitting grievances and appeals for members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with members and will not penalize providers for such discussions. Section 2, Paragraph S. *Medicaid Recipients Right to Participation*, page 12 RMHP recognizes the member's right to participate in decisions regarding the member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. Section 7, Paragraph G. *Limitations on Adverse Actions*, pages 21-22 RMHP will not take an adverse action against a provider for assisting a member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the member whether covered by the health plan or not. *VII_PNM_Professional Services Agreement* Section 2 Paragraph O. *Expressing Disagreement*, page 12 RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with members and will not penalize providers for such discussions. Section 2, Paragraph P. *Medicaid Recipients Right to Participation*, page 12 RMHP recognizes the member's right to participate in decisions regarding the member's health care, including the right to refuse treatment and to express preferences about future treatment decisions. Section 7, Paragraph G. *Limitations on Adverse Actions*, pages 22-23	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP will not take an adverse action against a provider for assisting a member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with the member whether covered by the health plan or not. *VII_PNM_Hospital Services Agreement* Section 2, Paragraph U. *Expressing Disagreement*, page 15 RMHP does not discourage providers from protesting or expressing disagreement with a medical decision, policy or practice without limitation and that RMHP has a process for submitting grievances and appeals for members that is described in the provider manual. RMHP encourages open communication regarding providers discussing appropriate treatment alternatives for medically necessary health care services with members and will not penalize providers for such discussions. Section 2, Paragraph V. *Medicaid Recipients Right to Participation*, page 15 RMHP recognizes the member's right to participate in decisions regarding the member's health care, including the right to refuse treatment and to express preferences about future treatment decisions.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Section 8, Paragraph G. *Limitations on Adverse Actions*, pages 24-25 RMHP will not take an adverse action against a provider for assisting a member in seeking reconsideration of a coverage decision or for discussing treatments or treatment alternatives with Member whether covered by the health plan or not. *2017 Provider Manual* Affirmative Statement, pages. 3-4 RMHP encourages open communication between providers and members in discussing appropriate treatment alternatives for medically necessary health care services, including medication treatment options, regardless of benefit coverage limitations. Contracted providers are not prohibited or discouraged from protesting or expressing disagreement with a medical decision, medical policy, or medical practice, including, without limitation, medication treatment options, made by RMHP or an entity representing or working for RMHP (e.g., a utilization review company).	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: • To the State upon contracting or when adopting the policy during the term of the contract. • To members before and during enrollment. • To members within 90 days after adopting the policy with respect to any particular service. *42 CFR 438.102(b)* CHP+ Contract: Exhibit B—14.1.3.14, Exhibit K—1.1.7 Prime Contract: (Not found)	RMHP does not have objections to providing services on moral or religious grounds; therefore this requirement is not applicable.	**CHP+:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
10. The Contractor has administrative and management arrangements or procedures, including a compliance program to detect and prevent fraud, waste, and abuse, and which includes: • Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal, State, and contract requirements. • The designation of a compliance officer who is responsible for developing and implementing policies, procedures and practices to ensure compliance with requirements of the contract and who reports directly to the CEO and Board of Directors. • The establishment of a compliance committee of the Board of Directors and at the senior management level	Bullet 1 *VII_LRA_Compliance Plan_101017* Page 3: *Compliance Plan Purpose Statement* - One purpose of Compliance Plan is to help promote compliance with applicable laws. Page 4: *Commitment Statement* Pages 5-6 & Page 41: *Code of Conduct* - expectation that employees strive to comply with compliance plan and ethical behavior in all circumstances. Specific compliance policies begin at page 24. Bullet 2 *VII_LRA_Compliance Plan_101017* Pages 13-14 describes the duties of the, compliance officer and that this position reports to the CEO and Board of Directors.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
charged with overseeing the organization's compliance program. • Training and education of the compliance officer, management, and organization's staff members for the federal and State standards and requirements under the contract. • Effective lines of communication between the compliance officer and the Contractor's employees. • Enforcement of standards through well-publicized disciplinary guidelines. • Implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks. • Procedures for prompt response to compliance issues as they are raised, investigation of of potential compliance problems identified in the course of self-evaluation and audits, corection of such problems quickly and thoroughly to reduce the potential for reoccurence, and ongoing compliance with the requirements under the contract. *42 CFR 438.608(a)(1)* CHP+ Contract: Exhibit B—14.2.5.2–4, 14.2.7.3–9 Prime Contract: Exhibit A-5—4.2.5.2, 4.2.5.7–10, 4.2.5.2.1.2	Bullet 3 The Board of Directors operates as the Compliance Committee. The Compliance Officer reports to the Board of Directors. Pages 11-12 details Compliance program oversight and how the Board of Directors conducts it. The duties of the Board of Directors and Board Members are delineated as it relates to Compliance program oversight. Bullet 4 *VII_LRA_Compliance Plan_101017* Pages 39-40: *Training and Education* – describes the training and education on compliance issues (including fraud, waste and abuse) that takes place through the compliance plan and other sources, e.g., corporate orientation. RMHP provides training to employees, Officers, Board Members and Contractors when appropriate. Bullet 5 *VII_LRA_Compliance Plan_101017* Page 13 (2nd bullet): Compliance Officer is responsible for overseeing creation of mechanisms and channels that encourage employee reporting of violations without fear of reprisal. The following sections of the Compliance Plan demonstrate that there are multiple effective lines of communication between the compliance officer and RMHP's employees:	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 23: *Significant Lines of Communication* Page 27: *Reporting Mechanisms* Pages 35-36: *Reporting Compliance Issues and Potential Violations* Pages 67-72: *Contact List* Bullet 6 *VII_LRA_Compliance Plan_101017* Pages 38-39: *Enforcement and Disciplinary Standards* provides that RMHP will publish and communicate standards to employees. *VII_LRA_Spring 2017 Compliance Corner* Page 1, *Compliance & Disciplinary Standards*, informs employees that HIPAA P&P violations and Compliance Plan violations can subject an employee to discipline, up to and including termination of employment, civil and/or criminal liability, or any combination of the above. This is an example of how RMHP publicizes disciplinary guidelines to employees. *VII_IA-209 FWA Deterrence Program PP_Disciplinary Guidelines* Describes procedure for enforcing disciplinary standards and how they are publicized. Bullet 7 *VII_LRA_Compliance Plan_101017*	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The following sections describe RMHP's procedures and system (with dedicated staff) for routine internal monitoring and auditing of compliance risks: Page 13, Bullet 3: Compliance officer is to request routine audits of company function. Pages14-15, *Duties of the Compliance Committee* to conduct investigations of alleged regulatory or policy violations and requesting monitoring initiatives and audits be conducted. Page 21: *Duties of Internal Audit* to conduct testing, audits, and monitoring as determined by the Compliance Officer for significant compliance business risk areas. Page 33: *Risk Areas* provides description of annual risk analysis. *VII_IA-211 FWA PP_Hotline Monitoring* Process for daily monitoring of internally and externally reported compliance issues. Bullet 8 *VII_LRA_Compliance Plan_101017* Page 17, Bullet 5: LRA Director tasked with oversight of the RMHP's compliance function to ensure areas of risk are effectively and expeditiously assessed and mitigated. Page 19: Department directors appoint compliance staffers to address departmental compliance risks and resolution.	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VII_IA_IA-200 FWA Policy and Procedure C360 Describes the Compliance 360 FWA incident reporting system. *VII_ IA-203 Medicaid FWA Deterrence & Reporting* Section 6, pages 4-5, describes the procedure for prompt response to compliance issues as they are raised, including identification by referral, preliminary review, conducting the review, reporting internally and reporting to Regulatory Agencies.	
11. The Contractor's administrative and management procedures to detect and prevent fraud, waste, and abuse include: • Written policies for all employees, contractors or agents that provide detailed information about the False Claims Act, including the right of employees to be protected as whistleblowers. • Provisions for prompt referral of any potential fraud, waste, or abuse to the State Medicaid program integrity unit and any potential fraud to the State Medicaid Fraud Control Unit. • Provisions for suspension of payments to a network provider for which the State determines there is credible allegation of fraud (in accordance with 455.12). *42 CFR 438.608(a)(6–8)*	Bullet 1 *VII_LRA_Compliance Plan_101017* Page 48: *Fraud, Waste, and Abuse Prevention* provides information regarding fraud, waste and abuse as it relates to the False Claims Act. Page 66: RMHP Policy – *Whistleblower Protection* describes the prohibition of retaliation when an employee provides any truthful information to a law enforcement officer that is related to any possible federal offense. *VII_HR_2016 RMHMC Employee Handbook* Page 57 states that employees have whistleblower protection under the False Claims Act, and health care workers have a right to be protected as whistleblowers when reporting issues of patient safety.	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
CHP+ Contract: Exhibit B—14.2.6.1, 14.2.7.1, 14.2.7.7 Prime Contract: Exhibit A-5—4.2.5.6, 4.2.5.2.1.2, 4.2.5.3	Bullet 2 and 3 *VII_ IA-203 Medicaid FWA Deterrence & Reporting* Section 5, page 5, indicates the process for reporting reasonable indications or suspicions of potential fraud to State Regulatory Agencies. Section 3.0.3: *Provider Related FWA* paragraph 3, page 2, states that RMHP shall suspend payments to any Participating Provider that is actively under investigation for a credible fraud allegation.	
12. The Contractor's compliance program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying which overpayments are due to potenial fraud. • Screening all provider claims, collectively and individually, for potential fraud, waste, or abuse—including mechanisms to identify and report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence or member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care	Bullet 1 *VII_IA-214 Prompt Reporting of Overpayments* This policy states that RMHP will exercise reasonable diligence to identify and attempt to recover any overpayments and that RMHP will promptly report to HCPF any such overpayments identified or recovered, including specifying any overpayments that are due to potential fraud.. Bullet 2 *VII_IA-004 CAS Policy and Procedure* Includes steps needed to complete the CAS monthly audit and quarterly savings report. Auditor will use CGI's CAS to identify claims RMHP may have processed incorrectly. Auditor and Claims' Research and Adjustment (R&A) Team will reconcile the improper claims. R&A retracts claims paid incorrectly.	**CHP+:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A **Prime:** ☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608(a)(2–5)* CHP+ Contract: Exhibit B—14.2.5.4.3–8 Prime Contract: Exhibit A-5—4.2.8.3, 4.2.5.2.1.3	*VII_IA-207 Correct Coding for E&M Codes (CCP)* Describes the post payment review of E&M coding practices designed to monitor for potential upcoding and to improve the accuracy of provider coding. *VII_IA-210 FWA Deterrence Program PP_ Internal Monitoring* Outlines internal monitoring and auditing process used to review Fraud and Abuse (FWA) cases. Bullet 3 *VII_ MEB_PP Notice to State_ Enrollee Circumstance Change* Procedure to follow to notify the State if enrollee's circumstances change that may affect eligibility. Bullet 4 *V_CM_Prov Term Cross Dept_PP* Page 2, indicates that RMHP will notify the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with RMHP Bullet 5 *VII_IA-207 Correct Coding for E&M Codes (CCP)*	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Describes the quarterly post payment review of E&M coding practices designed to monitor for potential upcoding and other discrepancies. Section 8.A. indicates that for providers initially found to have billed a claim(s) that cannot be supported by the documentation submitted, a letter will be sent from IA requesting the provider review the results of the audit, and if they do not agree with the results, to submit a response as to their disagreement along with any additional supporting documentation within 15 days for the discovered discrepancies. *VII_IA-210 FWA Deterrence Program PP_ Internal Monitoring* Outlines the internal monitoring and auditing process used to review Fraud and Abuse (FWA) cases. Page 2, Section 6.0, A.3., page 2 indicates that IA will develop and conduct investigations designed to identify potential fraudulent situations, including the review of cases to determine whether services charged were never rendered.	
Findings: RMHP demonstrated a comprehensive compliance program in most areas. RMHP had developed a process for reporting overpayments to the Department and appeared to be prepared to submit overpayment data to the Department once a method for reporting is established. RMHP was not able to demonstrate a method to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. During the interview process, Rocky Mountain Health Care confirmed that they did not have a process for validating whether or not services billed by providers were received by members.		
Required Actions: RMHP CHP+ and RMHP Prime must have a method to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members.		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. **CHP+ Only:** **The Contractor ensures that all network providers are enrolled with the State consistent with the provider disclosure, screening, and enrollment requirements of the State.** **Medicaid Prime Only:** The Contractor shall verify that all primary care providers in its network are contracted Primary Care Medical Providers (PCMPs) in the Accountable Care Collaborative. *42 CFR 438.608(b)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—3.6.1.1.3	*VII_PNM_Process to Initiate Credentialing PP* Statement on Page 2 (last bullet) indicates that if the provider serves Health First Colorado (Colorado Medicaid) or CHP+ members, then the provider must be enrolled with Health First Colorado consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR Part 455, Subparts B and E and requirements of the State of Colorado. The provider must include in its RMHP enrollment application its Medicaid Identification number and the date of Health First Colorado enrollment or most recent validation. *IX_LRA_ Law Exhibit Template_Provider 0717* Page 9, paragraph 8 states that Contractor shall be enrolled with the State of Colorado in accordance with the disclosure, screening, and enrollment requirements of 42 CFR Part 455, Subparts B and E and the requirements of the State of Colorado for Medicaid and CHP+ providers. *VII_PNM_Addendum to PMSA for ACC Medicaid* This is an addendum to the PCMP contract that is executed by all Prime PCPs. Page 3-4, Section 6.C provides that Contractor and each Physician shall provide Medical Services to ACC Prime Members under the same terms and conditions as set forth in the Agreement for the provision of Medical Services to ACC Medicaid	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Members. Contractor and RMHP shall have the same duties and obligations with regard to the provision of Medical Services for ACC Prime Members as such parties have in the Agreement with regard to the delivery of Medical Services to ACC Medicaid Members.	
14. The Contractor has procedures to provide to the State: • Written discosure of any prohibited affiliation (as defined in 438.610). • Written disclosure of ownership and control (as defined in 455.104). • Identification within 60 calendar days of any capitation payments or other payments in excess of the amounts specified in the contract. *42 CFR 438.608(c)* CHP+ Contract: 21.B, Exhibit B—19.4.1, 19.1.1.1 Prime Contract: Exhibit A-5—4.2.5.13	*VII_LRA_Prohibited Affiliations PP* This policy states that RMHP will disclose to Colorado's Department of Health Care Policy and Finance ("HCPF") any relationship RMHMO has with an individual who is debarred, suspended or otherwise excluded from participating in a federal or state health care program. *VII_LRA_Prohibition Against Contracting With Any Person Policy* This policy and procedure describes the process for ensuring that RMHP does not contract with ineligible persons. *VII_LRA_Ownership & Control PP* This policy indicates that RMHP will disclose to HCPF information on ownership and control in a form acceptable to HCPF, and delineates what the disclosures will include. *VII_MEB_PP Reporting of Overpayments to State MCD010*	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This describes the procedure to identify and report within 60 calendar days any capitation or other payments in excess of the amounts specified in the contract.	
15. The Contractor has mechanisms for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days of identifying the overpayment, and to notify the Contractor in writing of the reason for the overpayment. • The Contractor reports annually to the State on recoveries of overpayments. *42 CFR 438.608(d)(2) and (3)* CHP+ Contract: (Not found) Prime Contract: (Not found)	9/18 Message from HSAG: *HSAG recognizes that any annual reporting will not have occurred prior to the on-site audits scheduled for 2017-2018, so that evidence of actual reporting will not be possible. However, HSAG will look for evidence—either written procedures, processes, or interview—to determine whether the health plan has a mechanism for reporting of overpayments from providers and to the State—and will score it accordingly.* *2017 Provider Manual* Page 45, under the paragraph "Refunding Rocky Mountain Health Plans" instructions are given to providers for reporting overpayments no later than 60 days after the overpayment is identified. Providers are instructed to include a written statement of the reason for the overpayment. *VII_IA_Prompt Reporting of Overpayments* On page 1 under the Policy section, this P&P provides that RMHP will report overpayments according to the specifications and at the intervals established by HCPF.	**CHP+:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A **Prime:** ☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The Contractor provides that members are not held liable for: • The Contractor's debts in the event of the Contractor's insolvency. • Covered services provided to the member for which the State does not pay the Contractor. • Covered services provided to the member for which the State or the Contractor does not pay the healthcare provider that furnishes the services under a contractual, referral, or other arrangement. • Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42 CFR 438.106* CHP+ Contract: Exhibit B—16.4.1–4 Prime Contract: Exhibit A-5—7.6.1	*VII_PNM_Physician(s) Medical Services Agreement* Section 2, Paragraph P: No Recourse Against Medicaid Recipients, page 11, sections (1), (2), (3). Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *VII_PNM_Professional Services Agreement* Section 2, Paragraph M: No Recourse Against Medicaid Recipients, page 11, sections (1), (2), and (3). Provider contracts state that members are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *VII_PNM_Hospital Services Agreement* Paragraph S: No Recourse Against Medicaid Recipients, page 14, sections (1), (2), and (3). Provider contracts state that Medicaid recipients are not liable for RMHP's debts due to insolvency, health care services for which the State does not pay	**CHP+:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RMHP or that the provider does not receive payment for, payments furnished under a contract, referral, or other arrangement if those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *2017 Provider Manual* Cost Share Collection section, RMHP Prime Members page 30 The member may not be balance billed for any costs not covered by either RMHP or the State.	

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

CHP+ Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	13
				Total Score ÷ Total Applicable		=	93%

Medicaid Prime Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	13	X	1.00	=	13
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	14	**Total Score**		=	13
				Total Score ÷ Total Applicable		=	93%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. **Notwithstanding any relationship(s) with any subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.** The Contractor must: • Evaluate the prospective subcontractor's ability to perform the activities to be delegated. • Monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State. • Identify deficiencies or areas for improvement, and ensure that the subcontractor takes corrective action. *42 CFR 438.230(b)(1)* CHP+ Contract: Exhibit B—5.5.3.3 Prime Contract: Exhibit A-5—3.1.4.1	*IX_QI_Pre-Delegation Instructions* Describes the process RMHP follows to evaluate whether a prospective delegate is capable of performing delegated credentialing activities. *IX_QI_Pre-Contractual Delegation Evaluation* This questionnaire completed by the potential delegate is reviewed by RMHP (in accordance with the pre-delegation instructions) to determine whether the delegate can perform credentialing activities in compliance with government regulations and NCQA standards. *IX_QI_Delegated Pre Audit Tracking Sheet* This document is used internally to track the information and documents requested from the delegate prior to audit. *IX_QI_Delegated Cred Audit Activities Policy DEL.2.16* Describes policy and procedure to conduct pre-delegation and annual delegation audits, including issuance of findings, identification of areas for improvement and monitoring of implementation of audit recommendations. *VII QI_Semi-Annual Report* Delegates are required to complete this reporting template that identifies practitioners	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	approved, site visits for complaint monitoring, and any improvement activities. *IX_PH15_PBM Delegation Oversight* Provides that RMHP Pharmacy management has a comprehensive monitoring/auditing plan to ensure effective oversight of major functions that have been delegated to the PBM. The monitoring tool is reviewed at least annually. Any issues identified are reported to the PBM for correction. Weekly conference calls and periodic onsite visits also take place to address any issues as they arise to ensure corrective action is taken. *IX_UM_Delegation Policy* The Delegated Utilization Management policy describes the oversight process for delegated Utilization Management (UM) activities. It describes pre-delegation activities (Sections 3.8, page 3 and 6.0, pages 4-7) undertaken to evaluate the prospective subcontractor's ability to perform UM activities. Section 3.1, pages 1-2 provides that the process for monitoring and evaluating the delegated entity's performance and the remedies available for non-performance will be set forth in a written agreement between the parties. Section 6.0, pages 4-7 sets forth the procedure for oversight.	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_UM_CCN Contract_CareCore National_ Redacted (CareCore National, LLC d/b/a eviCore healthcare) Page 4, Paragraph 2.4, pages 4-6 specifies that the delegated entity agrees to allow RMHP to maintain reasonable oversight and what that includes. Exhibit 3, page 45, in its entirety sets forth the Table of performance standards and monitoring that will occur under the agreement. *IX_UM_Value Options PreDel Survey* This document provides the results of RMHP's pre-delegation audit of ValueOptions and is an example of the type of pre-delegation RMHP undertakes before entering into a contract that involves a delegation of duties. *IX_UM_Value Options Contract_Redacted* (Now known as Beacon Health Options) Paragraph 8.7. Delegation, page 11, provides that RMHP will monitor any and all delegated functions and is ultimately responsible for the performance of all delegated functions. Exhibit C, paragraph (h)(2), page 23 provides that RMHP will evaluate the UR program on at least an annual basis and will identify any deficiencies. Paragraph (h)(3) describes the	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	corrective action process. Exhibit F, Performance Guarantees, pages 40-41 describes performance standards that will be monitored by the parties. *The eviCore and Beacon Annual Delegation Oversight Reports will be available onsite. These reports will go to the Medical Advisory Council (November-December) for review and approval.*	
2. All contracts or written arrangements between the Contractor and any subcontractor specify: • The delegated activities **or obligations** and related reporting responsibilities. • **That the subcontractor agrees to perform the delegated activities and reporting responsibilities** • Provision for revocation of the delegation of activities or obligation, or **specify other remedies in instances where the State or Contractor determines** that the subcontractor has not performed satisfactorily. *42 CFR 438.230(b)(2) and (c)(1)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—3.1.4.1.3	Note: Subcontractor requirements do not apply to network provider agreements. *IX_ QI_ Delegated Credentialing Agmt* Paragraph 2.A., page 7 and Exhibit A describe the delegated credentialing activities and Paragraph 2.D., page 7 describes the reporting responsibilities of the delegate. Page 1 sets forth the delegate's agreement to perform the delegated credentialing activities and reporting responsibilities. Revocation/termination of delegated activities is addressed in Paragraph 4, pages 5-6. *IX_PH_MedImpact Contract_Redacted* The activities, obligations and related reporting responsibilities that have been delegated to the PBM (and that the PBM has agreed to perform)	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	are described in Exhibit A, Scope of Services, pages 24-51. Termination of the agreement is governed by Article 10, pages 15-17. Termination With Cause (paragraph 10.2, page 16) would allow RMHP to revoke the activities and obligations that have been delegated. *IX_UM_Delegation_Policy* Section 3.1.2, page 1 provides that a written agreement between the parties will describe the delegated activities. Section 3.1.5, page 2 provides that the written agreement will describe the remedies available if the delegate does not fulfill its oblations, including the circumstances that would cause revocation. **Obligations and reporting responsibilities in written delegation agreements** *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Exhibit 1, pages 26-30, describes the delegated activities. Section 1.E, Reporting Requirements, pages 27-28 describe the delegated entity's reporting responsibilities.	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_UM_Value Options Contract_Redacted (Now known as Beacon Health Options) Section 8.7, Delegation, page 11 provides that delegation of functions is in accordance with the agreement and Exhibit C. Exhibit C, paragraph 1, page 20 indicates the contractor's agreement to perform the UR activities and functions described in Exhibit C. Exhibit C in its entirety (pages 20-24) describes the delegated responsibilities of Beacon Health Options. *IX_UM_Value Options Contract_Redacted* (Now known as Beacon Health Options) Section 5.7, page 8 provides that the contractor will provide certain quarterly and annual reports describe in Exhibit C and other reports as agreed upon by the parties. Exhibit C, paragraph (i)(3) describes the reporting responsibilities of Beacon Health Options. **Provisions for revoking or other remedies in delegated agreements** *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Paragraph 3.6.1 Evaluation of Delegated Entity Services, page 9, provides that in the event of a	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	deficiency, the delegated entity shall implement and submit a corrective action plan within 15 business days of notification of the deficiency. Paragraph 10.3, page 21 provides for termination or suspension upon notice if the delegated entity is not performing UM activities in compliance with NCQA requirements or applicable law. *IX_UM_Value Options Contract_Redacted* (Now known as Beacon Health Options) Exhibit C, paragraph (h) (3), pages 23-24 describes the actions taken if a deficiency in performance is identified. Paragraph (l) specifies the circumstances for immediate termination of delegated UR functions. Paragraph (m) specifies the procedures for revoking delegation of UR functions.	
3. The Contractor's written agreement with any subcontractor includes: • **The subcontractor's agreement to comply with all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and contract provisions.** *42 CFR 438.230 (c)(2)* CHP+ Contract: N/A Prime Contract: (Not found)	*IX_LRA_Law Exhibit Template_Provider 07-17* This exhibit is part of the credentialing delegation agreement and contains the required language in Section III, Paragraph 8, page 9. *IX_LRA_Law Exhibit_Non-Provider 07-17* This exhibit is part of subcontracting agreements and contains the required language in Paragraph 22, page 8. *IX_PH_MedImpact Contract_Redacted*	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Exhibit G, Law Exhibit, Paragraph 14 State Contracts, page 97 provides that to the extent Medlmpact provides services in relation to RMHMO' s Medicaid, CHP+ and Regional Collaborative Care Organization (RCCO) contracts with the State of Colorado, Medlmpact agrees to comply with the requirements of such contracts that are applicable to subcontractors, as defined in such contracts. This provision incorporates the applicable regulatory language in this requirement that is contained in RMHP's contracts with HCPF. *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Page 7, Paragraph 3.1.4, page 7 specifies that the delegated entity agrees to meet or exceed RMHP standards, policies and procedures, NCQA standards and federal and state statutory or regulatory provisions. Further, if any accrediting organization standards, federal or state regulatory provisions are changed or revised, the delegated entity agrees to comply with or implement any such change as may be required by applicable law. This provision incorporates the applicable regulatory language in this requirement that is contained in RMHP's contracts with HCPF.	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	IX_UM_Value Options Contract_Redacted (Now known as Beacon Health Options) Exhibit D, Paragraph 9, page 33 provides that to the extent the contractor provides services in relation to RMHMO' s Medicaid, CHP+ and Regional Collaborative Care Organization (RCCO) contracts with the State of Colorado, the contractor agrees to comply with the requirements of such contracts that are applicable to subcontractors, as defined in such contracts. This provision incorporates the applicable regulatory language in this requirement that is contained in RMHP's contracts with HCPF.	
4. The written agreement with the subcontractor includes: • **The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Contractor's contract with the State.** – **The subcontractor will make available, for purposes of an audit, its premises, physical facilities, equipment, books, records, contracts, and computer or other electronic systems related to CHP+ members.**	*IX_LRA_Law Exhibit Template_Provider 07-17* This exhibit is part of the credentialing delegation agreement and contains the required language in Section III, Paragraph 2. *IX_LRA_Law Exhibit_Non-Provider 07-17* This exhibit is part of subcontracting agreements and contains the required language in Paragraph 12, page 4. *IX_PH_MedImpact Contract_Redacted* Article 5, Records, Paragraph 5.3.3, page 12 provides that MedImpact will allow Government Agencies to audit services provided under the contract to the extent	**CHP+:** ☒ Met ☐ Not Scored **Prime:** ☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– **The right to audit will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.** – **If the State, CMS, or HHS Inspector General determines that there is a reasonable probability of fraud or similar risk, the State, CMS, or HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.** *42 CFR 438.230(c)(3)* CHP+ Contract: N/A Prime Contract: (Not found)	required by law. This provision incorporates the regulatory language of this requirement. *IX_UM_CCN Contract_CareCore National_ Redacted* (CareCore National, LLC d/b/a eviCore healthcare) Paragraph 2.4.5, page 5 grants permission for federal, state and local governmental authorities to audit any and all documents and materials related to services under the agreement at the delegated entity's place of business Paragraph 2.4.10, page 6 provides that the period for retaining all data, information, records and documentation related to is performance of delegated entity services for the period required by law. *IX_UM_Value Options Contract_Redacted* (Now known as Beacon Health Options) Paragraphs 10.1 – 10.3, pages 12-13 describes provisions for record keeping and access to records for the purposes of inspection and audits.	

Note: While the scoring of evidence related to individual, new federal requirements in the tool may indicate *Met* or *Not Scored*, all new requirements were scored *Not Applicable* in the total results; new federal requirements do not apply to CHP+ until July 1, 2018.

CHP+ Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	0	X	1.00	=	NA
	Partially Met	=	0	X	.00	=	NA
	Not Met	=	0	X	.00	=	NA
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	0	**Total Score**		=	NA
				Total Score ÷ Total Applicable		=	NA

Medicaid Prime Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	4	**Total Score**		=	4
				Total Score ÷ Total Applicable		=	100%

Appendix B. Record Review Tools

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Rocky Mountain Health Plans CHP+

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	December 5, 2017
Reviewer:	Lee Ann Dougherty and Rachel Henrichs
Participating Health Plan Staff Member:	Sandy Dowd and Kim Nelson

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	******	07/10/17	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/21/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: An acknowledgement letter was sent on 07/14/17, which was out of compliance with the required time frame of two working days.											
2	******	08/01/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/02/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: None.											
3	******	08/16/17	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/24/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: No acknowledgement letter was mailed to the member.											
4	******	09/18/17	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/03/17	M ☐ N ☒	M ☒ N ☐	M ☒ N ☐
Comments: No acknowledgement letter was mailed to the member. Although the appeal was received by the plan on 09/18/17, the Appeals and Grievances department did not receive the appeal until 09/25/17. The resolution letter was not sent within the required time frame.											
5	******	10/09/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	none	M ☐ N ☒	M ☒ N ☐	M ☒ N ☐
Comments: An acknowledgment letter was sent to the member with decision-related language imbedded. No additional resolution letter was sent to the member.											
6			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
7			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
8			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
9			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
10			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Rocky Mountain Health Plans CHP+

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS1			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**4**	**5**	**5**				**5**	**5**	**5**
Column Subtotal of Compliant (M) Elements			**1**	**5**	**5**				**3**	**5**	**5**
Percent Compliant (Divide Compliant by Applicable)			**25%**	**100%**	**100%**				**60%**	**100%**	**100%**

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**29**
Total Compliant (M) Elements	**24**
Total Percent Compliant	**83%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Rocky Mountain Health Plans CHP+

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	December 5, 2017
Reviewer:	Lee Ann Dougherty and Rachel Henrichs
Participating Health Plan Staff Member:	Sandy Dowd and Kim Nelson

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	******	07/13/17	Y ☐ N ☐ N/A ☒	07/17/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: None.										
2	******	07/18/17	Y ☐ N ☒ N/A ☐	07/21/17	3	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: No acknowledgement letter was sent to the member.										
3	******	10/02/17	Y ☐ N ☐ N/A ☒	10/04/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: None.										
4	******	07/31/17	Y ☐ N ☒ N/A ☐	09/13/17	32	Y ☐ N ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☐ N ☒ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: No acknowledgement letter was sent to the member. Additionally, the appeal was not resolved timely and the resolution date documented in the letter was not accurate.										
5	******	08/07/17	Y ☐ N ☐ N/A ☒	08/08/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: None.										
6	******	08/08/17	Y ☐ N ☐ N/A ☒	08/10/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: None.										
7	******	09/27/17	Y ☐ N ☐ N/A ☒			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments: This case was not a member grievance and was removed from the grievance sample.										
8	******	08/24/17	Y ☐ N ☐ N/A ☒	08/25/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: The resolution letter contained typographical errors.										
9	******	08/29/17	Y ☐ N ☐ N/A ☒	08/31/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: None.										
10	******	09/01/17	Y ☐ N ☐ N/A ☒	09/05/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: None.										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Rocky Mountain Health Plans CHP+

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS 1	******	07/20/17	Y ☐ N ☒ N/A ☐	07/28/17	6	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: No acknowledgement letter sent to the member.										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**3**			**10**	**0**	**0**	**10**	**10**
Column Subtotal of Compliant (Yes) Elements			**0**			**9**	**N/A**	**N/A**	**9**	**10**
Percent Compliant (Divide Compliant by Applicable)			**0%**			**90%**	**N/A**	**N/A**	**90%**	**100%**

Key: Y = Yes; N = No
N/A = Not Applicable

Total Applicable Elements	**33**
Total Compliant (Yes) Elements	**28**
Total Percent Compliant	**85%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Rocky Mountain Health Plans Prime

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	December 5, 2017
Reviewer:	Lee Ann Dougherty and Rachel Henrichs
Participating Health Plan Staff Member:	Sandy Dowd and Kim Nelson

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	******	07/05/17	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/18/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: No acknowledgement letter was sent to the member.											
2	******	10/03/17	M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: This case was determined a grievance and was removed from the grievance sample.											
3	******	07/24/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	07/27/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: None.											
4	******	09/20/17	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	Yes ☒ No ☐	Yes ☐ No ☒	09/22/17	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: Resolution letter included incorrect State fair hearing time frame.											
5	******	08/15/17	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/18/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: No acknowledgement letter was sent to the member.											
6	******	08/25/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/06/17	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: Resolution letter included incorrect State fair hearing time frame.											
7	******	08/29/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/05/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: None.											
8	******	09/05/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/18/17	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: Resolution letter included incorrect State fair hearing time frame. Additionally, the date of resolution was not included in the letter as required.											
9	******	09/11/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	09/21/17	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: Resolution letter included incorrect State fair hearing time frame. Additionally, the date of resolution was not included in the letter as required.											
10	******	08/02/17	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	08/15/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: None.											

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Appeals Record Review Tool
for Rocky Mountain Health Plans Prime

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS1	******	09/20/17	M ☐ N ☒ N/A ☐	M ☒ N ☐	M ☒ N ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/04/17	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: No acknowledgement letter was sent to the member.											
OS2			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS3			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS4			M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
OS5	81656		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	Yes ☐ No ☐	Yes ☐ No ☐		M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments:											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**9**	**10**	**10**				**10**	**10**	**10**
Column Subtotal of Compliant (M) Elements			**6**	**10**	**10**				**10**	**6**	**10**
Percent Compliant (Divide Compliant by Applicable)			**67%**	**100%**	**100%**				**100%**	**60%**	**100%**

Key: M = Met; N = Not Met
N/A = Not Applicable

Total Applicable Elements	**59**
Total Compliant (M) Elements	**52**
Total Percent Compliant	**88%**

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Rocky Mountain Health Plans Prime

Review Period:	July 1, 2017–December 31, 2017
Date of Review:	December 5, 2017
Reviewer:	Lee Ann Dougherty and Rachel Henrichs
Participating Health Plan Staff Member:	Sandy Dowd and Kim Nelson

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
1	******	07/13/17	Y ☐ N ☐ N/A ☒	07/14/17	1	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
2	******	07/20/17	Y ☐ N ☐ N/A ☒	07/24/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
3	******	09/21/17	Y ☐ N ☒ N/A ☐	09/26/17	3	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: No acknowledgement letter was sent to the member.										
4	******	08/04/17	Y ☐ N ☐ N/A ☒	08/07/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
5	******	08/10/17	Y ☒ N ☐ N/A ☐	08/23/17	9	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
6	******	08/21/19	Y ☐ N ☐ N/A ☒	08/22/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
7	******	08/25/17	Y ☐ N ☒ N/A ☐	08/30/17	3	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: No acknowledgement letter was sent to the member. Additionally, the resolution letter contained typographical errors.										
8	******	10/03/17	Y ☐ N ☐ N/A ☒	10/05/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
9	******	09/06/17	Y ☐ N ☐ N/A ☒	09/07/17	1	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
10	******	09/01/17	Y ☐ N ☐ N/A ☒	09/06/17	2	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2017–2018 Grievance Record Review Tool
for Rocky Mountain Health Plans Prime

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame	Decision Maker Not Previous Level (If Clinical)	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content	Resolution Letter Easy to Understand
OS 1			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 2			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 3			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 4			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
OS 5			Y ☐ N ☐ N/A ☐			Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**3**			**10**	**1**	**1**	**10**	**10**
Column Subtotal of Compliant (Yes) Elements			**1**			**10**	**1**	**1**	**10**	**10**
Percent Compliant (Divide Compliant by Applicable)			**33%**			**100%**	**100%**	**100%**	**100%**	**100%**

Key: Y = Yes; N = No
N/A = Not Applicable

Total Applicable Elements	**35**
Total Compliant (Yes) Elements	**33**
Total Percent Compliant	**94%**

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2017–2018 site review of **RMHP CHP+** and **RMHP Prime**.

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

HSAG Review Team	Title
Rachel Henrichs	HSAG Auditor
Lee Ann Dougherty	HSAG Auditor
RMHP Participants	**Title**
Beth Montgomery	Administrative Assistant, CS
Cathy Rudd	Consultant/Steadman Group
Curtis Fleming	Staff Attorney
Dale Renzi	Director, Provider Network Management
David Mok-Lamme	Sr. Community Research Analyst
Greg Coren	Western Slope PR Manager and Provider Network Manager
Jerry Spomer	Director of Internal Audit, Member Benefit Administration, and Member Enrollment and Billing
Jill Bystol	Quality Assurance Compliance Coordinator
Judy Narenkivicius	Supervisor, Credentialing and Quality Improvement
Kendra Peters	Coordinator, RCCO Marketing & Communications
Kevin Fitzgerald	Chief Medical Officer
Kim Nelson	Supervisor, Appeals and Grievances
Laurel Walters	Chief Operations Officer
Lori Stephenson	Director, Clinical Program Development & Evaluation
Marci O'Gara	Director, Customer Service
Maura Cameron	Director, Quality Improvement
Meg Taylor	Consultant, Steadman Group
Mike Huotari	Vice President, Legal and Government Affairs
Molly Tonello	Associate, Pharmacy Compliance & Operation
Nicole Konkoly	Program Development Specialist, Community Integration
Nora Foster	Compliance/Audit Coordinator
Patrick Gordon	Associate Vice President, Community Integration
Pauline Casey	Senior Program Operations Leader

RMHP Participants	Title
Sandy Dowd	Director, Care Management
Sharon Steadman	Consultant, Steadman Group
Sheila Worth	Senior Corporate Management Analyst
Steve Nolan	Director, Pharmacy
Sue Baker	Manager, Customer Services
Department Observers	**Title**
Ben Harris	Policy Analyst, Accountable Care Collaborative (ACC)
Teresa Craig	CHP+ Contract and Program Manager
Tim Gaub	ACC Contract Manager and Program Performance Specialist
Russ Kennedy	Quality & Compliance Specialist
Patricia Connally	Quality & Compliance Specialist

Appendix D. Corrective Action Plan Template for FY 2017–2018

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 and HSAG will: • Approve the planned interventions and instruct the health plan to proceed with implementation, or • Instruct the health plan to revise specific planned interventions and/or documents to be submitted as evidence of completion and also to proceed with implementation.
Step 4	**Documentation substantiating implementation**
	Once the health plan has received Department approval of the CAP, the health plan will have a time frame of six months to complete proposed actions and submit documents. The health plan will submit documents as evidence of completion one time only on or before the six-month deadline for all required actions in the CAP. (If necessary, the health plan will describe in the CAP document any revisions to the planned interventions that were required in the initial CAP approval document or determined by the health plan within the intervening time frame.)

Step	Action
Step 5	**Technical Assistance**
	HSAG will schedule with the health plan a one-time, interactive, verbal consultation and technical assistance session during the six-month time frame. The session may be scheduled at the health plan's discretion at any time the health plan determines would be most beneficial. HSAG will not document results of the verbal consultation in the CAP document.
Step 6	**Review and completion**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the health plan as to whether or not the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements. Any documentation that is considered unsatisfactory to complete the CAP requirements at the six-month deadline will result in assignment as a delinquent corrective action that will be continued into the following compliance review year. (HSAG will list delinquent actions in the annual technical report and the health plan's subsequent year's compliance site review report.)

The CAP template follows.

Table D-2—FY 2017–2018 Corrective Action Plan for RMHP CHP+ and RMHP Prime

Standard VI—Grievance System—CHP+ and Prime		
Requirement	**Findings**	**Required Action**
9. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—14.1.5.5 Prime Contract: Exhibit A-5—4.1.2.5.3, 4.1.2.6.2 10 CCR 2505-10—8.209.5.A	The Grievance Policy and Process document supported that members receive written acknowledgement of the grievance within two working days. Through the on-site file review; however, RMHP did not consistently demonstrate that members receive written acknowledgement of each grievance timely. Specifically, for CHP +, the health plan did not send an acknowledgement letter or sent the acknowledgement to the member untimely in three of 10 cases reviewed. For Medicaid grievances, two of 10 cases reviewed indicated that members did not receive a written acknowledgement letter.	RMHP CHP+ and RMHP Prime must have mechanisms in place to ensure that members receive written acknowledgement of each grievance within two working days of the health plan's receipt of the grievance.
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 VI—Grievance System—CHP+ Only		
Requirement	**Findings**	**Required Action**
10. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and **within 15 working days of when the member files the grievance.** • **Notice to the member must be in a format and language that may be easily understood by the member.** *42 CFR 438.408(a) and (b)(1) and (d)(1)* CHP+ Contract: Exhibit B—14.1.5.7, 14.1.5.9 Prime Contract: Exhibit A-5—4.1.2.5.5 10 CCR 2505-10—8.209.5.B	RMHP's Grievance Policy specified that, for Medicaid members, any grievance must be resolved and notice sent to the member within 15 working days, or as expeditiously as the member's health condition requires. During the on-site file review, all Medicaid cases reviewed demonstrated that the health plan was compliant with resolving and sending resolution notices timely. However, one CHP+ grievance reviewed was not resolved timely, and resolution notice for that grievance was not sent to the member within 15 working days.	RMHP CHP+ must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance.
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 VI—Grievance System—CHP+ and Prime		
Requirement	**Findings**	**Required Action**
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* CHP+ Contract: Exhibit B—14.1.4.7 Prime Contract: Exhibit A-5—4.1.2.6.4 10 CCR 2505-10—8.209.4.D	RMHP's Member Appeals Time Grid specified that written acknowledgement of appeals must be sent to Medicaid and CHP+ members within two working days of receipt of the appeal. During the on-site file review; however, one of four applicable CHP+ appeals and six of nine applicable Medicaid appeals revealed that the health plan was not sending acknowledgement letters to members as required.	RMHP CHP+ and RMHP Prime must have mechanisms in place to ensure that written acknowledgement of each appeal is sent to members within two working days of receipt, unless the member or designated client representative requests an expedited resolution.
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 VI—Grievance System—CHP+ Only		
Requirement	**Findings**	**Required Action**
20. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. *Note: If the written appeal is not signed by the member or designated client representative (DCR), the appeal resolution will remain pending until the appeal is signed. All attempts to gain a signature shall be included in the record of the appeal.* • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* CHP+ Contract: Exhibit B—14.1.4.8 and 14.1.3.1 Prime Contract: Exhibit A-5—4.1.2.6.2, 4.1.2.6.8, and 4.1.1.3.3.1 10 CCR 2505-10—8.209.4.J(1), 8.209.4.L	RMHP's Appeals policy, Member Appeals Time Grid, and Notice of Appeal Resolution template supported that appeals are resolved and members receive written notice of appeal resolution within 10 working days from date of receipt and the written notice of the appeal is in a format and language that is easily understood by the member. During the on-site file review, two CHP+ member appeals were not resolved within the 10 working days' time frame.	RMHP CHP+ must have mechanisms in place to ensure that appeals are resolved and members receive written notice of appeal resolution within 10 working days from date of receipt.

Standard VI—Grievance System—CHP+ Only		
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 VI—Grievance System—Prime Only		
Requirement	**Findings**	**Required Action**
24. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. o That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend or reduce.* *42 CFR 438.408(e)* CHP+ Contract: Exhibit B—14.1.4.10 Prime Contract: Exhibit A-5—4.1.2.6.8.1–2 10 CCR 2505-10—8.209.4.M	RMHP's Member Appeals Process policy complied with written notice of appeal resolution requirements. During the on-site file review; however, four of 10 Medicaid resolution letters contained inaccurate State fair hearing time frame requirements and/or did not include the date that the resolution process was completed.	RMHP must ensure that the written notice of appeal resolution letter includes the date that the resolution process was completed and accurate State fair hearing time frame requirements.

Standard VI—Grievance System—Prime Only		
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 VI—Grievance System—Prime Only		
Requirement	**Findings**	**Required Action**
25. **The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution.** • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* CHP+ Contract: N/A Prime Contract: Exhibit A-5—4.1.2.8.1 10 CCR 2505-10—8.209.4.N, 8.209.4.O	RMHP's appeals policy and handbooks indicated that members could request a State fair hearing within 120 calendar days from the date of notice of resolution. During the on-site file review, four resolution letters sent to Medicaid members did not indicate that members may request State fair hearings within 120 calendar days from the dates of the notices of resolution. Instead, these letters inaccurately indicated that members had 30 days from the dates of the notices of resolution to request State fair hearings.	RMHP Prime must ensure that all documentation, including notice of resolution template letters, support that, for adverse benefit determinations, members may request State fair hearings within 120 calendar days from the dates of the notices of resolution.
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 VII—Provider Participation and Program Integrity—CHP+ and Prime		
Requirement	**Findings**	**Required Action**
12. The Contractor's compliance program includes: • Provision for prompt reporting (to the State) of all overpayments identified or recovered, specifying which overpayments are due to potenial fraud. • Screening all provider claims, collectively and individually, for potential fraud, waste, or abuse—including mechanisms to identify and report suspected instances of up-coding, unbundling of services, services that were billed for but never rendered, and inflated bills for services and goods provided. • Provision for prompt notification to the State about member circumstances that may affect the member's eligibility, including change in residence or member death. • Provision for notification to the State about changes in a network provider's circumstances that may affect the provider's eligibility to participate in the managed care program, including termination of the provider agreement with the Contractor. • Provision for a method to verify on a regular basis, by sampling or other	RMHP demonstrated a comprehensive compliance program in most areas. RMHP had developed a process for reporting overpayments to the Department and appeared to be prepared to submit overpayment data to the Department once a method for reporting is established. RMHP was not able to demonstrate a method to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members. During the interview process, Rocky Mountain Health Care confirmed that they did not have a process for validating whether or not services billed by providers were received by members.	RMHP CHP+ and RMHP Prime must have a method to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members.

Standard VII—Provider Participation and Program Integrity—CHP+ and Prime		
Requirement	**Findings**	**Required Action**
methods, whether services represented to have been delivered by network providers were received by members. *42 CFR 438.608(a)(2–5)* CHP+ Contract: Exhibit B—14.2.5.4.3–8 Prime Contract: Exhibit A-5—4.2.8.3, 4.2.5.2.1.3		
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 and CHP+ 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 two 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 and CHP+ appeals and grievances that occurred between July 1, 2017, and December 31, 2017 (to the extent possible). 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 managed care regulations related to Medicaid and CHP+ appeals and grievances. • 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 2017–2018 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.