Colorado Medicaid
Managed Care Program

# FY 2012–2013 Site Review Report

*for*

# Rocky Mountain Health Plans

June 2013

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

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## Overview of FY 2012–2013 Compliance Monitoring Activities

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

This is the fifth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Managed Care Program. For the fiscal year (FY) 2012–2013 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 four performance areas chosen. The standards chosen were 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.

The health plan's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal regulations was evaluated through review of the four standards. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2012–2013 site review activities for the review period—January 1, 2012, through December 31, 2012. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the health plan was successful in completing corrective actions required as a result of the 2011–2012 site review activities. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing 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 process the health plan will be required to complete for FY 2012–2013 and the required template for doing so.

## Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the health plan's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key health plan personnel to determine compliance. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The four standards chosen for the FY 2012–2013 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

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

## Objective of the Site Review

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

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

## Summary of Results

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

Table 1-1 presents the score for **Rocky Mountain Health Plans** (**RMHP**) for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

**Table 1-1—Summary of Scores for the Standards**

| Standard | # of Elements | # of Applicable Elements | # *Met* | # *Partially Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|---|
| III Coordination and Continuity of Care | 15 | 15 | 9 | 5 | 1 | 0 | 60% |
| IV Member Rights and Protections | 5 | 5 | 4 | 1 | 0 | 0 | 80% |
| VIII Credentialing and Recredentialing | 49 | 47 | 47 | 0 | 0 | 2 | 100% |
| X Quality Assessment and Performance Improvement | 13 | 13 | 10 | 3 | 0 | 0 | 77% |
| **Totals** | **82** | **80** | **70** | **9** | **1** | **2** | **88%** |

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

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

| Description of Record Review | # of Elements | # of Applicable Elements | # *Met* | # *Not Met* | # *Not Applicable* | Score (% of *Met* Elements) |
|---|---|---|---|---|---|---|
| Credentialing Record Review | 80 | 76 | 76 | 0 | 4 | 100% |
| Recredentialing Record Review | 80 | 75 | 75 | 0 | 5 | 100% |
| **Totals** | **160** | **151** | **151** | **0** | **9** | **100%** |

# 2. Summary of Performance Strengths and Required Actions

*for* **Rocky Mountain Health Plans**

## Overall Summary of Performance

For the four standards reviewed by HSAG, **RMHP** earned an overall compliance score of 88 percent. **RMHP**'s strongest performance was in Standard VIII—Credentialing and Recredentialing, which earned a compliance score of 100 percent. **RMHP** also performed relatively well in Standard IV—Member Rights and Protections, where it earned a score of 80 percent. HSAG identified several required actions in Standard III—Coordination and Continuity of Care (60 percent compliant) and in Standard X—Quality Assessment and Performance Improvement (77 percent compliant).

# Standard III—Coordination and Continuity of Care

## *Summary of Findings and Opportunities for Improvement*

**RMHP** implemented a comprehensive program to ensure the coordination and continuity of care for all **RMHP** members, with particular emphasis on members with complex problems and special health care needs. **RMHP** ensures that each member selects a primary care provider (PCP) upon enrollment or it automatically assigns a member to a PCP who is responsible for the coordination of covered services. Members with special health care needs have direct access to in-network specialists without referral, and **RMHP** provides for continuity of care with established providers when members transition into or out of the health plan. The case management program was designed to assist members in accessing services from multiple providers and social support programs. Members referred to case management received a comprehensive needs assessment, an individual care coordination plan, active case manager coordination of necessary services, and frequent follow-up.

During the on-site review, **RMHP** presented two coordination of care cases: (1) an adult male, referred by the provider, with substance abuse and multiple medical issues and previously discharged from multiple physician practices due to noncompliance, with a third-party caregiver and needs for dental care, wound care, substance abuse services, and health education in multiple areas; and (2) a toddler male with the need for multiple heart surgeries to be performed out of state, requiring coordination with out-of-state services and providers, and the need for follow-up home services and parental support following surgeries. Case presentations demonstrated that **RMHP** coordinated with multiple providers and services, including out-of-state providers and transportation, designated a PCP and care coordinator, and completed a comprehensive needs assessment that included high-risk health problems, language and comprehension problems, mental health status, and functional problems. Each case included an individual treatment plan with member goals, planned interventions, barriers, detailed progress/contact notes, and planned follow-up. The cases demonstrated active involvement of the member/parent in the development and implementation of the plan.

**RMHP** implemented a well-designed comprehensive case management software system to document the case management process. For members who do not require complex case management services, the PCP is responsible for the member assessment and a treatment plan. Requirements are conveyed through the physician medical record standards, which are periodically monitored through an audit of physician medical records.

**RMHP**'s policies required that it conduct a member welcome call upon enrollment, to include a screening for special health care needs. **RMHP** had not consistently conducted the welcome calls and needs assessment for all newly enrolled Medicaid members.

**RMHP** delegated to the Delta County and San Juan Basin health departments the comprehensive care coordination services for children with special health care needs. HSAG recommended that **RMHP** implement detailed oversight of the delegated entities to ensure that the specific case management services were being monitored in compliance with the requirements.

## Summary of Strengths

**RMHP** had a well-trained, experienced case management staff of licensed registered nurses who were actively engaged in providing diverse support to members and families and coordinating services with multiple providers and entities. The **RMHP** case management program was supported by an electronic documentation software system that was comprehensive and well-organized for ongoing case monitoring. The system supported individualized goals and interventions driven by the case manager's critical thinking skills rather than preprogrammed system algorithms. Tools and formats within the system, such as the comprehensive assessment and care plan, were aligned with the regulatory and contractual requirements but were flexible enough to encourage customized and detailed documentation of the member's needs and progress. **RMHP** was using multiple data-driven and referral avenues to identify members with the potential need for complex care management services. These avenues included data-driven cost reports, utilization and member risk levels, multiple sources of direct referral, and an outreach screening process for Medicaid members.

## Summary of Required Actions

The **RMHP** provider manual and the Medicaid member handbook communicated most, but not all, of the wraparound services available under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. The explanation of EPSDT services in the member handbook was confusing. The services were not consistently identified as EPSDT and were communicated throughout various sections of the handbook rather than in one section. **RMHP** must revise or reformat the handbook to clearly define the services available under the EPSDT program and where and how to obtain them.

**RMHP** must correct its provider communications regarding EPSDT to include:

- The complete listing of Medicaid wraparound services.
- The periodicity schedules for screening services.
- Referral to a dentist beginning at 1 year of age.
- Information on how providers may refer members for wraparound services, and inform providers of the availability of EPSDT support services through the local public health departments.
- The correct age range for eligibility of EPSDT services.

**RMHP** must also implement a process to ensure that all Medicaid members receive an initial screening for special health care needs after enrollment. **RMHP** must develop and approve a policy describing its screening package and the methods used to assure that screening requirements are met.

# Standard IV—Member Rights and Protections

## Summary of Findings and Opportunities for Improvement

**RMHP** had several polices in place that addressed member rights and protections in accordance with federal health care requirements. **RMHP**'s member handbook, distributed to each member at the time of enrollment, listed all of the member rights required in 42CFR438.100(b)(2)-(3). The provider manual also included the list of Medicaid member rights. Member rights were posted on the **RMHP** Web site, available through a link from the member tab. The list of member rights in the member handbook and on the **RMHP** Web site identified the member's right to bring complaints to **RMHP**, the insurance commissioner, or the Colorado Department of Health Care Policy and Financing and to freely exercise rights without being treated differently.

Provider newsletters included topics regarding cultural competency and cultural competency training available. Although the provider manual listed the Medicaid member rights, there was no discussion of provider responsibilities related to these rights. HSAG recommended that **RMHP** develop additional provider communications (either more specific discussion of provider responsibilities in the provider manual or topic-specific provider newsletter articles) designed to keep the topic of member rights prevalent in providers' minds.

## Summary of Strengths

On-site, the staff described a project recently initiated whereby the **RMHP** Member Experience Advisory Committee (MEAC) will evaluate customer "touch points" (defined as points within the **RMHP** system where members will interact in some way with **RMHP** or its staff members) to evaluate members' experience with **RMHP** and opportunities to improve it. The staff reported that this project involves all departments and regions served by **RMHP** and could impact members within all lines of business.

## Summary of Required Actions

Although member rights were listed on the Web site and in the member handbook, information on the Web site related to behavioral health services was outdated by more than seven years. **RMHP** must work with its behavioral health organization partner to ensure accurate presentation of mental health/behavioral health information on **RMHP**'s Web site. In addition, the member handbook posted on the Web site was not the current one. **RMHP** must update its Web site and develop processes to ensure members who choose to use the **RMHP** Web site receive the most accurate information, and that that information does not conflict with previous hard copy information the member may have received.

The annual Medicaid enrollment letter (provided on-site) did not inform members of their right to receive a copy of the member handbook upon request, as staff members stated on-site that it did. This having been a previous corrective action, HSAG once again recommends that **RMHP** evaluate its systems and processes for implementing corrective actions and following through with

processes. In order for members to fully understand benefits guaranteed under the Medicaid program and rights associated with these benefit programs, members must receive accurate and timely information because conflicting information from various sources is confusing. **RMHP** must also ensure that members are notified annually of their right to request and receive a copy of the member handbook.

## Standard VIII—Credentialing and Recredentialing

### *Summary of Findings and Opportunities for Improvement*

**RMHP**'s policies and procedures addressed all of the requirements related to credentialing and recredentialing providers and organizations. The policies listed the types of providers required to be credentialed and recredentialed and the criteria for each. **RMHP** identified multiple credentialing committees, based on location, and its policies and procedures delineated the roles and responsibilities of the committees and the medical director or designee. The credentialing application included provider rights and collected the required information and attestations. **RMHP**'s Reduction, Suspension, or Termination Policy outlined its provider appeal process and **RMHP** notified providers of this process in letters used to inform a provider of action taken against him or her. The on-site review of 10 credentialing files, 10 recredentialing files, and five organizational provider files demonstrated that **RMHP** implemented its policies and procedures as written.

### *Summary of Strengths*

**RMHP**'s policies and processes were well-organized and clearly NCQA-compliant. **RMHP**'s processes for maintaining documents obtained for credentialing and recredentialing provided secure record-keeping and easy access to the staff for processing and accessing provider files, as needed. **RMHP**'s medical practice review committees (MPRCs), which served as **RMHP**'s geographical area-specific peer review and credentialing committees, incorporated the **RMHP** medical director, or a qualified designee, and included a variety of provider types.

Credentialing Committee/MPRC meeting minutes demonstrated the role of the medical director consistent with the **RMHP** policy and that the committee reviewed files that did not initially meet criteria. The credentialing committees also reviewed ongoing monitoring for sanction activity, quality of care issues, and delegates' reports of credentialing activities.

Practitioner credentialing and recredentialing files were comprehensive and very well-organized, as were organizational provider records. Practitioner and provider records demonstrated **RMHP**'s performance of all required credentialing and recredentialing activities.

### *Summary of Required Actions*

There were no required actions for this standard.

# Standard X—Quality Assessment and Performance Improvement

## *Summary of Findings and Opportunities for Improvement*

**RMHP** had a comprehensive corporate-wide quality improvement (QI) program that applied to members from all lines of business and generally used a population-wide approach for analysis and interventions for improvement. **RMHP** identified Medicaid-specific results for CAHPS surveys, HEDIS performance measures, and Medicaid PIPs in the QI annual report. Members with special health care needs were incorporated into all QI activities as a component of the overall member population. The QI program was defined in the Quality Improvement Program description, corporate QI work plan, and corporate QI annual report. HSAG recommended that **RMHP** include specific goals and benchmarks for performance in the QI work plan. HSAG also recommended that the QI work plan and the QI annual report clearly designate which QI activities applied to the Medicaid population. The QI program was accountable to the **RMHP** Board of Directors through the Quality Improvement Committee (QIC), which had numerous subcommittees for oversight or performance of specific program components. QIC meeting minutes documented that QI results were being reviewed through the committee infrastructure and reported to the QIC. HSAG recommended that **RMHP** consistently document recommendations or conclusions related to the results of each QI activity in the QIC meeting minutes and the QI annual report. **RMHP** monitored utilization trends and Medicaid member satisfaction through data reports, the CAHPs survey, and member grievance reports, and it implemented appropriate corrective action when significant concerns were identified. The corporate QI annual report included the content outlined in the requirement, with the exception of a statement regarding the overall effectiveness of the program. HSAG also recommended that **RMHP** include the analysis of member grievances in the annual report.

**RMHP** adopted clinical practice guidelines (CPGs) in compliance with professional standards and applicable to the conditions specified in the requirements. **RMHP** used additional practice guidelines applicable to members with special health care needs in the case management program, and HSAG recommended that **RMHP** consider formally adopting and distributing these additional guidelines. Staff members described internal processes for reviewing guidelines at least annually and ensuring the integration of CPGs into other **RMHP** operations. **RMHP** did not have a process for an annual formal review and approval. CPGs were disseminated to providers through the **RMHP** Web site, but members were not informed of their availability. HSAG recommended that **RMHP** inform members of the availability of CPGs at no cost, and how they could access them. **RMHP** had well-designed member health education materials that were based on information in CPGs.

**RMHP** had a health information system that collected and integrated data from multiple sources, included information on provider and member characteristics and services furnished to members, and generated multiple reports for QI monitoring activities and studies. **RMHP** conducted a review of encounter claims for accuracy and completeness but did not confirm this information with medical record documentation, per the requirement.

## Summary of Strengths

**RMHP** implemented a very active QI program of diverse monitoring and improvement initiatives relative to the overall **RMHP** membership. **RMHP** invested in personnel expertise and systems to support a comprehensive QI program. The program appeared to be transitioning, since improvement in operational approaches are designed to support and integrate with other **RMHP** initiatives, such as the physician practice enhancement program and integration with the health information exchange. These initiatives are intended to improve the overall quality of services to members and enhance population-based outcomes. **RMHP** views Medicaid members as an important and integral component of the overall population and **RMHP** membership.

## Summary of Required Actions

**RMHP** must include an assessment of the overall impact and effectiveness of the QI program in the QI annual report.

**RMHP** must modify its policies and processes to ensure that CPGs applicable to Medicaid members are reviewed and approved annually.

**RMHP** must perform and document an audit of a statistically valid sample of Medicaid encounter claims that includes verification of claims information against medical record documentation.

## Methodology

As a follow-up to the FY 2011–2012 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 the health plan successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP** until the health plan completed each of the required actions from the FY 2011–2012 compliance monitoring site review.

## Summary of 2011–2012 Required Actions

As a result of the 2011–2012 site review, **RMHP** was required to address the following corrective actions:

**RMHP** must inform members of the rules that govern representation at the State fair hearing process, including the right to represent themselves or have a designated client representative, the right to present information or evidence, and the right to examine **RMHP** documentation related to the appeal.

**RMHP** must address the poststabilization care financial responsibility rules as outlined in 42 CFR 422.113 (c) and make such information available to members. HSAG's staff suggested that an internal policy specifying the payment criteria be developed and that members and providers be informed of how to access the policy.

At the time of this review**,** **RMHP** had not sent grievance resolution letters for quality of care grievances. **RMHP** must send each member a notice of resolution for all grievances and must also revise its procedures to accurately reflect the grievance resolution time frame as 15 working days.

**RMHP** must review claims denial letters and revise them, as needed, to ensure accurate reflection of the appeal filing time frame and consistency of compliance with Medicaid managed care regulations among **RMHP**'s functional departments.

**RMHP** must revise its applicable policies and procedures to accurately reflect that expedited appeals must be decided, with written notice to the member, within three working days from the date **RMHP** received the appeal.

**RMHP** must ensure that the individuals who make decisions on grievances and appeals were not involved in any previous level of review or decision-making.

**RMHP** must clarify its policies to accurately reflect the time frame for requesting a State fair hearing as 30 calendar days from the notice of action and ensure that appeal resolution letters accurately reflect the time frame.

**RMHP** must revise applicable documents such as notice of action and appeal resolution template letters, claims denial letters, member and provider materials, and policies, procedures, and processes to accurately reflect that members may request the continuation of previously authorized services during the appeal or State fair hearing if:

- The appeal is filed timely—defined (only for continuing benefits) as within 10 calendar days of the date of the notice of action, or before the intended effective date of the action, whichever is later.
- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.
- The enrollee requests the extension of services.

**RMHP** documents must also clearly reflect the circumstances under which members may be held liable for the cost related to those services that were previously authorized and continued as required in 42CFR438.420. Claims denials must not contain the general statement that members must pay for the services because the situations under which members may be held liable for the costs are limited.

**RMHP** must revise the provider manual to ensure that the 30-day filing time frame appears consistently in the manual. **RMHP** must also include in its provider materials the rules that govern representation at the State fair hearing. HSAG recommends that **RMHP** inform members that they may present evidence of fact or law and may examine the case file.

**RMHP** must evaluate its policy that addresses internal auditing and monitoring to identify potential fraud and abuse and develop procedures for the threshold and frequency of auditing described in the policy. **RMHP** should maintain documentation of fraud and abuse-deterrent activities, such as audits and fraud and abuse-deterrent committee meetings.

**RMHP** must correct its reporting policies and guidelines to be in compliance with the time frames for reporting to the Department as specified in the contract.

## Summary of Corrective Action/Document Review

**RMHP** submitted its plan to address all required actions to HSAG and the Department in May 2012. HSAG and the Department required that adjustments be made to the plan. **RMHP** submitted a revised plan along with documents to demonstrate areas of completion in August, September, and December 2012. While **RMHP** was able to satisfy many of the requirements, as of December 2012 it had one remaining corrective action still outstanding.

## Summary of Continued Required Actions

At the time of the 2012–2013 site review, **RMHP** had one outstanding action from the 2011–2012 site review:

- The Explanation of Benefits auto-generated for claims denials had incorrect information and time frames.

Since this corrective action requires computer system programming time, **RMHP** did not have an estimated date of completion. HSAG and the Department will continue to work with **RMHP** until all corrective actions are implemented.

The completed compliance monitoring tool follows this cover page.

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The Contractor has written policies and procedures to ensure timely coordination of the provision of Covered Services to its members and to ensure:<br>◆ Service accessibility.<br>◆ Attention to individual needs.<br>◆ Continuity of care to promote maintenance of health and maximize independent living.<br><br>DH Contract: II.D.4.a<br>RMHP Contract: II.E.4.a | Standard IV Member Rights and Protections\CM III. 1.List of Case Management Assessments.docx<br><br>Standard III Coordination and Continuity of Care\III.1. CS Medicaid Welcome Letter.doc<br><br>Standard III Coordination and Continuity of Care\III.3. CS Medicaid Welcome Call Script SOP.doc<br><br>Standard III Coordination and Continuity of Care\2012 Medicaid Access Plan - Draft.docx<br><br>Standard III Coordination and Continuity of Care\Case Management Policy and Procedure.doc pp. 1,11<br><br>Standard III Coordination and Continuity of Care\Delta County Health Department Delegated CM agreement .pdf<br><br>Delta County Business Associate Agreement<br><br>Delta County Health Department Contract | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

**Findings:**
The Medicaid Access Plan described RMHP's process for providing members with geographic access to providers and included targeted provider/member ratios and distances from members to providers. The plan also addressed appointment and wait time standards for various types of services, obtaining services for members with special health care needs, and continuity of care for a member whose provider is terminating from the plan.

The Case Management Policy (applicable to all lines of business) stated that RMHP would use the case management process to ensure timely coordination of services, service accessibility, attention to individual needs, and continuity of care, as defined in the requirement. The policy explained that the case manager assesses member needs and refers the member to an appropriate program such as transition of care, disease management, or complex care management.

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| The Medicaid Access Plan and the Continuity, Coordination, and Transition of Care Policy outlined the procedures to ensure members who are transitioning into or out of the plan have access to continued care with an existing medical provider when the member is undergoing an active course of treatment. During the on-site interview, the RMHP staff stated that members who were transitioning from an inpatient setting to another level of care were identified through the concurrent utilization review and received discharge planning to maintain continuity of care. The staff also stated that members transitioning from one outpatient care setting to another may be referred to care management to develop a coordination plan. | | |
| **Required Actions:**<br>None. | | |
| 2. The Contractor's procedures are designed to address those members who may require services from multiple providers, facilities, and agencies; and require complex coordination of benefits and services and members who require ancillary, social, or other community services.<br><br>The Contractor coordinates with the member's mental health providers to facilitate the delivery of mental health services, as appropriate.<br><br>*42CFR438.208(b)(2)*<br>DH Contract: II.D.4.c, II.D.4.b<br>RMHP Contract: II.E.4.b and II.E.4.c | Standard III Coordination and Continuity of Care\Case Management Policy and Procedure.doc pp. 1<br><br>Standard III Coordination and Continuity of Care\III.1. CS Medicaid Welcome Letter.doc<br><br>Standard III Coordination and Continuity of Care\III.3. CS Medicaid Welcome Call Script SOP.doc<br><br>Standard III Coordination and Continuity of Care\2012 Medicaid Access Plan - Draft.docx<br><br>Delta County Business Associate Agreement<br><br>Delta County Health Department Contract | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Case Management Policy stated that procedures were designed to ensure that RMHP addresses members who require services from multiple entities (specifically as defined in the requirement) and that RMHP coordinates with mental health providers, as appropriate. The policy outlined the procedures for completing a comprehensive assessment, defining a care plan, and coordinating services with multiple providers and community-based organizations. The policy also stated that RMHP contracted with the Delta County and San Juan Basin health departments to provide comprehensive case management for children with special health care needs.<br><br>The delegated case management agreements with the Delta County Health Department and the San Juan Basin Health Department outlined the terms and conditions for comprehensive case management services to children with special health care needs. The agreements specifically outlined the required case management processes, documentation requirements, compensation for services by RMHP to the contractor, and contractor reporting requirements | | |

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| to RMHP. During the on-site interview, staff members stated that RMHP also tracked the members with special health care needs through the RMHP case management department, and communicated frequently with the county health department case managers concerning member needs and services. HSAG recommended that RMHP consider a more detailed audit of the delegated entities to ensure that the delegated functions were being monitored adequately.<br><br>During the on-site interview, RMHP presented two care coordination cases: (1) an adult male—referred by his provider—with substance abuse and multiple medical issues, previously discharged from multiple physician practices due to noncompliance, with a third-party caregiver and the need for dental care, wound care, and health education in multiple areas; and (2) a male toddler with the need for multiple heart surgeries to be performed out of state, requiring coordination with out-of-state services and providers, and the need for follow-up home services and parental support following surgeries. Both cases demonstrated coordination with multiple providers (including mental health providers), home-based services, patient education, and community-based resources, such as transportation, lodging, and funding for non-covered services. | | |
| **Required Actions:**<br>None. | | |
| 3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member.<br><br>If a Member does not select a primary care physician (PCP), the Contractor assigns the member to a PCP or a primary care facility and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number.<br><br>*42CFR438.208(b)(1)*<br>DH Contract: II.D.3.b<br>RMHP Contract: II.E.3.b | Standard III Coordination and Continuity of Care\Case Management Policy and Procedure.doc pp. 2<br><br>Standard III Coordination and Continuity of Care\III.3 CS PCP Change in Facets SOP.doc | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The new member welcome letter and the Medicaid member handbook informed members that they must choose a PCP and directed members to the provider directory or to call customer services for assistance. The RMHP provider manual informed providers that members selected a PCP and that the member may request a change in PCP at any time. The manual stated that the PCP was responsible for the patient's total care and coordinated all medical care provided to the member. The Case Management Policy stated that all new Medicaid members received a welcome call to ensure that each one had an | | |

| Standard III—Coordination and Continuity of Care | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| ongoing source of primary care. The new member welcome call script inquired about the member's selection of a PCP. Although the welcome was an additional mechanism to remind members to choose a PCP, during the on-site interview staff members clarified that the new member welcome call was used only for a specific population (see requirement # 4 for scoring related to this).<br><br>The Primary Care Physician Assignment for HMO Members Policy stated that members are encouraged to select a PCP upon enrollment, and that if a member fails to select a PCP, RMHP had an automated process to assign a PCP based on prior claims history, family PCP history, or geographic location. RMHP informs Medicaid members by mail of the assigned PCP name, location, and contact information. The policy outlined the detailed operating procedures for each department as they relate to assigning the member to the most appropriate PCP. The Medicaid Access Plan also described the PCP selection and assignment process.<br><br>The two care coordination cases presented on-site demonstrated that each member had a designated PCP and care coordinator. | | |
| **Required Actions:**<br>None. | | |
| 4. The Contractor implements procedures to provide individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals.<br><br>*42CFR438.208(c)(2)*<br><br>DH Contract: II.D.4.c.1<br>RMHP Contract: II.E.4.c.1 | Standard III Coordination and Continuity of Care\Case Management Policy and Procedure.doc pp. 2-3 | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Case Management Policy stated that all new Medicaid members receive a customer service call for a brief needs assessment, and members with identified special needs are referred to a case management intake coordinator for additional screening. Members may also be identified through data, internal departments, member self-referral, or provider referral. The case management staff conducts an initial screening with the member within one to three days of being identified and/or referred to complex case management. The policy also stated that upon enrollment into complex case management, case management nurses perform a comprehensive assessment of the member's needs, including assessment for the special health care needs outlined in the requirement. RMHP provided sample data reports that documented the use of claims information to assign a risk score and identify members with potential need for complex case management services. During the on-site interview, the RMHP staff reported that the new member welcome call and | | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| needs assessment were conducted only for members identified by the State at enrollment as needing to be engaged in an ongoing course of treatment. Staff members stated that there was not a routine call and needs assessment for all newly enrolled Medicaid members.<br><br>The on-site presentation of care coordination cases demonstrated that members referred to case management received a comprehensive needs assessment that included assessment of high-risk health problems, language and comprehension problems, mental health status, and functional problems. The assessments were performed by a registered nurse case manager. Staff members stated that all case managers are licensed nurses. | | |
| **Required Actions:**<br>RMHP must implement a process to ensure that following enrollment, all Medicaid members receive initial screening for special health care needs and qualification for complex case management. | | |
| 5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities.<br><br>*42CFR438.208(b)(3)*<br>DH Contract: II.D.5.a<br>RMHP Contract: II.E.5.a | Standard III Coordination and Continuity of Care\Case Management Policy and Procedure.doc pp. 7,11 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Case Management Policy stated that for members enrolled in complex case management, RMHP will coordinate with other health care organizations providing services to the member and will notify organizations serving members with special health care needs of the results of RMHP's needs assessments to prevent duplication of services and activities. The policy outlined the process for communicating with county health departments that have been delegated by RMHP to perform needs assessment and case management for children with special health care needs. During the on-site interview, staff members described several examples of communicating and coordinating member needs with other health care organizations, such as foundations providing charity funding for services and the region's behavioral health organization, or facilitating transfer of records to out-of-state providers. Staff members stated that information may be shared verbally or through the electronic referral process, as appropriate. | | |
| **Required Actions:**<br>None. | | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 6. The Contractor implements procedures to develop an individual treatment plan as necessary.<br><br>*42CFR438.208(c)(3)*<br><br>DH Contract: II.D.4.c.1<br>RMHP Contract: II.E.4.c.1 | Standard III Coordination and Continuity of Care\Case Management Policy and Procedure.doc p. 5 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

**Findings:**

The Case Management Policy explained that the case management plan is designed to help the member meet his/her clinical, functional, and social health care goals, while treatment plans are developed by the member's PCP when they need a specific course of treatment. The policy stated that the complex case manager will develop an individualized case management plan with the participation of the member and providers, based on the identified needs of the member. The care plan will include the member/caregiver's prioritized measurable goals, defined interventions, barrier analysis, and regularly scheduled follow-up and re-evaluation.

During the on-site interview, the staff stated that the provider's responsibility to develop a treatment plan was referenced in the office records section of the provider manual, which listed the required components of the medical record. The staff described the periodic office record review process as one that includes an audit to document the required medical record components in physician office records and to provide practice quality management coaching as mechanisms for ensuring that an appropriate member treatment plan is developed. The physician medical record audit tool confirmed that the audit included a review of the physician's documentation of a care plan based on the medical condition of the member. HSAG recommended that RMHP consider enhancing its provider communications to inform them of the responsibility to develop an individual treatment plan based on an assessment of the member's medical, functional, and social needs.

The on-site presentation of care coordination cases demonstrated that each member had an individual treatment/care plan, with member goals, planned interventions, barriers, detailed progress/contact notes, and scheduled follow-up.

**Required Actions:**

None.

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 7. The Contractor's procedures for individual needs assessment and treatment planning are designed to:<br>◆ Accommodate the specific cultural and linguistic needs of the members.<br>◆ Allow members with special health care needs direct access to a specialist as appropriate to the member's conditions and needs.<br><br>*42CFR438.208(c)(3)(iii)*<br>DH Contract: II.D.4.c.1<br>RMHP Contract:II.E.4.c.1 | Standard III Coordination and Continuity of Care\Case Management Policy and Procedure.doc pp. 4,5,8<br><br>Standard III Coordination and Continuity of Care\QI 111.7_RMHP Annual Cultural and Linguistics Needs Report 112812.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Case Management Policy and Procedure stated that the case manager would evaluate the cultural norms, practices, language proficiency, and preferences of members. The case manager is also responsible for identifying cultural or language barriers to meet the goals of the treatment plan. The on-site presentation of two care coordination cases demonstrated that the members' cultural and language needs were included in the assessment and the individual care plan. The RMHP Cultural and Linguistic Needs Report identified a number of initiatives related to the cultural and language needs of the RMHP population, which included assessing member cultural barriers and recommendations for treatment based on the disease management programs and materials.<br><br>The Medicaid member handbook, the RMHP provider manual, and the Medicaid Access Plan stated that members do not need a referral to see an in-network specialist, and that access to an out-of-network specialist may be allowed when authorized by RMHP. | | |
| **Required Actions:**<br>None. | | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable.<br><br>In all other operations as well, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.<br><br>*42CFR438.208(b)(4)*<br>*42CFR438.224*<br><br>DH Contract: II.D.4.a, II.E.3.c<br>RMHP Contract: II.E.4.a, II.F.3.c | HIPAA Privacy P&Ps Tracking Chart<br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf (see book arks)<br><br>Standard III Coordination and Continuity of Care\Case Management Policy and Procedure.doc p. 4<br><br>Standard III Coordination and Continuity of Care\Confidentiality and Retention of Member Records Policy 1.7.13.doc | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP submitted a list of all HIPAA privacy policies and procedures that addressed physical record security, training, violations, work force sanctions, notice of privacy practices, use and disclosure of protected health information (PHI), obtaining release of information authorizations, verification of identity/authority, de-identification of PHI, and minimum necessary use. RMHP submitted several policies from the list that demonstrated compliance with HIPAA regulations. The Confidentiality and Retention of Members Record Policy stated that no member PHI would be disclosed without the member's prior written consent. The policy also defined processes for maintaining confidentiality of all RMHP records and materials, and stated that access to PHI or other confidential information was restricted to individuals or committees with the need to know based on defined responsibilities. The provider manual described the maintenance of confidentiality in all communications and records related to care management. The manual described the general RMHP policies related to confidentiality of member information in accordance with HIPAA regulations, including obtaining a member's routine consent for access to information from other providers/entities, as well as the member's right to release information through specific consents. The manual also informed providers that they must comply with all applicable HIPAA regulations. | | |
| **Required Actions:**<br>None. | | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 9. The Contractor's procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment.<br><br>DH Contract: II.D.4.c.3<br>RMHP Contract:II.E.c.3 | Standard III Coordination and Continuity of Care\Case Management Policy and Procedure.doc pp. 4,5,8 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Case Management Policy stated that the case management plan's goal development should include member and family participation and a relevant note must be entered if the member/family chooses not to participate. The policy also stated that self-management goals were a component of the care plan. The two care coordination cases presented on-site demonstrated that the case manager obtained the member's consent to participate in case management and active involvement of the member/parent in the development and implementation of the plan.<br><br>The provider manual described the role of RMHP case management to support providers and members/families in complying with the treatment plan. The Medicaid member handbook informed members of their right to participate in making decisions about their care, including whether to accept or refuse medical treatment. During the on-site interview, the RMHP staff stated that member newsletters contained articles and tools that encouraged members to participate as partners with the physician in treatment planning.<br><br>Although case management documentation clearly indicated that the member/family participated in case management activities, HSAG recommended that RMHP define a mechanism to consistently document the member's consent to the individual care coordination plan in the case management record. | | |
| **Required Actions:**<br>None. | | |
| 10. The Contractor:<br>◆ Instructs its participating providers on how to refer a member for wraparound services.<br>◆ Advises participating providers of EPSDT support services that are available through local public health departments.<br>◆ Informs the provider of the availability of the following wraparound services:<br>• Auditory services (children)—HMO covered services include screening, medically necessary | Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf Please also see Wrap-Around bookmark<br><br>Medicaid Member Handbook Please see covered services and benefits beginning p. 15 | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| ear exams, and audiological testing. Wraparound benefits include hearing aids, auditory training, audiological assessment, and hearing evaluation.<br>• Dental services (children)—comprehensive dental assessment, care, and treatment (age 1 or before).<br>• Drug/Alcohol treatment for pregnant women—assessment and treatment (Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only).<br>• Extraordinary Home Health Services—expanded EPSDT benefit includes any combination of necessary home health services that exceed the maximum allowable per day; and services that must, for medical reasons, be provided at locations other than the child's place of residence.<br>• HCBS services—case management, home modification, electronic monitoring, personal care, and non-medical transportation.<br>• Hospice services—client may continue to receive care not related to the terminal illness from the HMO.<br>• Hospital back-up level of care as set forth in 10 CCR 2505-10, Section 8.470.<br>• Inpatient substance abuse rehabilitation DRG 936 (Valley View).<br>• Intestinal transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (e.g., liver); coordinated by the Department and HMO case | | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| manager (provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai).<br>• Non-emergency transportation to medical appointments—covered services (through the client's county of residence).<br>• Private duty nursing (nursing services only).<br>• Skilled nursing facility services (skilled nursing and rehabilitation services) if client meets level of care certification.<br><br>DH Contract: II.D.4.g<br>RMHP Contract: II.C.4.i | | |
| **Findings:**<br>RMHP's provider manual defined many of the wraparound services outlined in the requirement. The manual did not inform providers of the following wraparound services: inpatient substance abuse rehabilitation through Valley View and hospital backup level of care (e.g., subacute care). The provider manual also did not provide information on how providers may refer members for wraparound services or information on the availability of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) support services through the local public health departments. During the on-site interview, RMHP stated that hospital backup level of care is a covered service of RMHP; however, it was not listed in the description of RMHP covered services.<br><br>The member handbook identified Medicaid wraparound services as those covered services that were paid by Medicaid and not RMHP. The identified services included routine dental care for children, home health care over the 60-day limit, private duty nursing, hospice care, mental health through the behavioral health organization, and transportation to health care appointments. | | |
| **Required Actions:**<br>RMHP must revise its provider communications to include the complete listing of Medicaid wraparound services, as outlined in the requirement. RMHP must also revise its provider communications to include information on how providers may refer members for wraparound services, that EPSDT services are available for members through age 20 (currently stated as age 21), and inform providers of the availability of EPSDT support services through the local public health departments. | | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 11. The Contractor informs all members aged 20 and under that EPSDT services are available. Information must effectively inform those individuals who are blind or deaf, or who cannot read or understand the English language and must include:<br>◆ The benefits of preventive health care.<br>◆ That services provided under the EPSDT program are without cost to the individual.<br>◆ The services available under the EPSDT program and where and how to obtain those services, which include:<br>• Auditory devices (children)—HMO covered services include screening, medically necessary ear exams, and audiological testing. Wraparound benefits include hearing aids, auditory training, audiological assessment, and hearing evaluation.<br>• Dental services (children)—comprehensive dental assessment, care, and treatment (age 1 or before).<br>• Drug/Alcohol treatment for pregnant women—assessment and treatment (Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only).<br>• Extraordinary Home Health Services—expanded EPSDT benefit includes any combination of necessary home health services that exceed the maximum allowable per day; and services that must, for medical reasons, be provided at locations other than the child's place of residence.<br>• HCBS services—case management: home modification, electronic monitoring, personal | Medicaid Member Handbook Please see Keeping your child healthy page 5 and Services and Benefits beginning p. 15<br><br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf See covered services table beginning p. 63 | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| care, and non-medical transportation.<br>• Hospice services—client may continue to receive care not related to the terminal illness from the HMO.<br>• Hospital back-up level of care as set forth in 10 CCR 2505-10, Section 8.470.<br>• Inpatient substance abuse rehabilitation DRG 936 (Valley View).<br>• Intestinal transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (e.g., liver); coordinated by the Department and HMO case manager (provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai).<br>• Non-emergency transportation to medical appointments—covered services (through the client's county of residence).<br>• Private duty nursing (nursing services only).<br>• Skilled nursing facility services (skilled nursing and rehabilitation services) if client meets level of care certification.<br>*42CFR441.56(a)(1)—(3)*<br>DH Contract: II.E.6.e<br>RMHP Contract: II.D.6.e | | |
| **Findings:**<br>The Medicaid member handbook informed members of the EPSDT services for members 0 to 21 years of age at no cost to the member, described the preventive benefit of the services, and provided a general description of recommended checkups and immunizations by age and the screenings provided; however, did not include a periodicity schedule. The handbook stated that EPSDT services were part of the Medicaid benefits at no cost to the member. The handbook was printed in Spanish and English and informed members that the handbook was available in Braille, other languages, audiotape, or in large print. The handbook provided a short list of generally defined benefits (e.g., immunizations, eyeglasses, dental care, hearing exams, home visits) | | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| and provided telephone numbers for the member to obtain more information. The Covered Services and Community Resource sections of the handbook included a listing of some, but not all, of the available EPSDT services, and did not clearly identify that they were EPSDT services.<br><br>The format of the member handbook did not clearly define the list of EPSDT program services or where/how to obtain them, as follows:<br>◆ The handbook did not address who provides the screening and exam services (e.g., primary care provider).<br>◆ The handbook stated that the provider may refer the member for wraparound services but did not provide direct contact numbers or how to obtain specific wraparound services.<br>◆ The handbook did not include information about how to obtain the following EPSDT services: drug and alcohol treatment for pregnant women; inpatient drug rehabilitation at Valley View; intestinal transplants at specific facilities; hospital backup level of care.<br><br>The handbook described some services available through the EPSDT program in a manner confusing to the member. The handbook:<br>◆ Stated that EPSDT included routine dental care but did not address comprehensive oral assessment and treatment services for children younger than one year of age. The covered services section stated dental services were only covered if provided by a doctor, not a dentist, and only in specific circumstances, and it did not explain that other dental service may be obtained under the EPSDT program, such as wraparound services.<br>◆ Stated that drug/alcohol treatment and skilled nursing facility/rehabilitation services were not covered, but did not address special circumstances for EPSDT.<br>◆ Defined Home and Community-Based Services (HCBS) and Special Connections programs as community resources, but did not mention them as EPSDT benefits. The covered services section stated that home modifications were not a covered benefit, with no mention of the HCBS exception and how to obtain this from other sources.<br>◆ Stated private duty nursing may be covered, but this was addressed only under home health benefits, and did not explain how additional services may be obtained under the EPSDT program. | |
| **Required Actions:**<br>RMHP member materials must inform members of the complete list of services available through the EPSDT program, as defined in the requirement. Specifically, RMHP must address the following omissions: drug and alcohol treatment for pregnant women; inpatient drug rehabilitation at Valley View; intestinal transplants at specific facilities; and hospital backup level of care. RMHP must clarify benefit descriptions and explain additional services available under the Medicaid fee-for-service payment structure, although not covered under RMHP's managed care contract. RMHP must also develop a designated EPSDT section of the member handbook or some other method to clearly define the services available under the EPSDT program and where and how to obtain them. | | |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 12. The Contractor provides referral assistance for treatment that is not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis.<br>*42CFR441.61(a)*<br>DH Contract: II.D.4.g<br>RMHP Contract: II.C.4.i | Medicaid Member Handbook<br><br>Standard III Coordination and Continuity of Care\Continuity.Coordination and Transition of Medical Care 2012.doc | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| **Findings:**<br>The Case Management Policy stated that complex case management would educate members regarding the availability of wraparound services. During the on-site interview, the staff stated that case managers would also actively arrange for referral to a provider of wraparound services or contact the appropriate health department on behalf of a member. The Medicaid member handbook stated that the provider may refer the member to the Medicaid hotline or county health department for wraparound services, but it did not provide direct contact numbers. The Community Resources section of the handbook provided contact numbers for some specific benefits paid by Medicaid, but these numbers were not provided in sections that referenced wraparound services/Medicaid covered benefits. HSAG recommended that RMHP clearly and consistently define the contact numbers for members to access wraparound services in the member handbook. | | |
| **Required Actions:**<br>None. | | |
| 13. The Contractor provides to members regularly scheduled examinations and evaluations of general physical and mental health, growth, and development, and nutritional status of infants, children, and youth. Screenings must include:<br>◆ Comprehensive health and developmental history.<br>◆ Comprehensive, unclothed physical examination.<br>◆ Appropriate vision testing.<br>◆ Appropriate hearing testing.<br>◆ Appropriate laboratory testing.<br>◆ Dental screening services furnished by direct referral to a dentist for children beginning at 1 year of age.<br>◆ If it is determined at the time of screening that immunization is needed, and appropriate, then | Medicaid Member Handbook<br><br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| immunizations must be provided at the time of treatment.<br><br>*42CFR441.56(a)(4)(b)—(c)*<br>DH Contract II.E.6.e<br>RMHP Contract II.E.6.e | | |
| **Findings:**<br>The RMHP provider manual defined the components of a comprehensive EPSDT well-child exam, which included all of the elements in the requirement except referral to a dentist beginning at one year of age. The manual outlined the intervals for EPSDT well-child exams but did not recommend intervals for the specific screening services. The member handbook described the availability of periodic well-child exams and immunizations through the EPSDT program, with a general description of the screenings included in the exams and the types of immunizations administered within broad age categories. | | |
| **Required Actions:**<br>RMHP must correct its provider communications regarding EPSDT screening services to include "referral to a dentist beginning at one year of age." RMHP also must define more specifically the expected intervals for the screening services in both the provider manual and the member handbook. | | |
| 14. The Contractor has implemented the State's periodicity schedule for screening services and specifies screening services applicable at each stage of the member's life, beginning with neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services.<br><br>(The Contractor must demonstrate outreach efforts based on established periodicity schedules)<br><br>*42CFR441.58*<br>DH Contract II.E.6.e<br>RMHP Contract II.E.6.e | GO EPSDT Report<br><br>Standard III Coordination and Continuity of Care\QI 111.14 AAP Bright Futures Well Child Guideline.pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 Imm Schedule_WCC schedule.pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 Immunization Letter QI81 - Don't Get Behind.pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 Immunization Reminder- Missed Shots QIM30 WellnessThatRewards (Missing information).pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 Newborn Well Care QI95.pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 One | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | year Well Care QI96-A.pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 Well Adolsecent Female Reminder QI84.pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 Well Adolsecent Male QI102.pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 Well Child Reminder QI100.pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 Well Adolsecent Male QI102.pdf<br><br>Standard III Coordination and Continuity of Care\QI 111.14 Well Child Reminder QI100.pdf | |

**Findings:**
The RMHP provider manual defined the components and time intervals for comprehensive EPSDT well-child exams; however, it did not address screenings (such as hearing and vision) or indicate specific screening intervals outlined in the State's periodicity schedule. The Bright Futures Well-Child guidelines defined the recommended well-child exam and screening schedule from the American Academy of Pediatrics, which was consistent with the State periodicity schedule. The CMS 416 report quantified the number of well-child exams, immunizations, and screenings performed by RMHP providers. During the on-site interview, the staff stated that RMHP used the Bright Futures schedule as a clinical guideline to monitor gaps in care and plan the distribution of educational materials related to EPSDT and wellness/prevention services. The staff reported that RMHP used reports from the State immunization registry and claims data to identify missed immunizations for individual members and to generate "gaps in care" reports to providers. Staff members stated the CMS 416 report was also used as a reference to identify high-priority areas for member education materials concerning prevention and wellness services. RMHP submitted several samples of well-designed member education materials based on the periodicity schedule for well-child visits, including brochures regarding immunizations and well-child visits with appropriate schedules, member reminder letters with incentives, reminder birthday cards, and postcard reminders at appropriate age intervals. The staff stated that these materials were distributed through quarterly mailings to members.

**Required Actions:**
RMHP must revise the provider manual to specifically address recommended screenings as outlined in the State's EPSDT periodicity schedule.

| Standard III—Coordination and Continuity of Care | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 15. The Contractor maintains policies describing its screening package and the methods used to assure that screening requirements are met.<br><br>*42CFR441.56(d)*<br><br>DH Contract II.E.6.e<br>RMHP Contract II.E.6.e | Standard III Coordination and Continuity of Care\2012 Medicaid Access Plan - Draft.docx Please see highlight p.10<br><br>Medicaid Member Handbook\Medicaid Handbook- 1012.pdf<br><br>Standard III Coordination and Continuity of Care\CMS416_EPSDT10012011_09302012.xls<br><br>Note: CMS 416 Report submitted this year for the period 10/1/2011 to 9/31/2012<br><br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf | ☐ Met<br>☐ Partially Met<br>☒ Not Met<br>☐ N/A |

**Findings:**
The Bright Futures Well-Child guidelines described a schedule for well-child exams and screenings. The provider manual, member handbook, and Medicaid Access Plan stated that providers must schedule a visit for EPSDT services within two weeks of request by the member. The CMS 416 report (EPSDT Participation Report) provided data on the number of EPSDT tests performed by RMHP for the overall Medicaid population. The medical record audit tool, used in the periodic on-site audit of physician offices, included criteria to document well-child exams and screenings based on the Bright Futures guidelines. During on-sight interviews, the staff confirmed that RMHP had not developed a policy describing the EPSDT screening package and methods used to assure that screening requirements were met. Staff members stated that RMHP had not formally adopted the Bright Futures guidelines, but the schedule was used as an internal reference for child wellness and preventive services.

**Required Actions:**
RMHP must develop and approve a policy describing its screening package and the methods used to assure that screening requirements are met. RMHP must formally adopt a periodicity schedule consistent with the State's EPSDT requirements, and clearly communicate expectations regarding EPSDT services to RMHP providers.

| Results for Standard III—Coordination and Continuity of Care | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 9 | X | 1.00 | = | 9 |
| | Partially Met | = | 5 | X | .00 | = | 0 |
| | Not Met | = | 1 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | 0 |
| **Total Applicable** | | = | 15 | **Total Score** | | = | 9 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 60% |

| Standard IV—Member Rights and Protections | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The Contractor has written policies and procedures regarding member rights.<br><br>*42CFR438.100(a)(1)*<br>DH Contract: II.E.1.a<br>RMHP Contract: II.F.1.a | Standard IV Member Rights and Protections\IV.4.CS Medicaid Member Rights P&P.doc<br><br>Medicaid Member Handbook\Medicaid Handbook- 1012.pdf<br><br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP had several polices in place that addressed member rights and protections in accordance with federal health care requirements. RMHP's Medicaid Member Rights Policy described how member rights are communicated to members and providers. In addition, RMHP had several policies that addressed topic-specific issues such as advance directives, confidentiality and the handling of PHI, nondiscrimination, and grievances and appeals. | | |
| **Required Actions:**<br>None. | | |
| 2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members.<br><br>*42CFR 438.100(a)(2)*<br>DH Contract: None<br>RMHP Contract: None | Standard IV Member Rights and Protections\IV.4.CS Medicaid Member Rights P&P.doc<br><br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The list of member rights was posted on the RMHP Web site (obtainable from a link under the member tab) and was included in RMHP's Medicaid Member Handbook (the member handbook) as found under the member tab on RMHP's Web site. During the on-site interview, RMHP staff members described the "Bridges out of Poverty" training program and stated that this program was offered to the Mesa County Independent Providers Association. Staff members described this training as an excellent opportunity for providers to understand barriers to accessing care and the different needs and communication styles common to some of the Medicaid population. Provider newsletters included topics regarding cultural competency and cultural competency training available. Although the provider manual listed the Medicaid member rights, there was no discussion of provider responsibilities related to member rights. HSAG recommended that RMHP develop additional provider communications (e.g., more specific discussion of provider responsibilities in the provider manual or rights topic-specific provider newsletter articles) designed to keep the topic of member rights prevalent in providers' minds. On-site, staff members also described a project recently initiated whereby the RMHP Member Experience Advisory Committee (MEAC) would evaluate customer "touch points" (defined as points within the RMHP system wherein members will interact in some way with RMHP or its staff members), to evaluate members' experiences with RMHP and opportunities to improve them. Staff members reported that this project involved all departments and regions served by RMHP and could impact members within all lines of business. | | |

| Standard IV—Member Rights and Protections | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Required Actions:**<br>None. | | |
| 3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights:<br>◆ Receive information in accordance with information requirements (42CFR438.10).<br>◆ Be treated with respect and with due consideration for his or her dignity and privacy.<br>◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.<br>◆ Participate in decisions regarding his or her health care, including the right to refuse treatment.<br>◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.<br>◆ Obtain family planning services directly from any provider duly licensed or certified to provide such services without a referral.<br>◆ Request and receive a copy of his or her medical records and request that they be amended or corrected.<br>◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210).<br><br>*42CFR438.100(b)(2) and (3)*<br>DH Contract: II.E.1.a<br>RMHP Contract:II.F.1.a | Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf<br><br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf<br><br>Standard IV Member Rights and Protections\CM IV 3. BOP Program Description.doc<br><br>Standard IV Member Rights and Protections\IV. 3. BOP Sign up sheets 2 1.6.12 to RMHP Mgmt staff.doc | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard IV—Member Rights and Protections | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Findings:** RMHP's member handbook, distributed to each member at the time of enrollment, included the list of member rights required in 42CFR438.100(b)(2)&(3). The provider manual included the list of Medicaid member rights. Member rights were also posted on the RMHP Web site, available through a link from the members tab. The rights list found on the Web site included each right as required by 42CFR438.100. In addition, the member handbook separately and more specifically explained processes and information related to specific rights such as access to services, second opinions, grievances and appeals, and advance directives. On site, staff members described RMHP's care management and utilization management processes, during which the care management staff works closely with providers and members to ensure members receive the appropriate services, that they understand their rights, and that those rights are taken into consideration during the episode of care. | | |
| **Required Actions:**<br>None. | | |
| 4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member.<br><br>*42CFR438.100(c)*<br>DH Contract: II.E.1.a.7<br>RMHP Contract: II.F.1.a.7 | Medicaid Member Handbook<br><br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf<br><br>Standard IV Member Rights and Protections\CM IV 3. BOP Program Description.doc<br><br>Standard IV Member Rights and Protections\IV. 3. BOP Sign up sheets 2 1.6.12 to RMHP Mgmt staff.doc<br><br>Standard IV Member Rights and Protections\IV.3. BOP sign up sheets 3 10.25.12 RMHP New Staff.PDF | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The list of member rights included in the member handbook and posted on the RMHP Web site identified the member's right to bring complaints to RMHP, the insurance commissioner, or the Colorado Department of Health Care Policy and Financing and to freely exercise rights without being treated differently. Although member rights were listed on the Web site and in the member handbook, information on the Web site was outdated. The member handbook on the Web site was not the newest member handbook (dated October 20, 2012) that was sent to HSAG for review. In addition, information on the Web site directing the member about receiving mental health services was outdated and described the Mental Health Assessment and Services Agency (MHASA) system (outdated since 2005), stating the MHASA for western Colorado was Colorado Health Network. A member who called the number provided would not understand whether he or she was calling the correct number. Furthermore, the annual Medicaid enrollment letter (provided on-site) did not inform members of their right to request and receive a copy of the member handbook on request, as the staff stated on-site that it did. This having been a previous corrective action, HSAG once again recommends that RMHP evaluate its systems and processes for both implementing corrective actions | | |

| Standard IV—Member Rights and Protections | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| and following through with processes. In order for members to fully understand benefits guaranteed under the Medicaid program and the rights associated with these benefit programs, they must receive accurate and timely information. Conflicting information from various sources is confusing. | | |
| **Required Actions:**<br>RMHP must work with its BHO partner to ensure accurate presentation of mental health/behavioral health information on RMHP's Web site. RMHP must update its Web site and develop processes to ensure that members who choose to use the RMHP Web site receive the most accurate information, and that this information does not conflict with previous hard copy information the member may have received. RMHP must also ensure that members are notified annually of their right to request and receive a copy of the member handbook. | | |
| 5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act.<br>*42CFR438.100(d)*<br>DH Contract: IV.W<br>RMHP Contract: VI.X | Medicaid Member Handbook<br><br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf<br><br>Standard IV Member Rights and Protections\IV.4.CS Medicaid Member Rights P&P.doc | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Medicaid Member Rights Policy included a definitive policy statement that articulated RMHP's intention to provide equal opportunity and to prevent discrimination based on race, color, national origin, age, or disability in access to treatment or employment. The same policy statement was found in the member handbook and the provider manual. The spring 2012 provider newsletter included an affirmation statement of nondiscrimination. During the on-site interview, RMHP staff members reported that information regarding these federal laws was part of new-employee orientation and was revisited during annual "Compliance Week" activities, during which staff members engage in games, activities, and training to remind them of these and other federal laws and requirements in a nonthreatening manner that encourages learning. | | |
| **Required Actions:**<br>None. | | |

| Results for Standard IV—Member Rights and Protections | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | **Met** | **=** | 4 | X | 1.00 | = | 4 |
| | **Partially Met** | **=** | 1 | X | .00 | = | 0 |
| | **Not Met** | **=** | 0 | X | .00 | = | 0 |
| | **Not Applicable** | **=** | 0 | X | NA | = | NA |
| **Total Applicable** | | **=** | 5 | **Total Score** | | **=** | 4 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | **=** | 80% |

| Standard VIII—Credentialing and Recredentialing | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.<br><br>NCQA CR1 | CR-Credentialing Process CR.1.12.pdf<br>CR-Recredentialing Process RC.1.12.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy provided an overview of RMHP's credentialing and recredentialing processes, referring to other pertinent policies for details. Processes reviewed on-site were consistent with the policies and provided evidence of RMHP's well-defined credentialing and recredentialing processes. | | |
| **Required Actions:**<br>None. | | |
| 2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify:<br><br>2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include doctors of medicine [MDs], doctors of osteopathy [DOs], and podiatrists.)<br><br>*42CFR438.214(a)*<br><br>NCQA CR1—Element A1 | CR-Credentialing Process CR.1.12.pdf– Pg 4-6<br>CR-Recredentialing Process RC.1.12.pdf– Pg 4-6 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy included tables that depicted the types of practitioners that RMHP credentials and recredentials and the credentialing criteria for each type. Examples included medical doctors, doctors of osteopathic medicine, physician assistants, and certified registered nurse anesthetists, among others. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.B. The verification sources used.<br><br>NCQA CR1—Element A2 | CR-Credentialing Process CR.1.12.pdf – Pg 8-9<br>CR-Recredentialing Process RC.1.12.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The primary verification sources described in RMHP's policy met NCQA requirements for primary-source verification. RMHP used primary sources such as the Colorado Department of Regulatory Agencies to verify State licenses and the National Practitioner Data Bank to verify eligibility to participate in federal health care programs. | | |
| **Required Actions:**<br>None. | | |
| 2.C. The criteria for credentialing and recredentialing.<br><br>NCQA CR1—Element A3 | CR-Credentialing Process CR.1.12.pdf– Pg 2-6<br>CR-Recredentialing Process RC.1.12.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy described the credentialing criteria for each type of practitioner that RMHP credentials and recredentials. | | |
| **Required Actions:**<br>None. | | |
| 2.D. The process for making credentialing and recredentialing decisions.<br><br>NCQA CR1—Element A4 | CR-Credentialing Process CR.1.12.pdf– Pg 10-12<br>CR-Recredentialing Process RC.1.12.pdf– Pg 10-13<br>CR-Credentialing Recredentialing Approval Workflow.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP's policy described processes for making credentialing and recredentialing decisions and delineated the role of the Medical Practice Review Committees (MPRCs). RMHP uses five distinct MPRCs in its regions throughout the State to carry out credentialing committee activities and employ local physicians to accomplish the tasks in each region. The policy described three categories of files and the process for sending files to a medical director for approval or to one of the MPRCs for discussion. The policy described the committee's process to make decisions against established RMHP criteria. The Credentialing and Recredentialing work flow diagram depicted the procedure to determine the category and the approval process. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria.<br><br>NCQA CR1—Element A5 | CR-Credentialing Process CR.1.12.pdf– Pg 10<br>CR-Recredentialing Process RC.1.12.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy listed the documents that must be present for the credentialing and recredentialing files to be complete, and they described three categories of files with circumstances that require review by the committee. During the on-site interview, RMHP staff members confirmed that, for clean files, the medical director (or designee) approval date is the credentialing/recredentialing date, and the MPRC date is the credentialing date for providers reviewed by the MPRC. | | |
| **Required Actions:**<br>None. | | |
| 2.F. The process for delegating credentialing or recredentialing (if applicable).<br><br>NCQA CR1—Element A6 | CR-Delegated Cred-Recred Process DEL.1.12.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Delegated Credentialing and Recredentialing Policy described processes for delegation and oversight of delegates who credential and recredential practitioners on behalf of RMHP. The policy described activities that may be delegated and the required provisions for the content of the delegation agreement. Processes to delegate credentialing included a review of the delegate's credentialing/recredentialing policies and procedures and predelegation audit of files. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes).<br><br>NCQA CR1—Element A7 | CR-Non-Discriminatory Credentialing 14.12.pdf<br>CR-Non-Discriminatory Review thru 12-31-12.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Non-discriminatory Credentialing Policy stated that members of the MPRCs make decisions in accordance with the guidelines specified in the Quality Improvement (QI) Program. During the on-site interview, RMHP staff members stated that the QI program guide describes expectations and required conduct for staff and committee members involved in QI activities and committees. On-site, the staff provided a template agreement that MPRC members sign and that includes attestation and agreement to conduct nondiscriminatory decision-making. The policy also stated that the credentialing manager tracks denials and terminations and annually audits the credentialing file of providers who had been denied or terminated for noncompliance with the nondiscriminatory standards and guidelines. | | |
| **Required Actions:**<br>None. | | |
| 2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor.<br><br>NCQA CR1—Element A8 | CR-Credentialing Process CR.1.12.pdf – Pg 8<br>CR-Recredentialing Process RC.1.12.pdf – Pg 9 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy described the process for notifying the applicant, by phone, of discrepancies in information and for giving the applicant the opportunity to provide additional information or clarify the discrepancy. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision.<br><br>NCQA CR1—Element A9 | CR-Credentialing Process CR.1.12.pdf – Pg 11<br>CR-Recredentialing Process RC.1.12.pdf– Pg 12<br>CR-Guidelines to notify within 60 days.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy stated that the time frame for notifying practitioners of the credentialing decision was 60 days. The on-site review of credentialing and recredentialing records demonstrated that notifications were made within the time frame, often within 30 days. | | |
| **Required Actions:**<br>None. | | |
| 2.J. The medical director's or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program.<br><br>NCQA CR1—Element A10 | CR-Credentialing Process CR.1.12.pdf– Pg 1, 10-11<br>CR-Recredentialing Process RC.1.12.pdf– Pg 1, 10-11 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy described the process for medical director review and sign-off on the list of clean files. On-site, RMHP staff members reported that either the medical director or a designee was the designated chairperson for each of the MPRCs. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law.<br><br>NCQA CR1—Element A11 | CR-Credentialing Process CR.1.12.pdf– Pg 12<br>CR-Recredentialing Process RC.1.12.pdf– Pg 13 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy described processes to ensure the confidentiality of credentialing records. These processes included limited electronic and physical access based on job category and the need for the information. The need for the information was related to completion of the credentialing or recredentialing processes. Limited physical access included maintaining applications in a locked file cabinet. Electronic security included password protections based on job category. | | |
| **Required Actions:**<br>None. | | |
| 2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty.<br><br>NCQA CR1—Element A12 | CR-Practitioner Specialties CR.12.12.pdf – Pg 12<br>CR-Directory Validation process.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Practitioner Specialties Policy stated that the provider directory was created from the FACETS tables using information that was entered during the credentialing process. The Physician Directory Updates Policy stated that provider relations staff members would review the provider panel biannually and enter updates to the FACETS tables, as needed. During the on-site interview, RMHP staff members clarified that two times per year (fall and spring), provider the network staff performed a review to verify the accuracy of the provider directory. Staff members reported that the on-line provider directory was refreshed/updated daily. The staff also stated that the data base tables were sent to the vendor annually to print hard copy directories. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request.<br><br>NCQA CR1—Element B1 | CR-Credentialing Process CR.1.12.pdf– Pg 7<br>CR-Recredentialing Process RC.1.12.pdf– Pg 7 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy described the process for providing information to applicants upon request. RMHP informed applicants of this right via the provider application. | | |
| **Required Actions:**<br>None. | | |
| 2.N. The right of practitioners to correct erroneous information.<br><br>NCQA CR1—Element B2 | CR-Credentialing Process CR.1.12.pdf– Pg 7<br>CR-Recredentialing Process RC.1.12.pdf– Pg 7 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy addressed the applicant's right to correct erroneous information. RMHP informed applicants of this right via the provider application. | | |
| **Required Actions:**<br>None. | | |
| 2.O. The right of practitioners, upon request, to receive the status of their application.<br><br>NCQA CR1—Element B3 | CR-Credentialing Process CR.1.12.pdf– Pg 7<br>CR-Recredentialing Process RC.1.12.pdf– Pg 7 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy stated that applicants could request and receive the status of their credentialing or recredentialing application. RMHP informed applicants of this right via the provider application. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.P. The right of applicants to receive notification of their rights under the credentialing program.<br><br>NCQA CR1—Element B4 | CR-Credentialing Process CR.1.12.pdf– Pg 7<br>CR-Recredentialing Process RC.1.12.pdf– Pg 7<br>CR-App Attestation Notification of Rights.pdf<br>CR-Website screenshot practitioner rights.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Credentialing Criteria and Process Policy and the Recredentialing Process Policy stated that applicants were to be notified of their rights under the credentialing program via the application process. The Colorado credentials application informed applicants of their rights under the credentialing program. | | |
| **Required Actions:**<br>None. | | |
| 2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including:<br>◆ Collecting and reviewing Medicare and Medicaid sanctions.<br>◆ Collecting and reviewing sanctions or limitations on licensure.<br>◆ Collecting and reviewing complaints.<br>◆ Collecting and reviewing information from identified adverse events.<br>◆ Implementing appropriate interventions when it identified instances of poor quality related to the above.<br><br>NCQA CR9—Element A | CR-On-going Monitoring CR.7.12.pdf<br>CR-OIG-CBME-CAQH Mid-cycle monitoring sample reports.pdf<br>CR-QA process workflow diagram.pdf<br>CR-MPRC Meeting Minutes.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Ongoing Monitoring Policy described the process for using the federal and State licensing databases monthly to ensure that RHMP providers were eligible for federal health care participation. RMHP provided sample documentation that demonstrated how RMHP's data system compared the RMHP provider list to the queries for sanctions. Any providers on the list were terminated per RMHP policy. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Required Actions:**<br>None. | | |
| 2.R. The range of actions available to the Contractor against the practitioner (for quality reasons).<br><br>NCQA CR10—Element A1 | CR-Reduction, Suspension, Termination RC.4.12.pdf – Pg 2 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Reduction, Suspension, or Termination Policy provided the range of actions available to RMHP for quality reasons. Possible actions included monitoring, increased oversight, suspension of privileges, limitation or restriction of practice, or termination. | | |
| **Required Actions:**<br>None. | | |
| 2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]).<br><br>NCQA CR10—Element A2 and B | CR-Reduction, Suspension, Termination RC.4.12.pdf– Pg 6 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Reduction, Suspension, or Termination Policy addressed reporting to NPDB, the Healthcare Integrity and Protection Data Bank (HIPDB), and State licensing agencies. The policy stated that final board of director approval was required prior to reporting. RMHP staff members reported that there had been no actions that required reporting during the review period. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service which includes:<br>◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process.<br>◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request.<br>◆ Allowing at least 30 days after the notification for the practitioner to request a hearing.<br>◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice.<br>◆ Appointing a hearing officer or panel of the individuals to review the appeal.<br>◆ Providing written notification of the appeal decision that contains the specific reasons for the decision.<br><br>NCQA CR10—Element A3and C | CR-Reduction, Suspension, Termination RC.4.12.pdf– Pg 2-3<br>CR-Initial Denial Letter example.pdf<br><br>RMHP did not suspend or terminate any practitioners for quality reasons within the look-back period. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Reduction, Suspension, or Termination Policy described the appeal process, which included all the required elements. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 2.U. Making the appeal process known to practitioners.<br><br>NCQA CR10—Element A4 | CR-Reduction, Suspension, Termination RC.4.12.pdf– Pg 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Reduction, Suspension, or Termination policy stated that the appeal process is outlined in the letter informing the provider of the action taken. | | |
| **Required Actions:**<br>None. | | |
| 3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners.<br><br>NCQA CR2—Element A | CR-Credentialing Committee CR.13.12. pdf<br>CR-MPRC Member List and Attendance.2012.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The on-site review of MPRC meeting minutes demonstrated the use of the peer review process to make credentialing and recredentialing decisions. Physicians participating in the MPRCs represented physicians from a variety of specialties. RMHP used five regional MPRCs to ensure representation within the large geographic area that RMHP serves. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 4. The Contractor provides evidence of the following:<br>◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds.<br>◆ Medical director or equally qualified individual review and approval of clean files.<br><br>NCQA CR2—Element B | CR-Credentialing Process CR.1.12.pdf – Pg 10-11<br>CR-Recredentialing Process RC.1.12.pdf – Pg 10-11<br>CR-MPRC Meeting Minutes.pdf<br>CR-Medical Director Review of Clean files.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The on-site review of MPRC meeting minutes demonstrated the committee reviewed providers who did not initially meet established criteria. The on-site review of 10 credentialing and 10 recredentialing records demonstrated the medical director (or designee) reviewed and approved a list of providers with clean files meeting RMHP's credentialing criteria. | | |
| **Required Actions:**<br>None. | | |
| 5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes:<br>◆ A current, valid license to practice (verification time limit = 180 calendar days).<br>◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision).<br>◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ | CR-Credentialing Process CR.1.12.pdf– Pg 8-9<br>CR-Recredentialing Process RC.1.12.pdf– Pg 8-9<br>CR-State Licensing Agency Verification Letters.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| professional school, residency, or board certification [board certification time limit = 180 calendar days]).<br>◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years).<br>◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days).<br><br>NCQA CR3—Elements A and B | | |
| **Findings:**<br>RMHP's policies stated that all credentials would be verified within 180 days prior to the medical director or MPRC approval date. The on-site review of credentialing and recredentialing records demonstrated that all primary source verification and the credentialing and recredentialing for individual practitioners were completed within the NCQA-required time frames. | | |
| **Required Actions:**<br>None. | | |
| 6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following:<br>◆ Reasons for inability to perform the essential functions of the position, with or without accommodation.<br>◆ Lack of present illegal drug use.<br>◆ History of loss of license and felony convictions.<br>◆ History of loss or limitation of privileges or disciplinary actions. | CR-Credentialing Process CR.1.12.pdf– Pg 7 (reference to State App)<br>CR-Recredentialing Process RC.1.12.pdf– Pg 8 (reference to State App)<br>CR-State Credentialing Application.pdf<br>Pg 26<br>Pg 25<br>Pg 19-20<br>Pg 19<br>Pg 17<br>Pg 21<br>RMHP utilizes the Department of Public Health & Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentialing Application or the Council for Affordable Quality Healthcare's (CAQH) Universal Provider Datasource for credentialing and recredentialing applications. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil).<br>◆ The correctness and completeness of the application.<br><br>NCQA CR4—Element A<br>NCQA CR7—Element C<br>C.R.S.—13-64-301-302 | | |
| **Findings:**<br>RMHP's policies stated that RMHP required all practitioners to complete the Colorado Health Care Professional Credentials application. The application included each of the required attestations. The on-site review of 10 credentialing and 10 recredentialing files provided evidence that each file contained a completed and signed application and attestation from the provider. | | |
| **Required Actions:**<br>None. | | |
| 7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing:<br>◆ State sanctions, restrictions on licensure, or limitations on scope of practice.<br>◆ Medicare and Medicaid sanctions.<br><br>*42CFR438.610(b)(3)*<br><br>NCQA CR5—Element A<br>NCQA CR7—Element D | CR-Credentialing Process CR.1.12.pdf– Pg 7, 9<br>CR-Recredentialing Process RC.1.12.pdf– Pg 10<br>CR-NPDB CR.5.12.pdf<br>CR-OIG Check pre-cred.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP's policies stated that an appropriate database search was to be completed prior to initiating the credentialing process, ensuring eligibility to participate in federal health care programs. The on-site review of credentialing and recredentialing records demonstrated that RMHP used the NPDB to verify sanction or exclusion activity. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for:<br>◆ Physical accessibility.<br>◆ Physical appearance.<br>◆ Adequacy of waiting and examining room space.<br>◆ Adequacy of treatment record-keeping.<br><br>NCQA CR6—Element A | CR-Office Site Visit Standards CR.10.12.pdf<br>CR-Office Site Visit Evaluation Form.pdf<br><br>Note – Credentialing maintains the P&P and partners with PR if a Site visit needs to be conducted. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Office Site Quality Policy stated that RMHP's criterion for complaints that triggered a site visit (for individual practitioners) was three complaints within a 12-month period related to office site quality. The policy also stated that site visits could be performed after one complaint or when RMHP was on-site for a medical record audit. On-site, the RMHP staff reported that there had been no site visits based on office site quality. | | |
| **Required Actions:**<br>None. | | |
| 9. The Contractor implements appropriate interventions by:<br>◆ Conducting site visits of offices about which it has received member complaints.<br>◆ Instituting actions to improve offices that do not meet thresholds.<br>◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds.<br>◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining a complaint threshold was met. | CR-Office Site Monitoring CR.4.12.pdf<br>CR-Office Site Visit Evaluation Form.pdf<br><br>Note – The threshold for triggering a site visit was not met during the review period. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard VIII—Credentialing and Recredentialing | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| ◆ Documenting follow-up visits for offices that had subsequent deficiencies.<br><br>NCQA CR6—Element B | | |
| **Findings:**<br>RMHP's policy stated that if an office site did not meet RMHP's standards, RMHP would request in writing that the site correct the issue. A revisit would be performed in six months and subsequent site visits would continue until the deficiencies were corrected. The policy included all of the required elements. | | |
| **Required Actions:**<br>None. | | |
| 10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes:<br>◆ A current, valid license to practice (verification time limit = 180 calendar days).<br>◆ A valid DEA or CDS certificate (effective at the time of recredentialing).<br>◆ Board certification (verification time limit = 180 calendar days).<br>◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days).<br><br>NCQA CR7—Elements A and B<br>NCQA CR8—Element A | CR-Recredetialing Process RC.1.12.pdf Pg 2, 9-10 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Recredentialing Process Policy described recredentialing independent practitioners at least every 36 months using primary-source verification and all required processes. The on-site review of 10 practitioner recredentialing records demonstrated that RMHP recredentialed its practitioners within the required 36-month time frame. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Required Actions:**<br>None. | | |
| 11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include:<br><br>11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies.<br><br>NCQA CR11—Element A1 | CR-Organizational Providers Credentialing HDO.1.12.pdf<br>11 – entire document<br>11A – Pg 2 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Health Delivery Organizations Policy described NCQA-compliant procedures for assessing organizational providers. The on-site review of five organizational provider records demonstrated that RMHP had documentation of organizational provider assessments. | | |
| **Required Actions:**<br>None. | | |
| 11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body.<br><br>NCQA CR11—Element A2 | CR-Organizational Providers Credentialing HDO.1.12.pdf – Pg 3 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Health Delivery Organizations Policy described verification of whether the organizational provider had been reviewed and approved by an accrediting body. The on-site record review demonstrated that RMHP verified accreditation status for accredited organizations. The on-site review of organizational provider files included one organization accredited by The Joint Commission. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status.<br><br>NCQA CR11—Element A3 | CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3-4<br>CR-Mechanism for Evaluation of Co State Ops Manual.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Health Delivery Organizations Policy stated that RMHP would not contract with organizations that either were accredited by an acceptable accrediting body or certified by CMS. The on-site review of five organizational provider files demonstrated that the organizations reviewed were either accredited or were surveyed by the Colorado Department of Public Health and Environment (CDPHE), which uses the CMS survey form and provides CMS certification for organizations that successfully complete the CDPHE survey. | | |
| **Required Actions:**<br>None. | | |
| 11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status.<br><br>NCQA CR11—Element A | CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 4 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP's policy addressed reassessment of organizational providers every three years. The on-site review of organizational providers demonstrated that RMHP had successfully reassessed organizational providers within the 36-month time frame. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.)<br><br>NCQA CR11—Element A | CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Health Delivery Organizations Policy listed acceptable accrediting bodies that included The Joint Commission, the Accreditation Association of Ambulatory Health Care, the Commission on Accreditation of Rehabilitation Facilities, the Community Health Accreditation Program, and the Healthcare Facilities Accreditation Program. On-site review of organizational provider files reviewed included one organization accredited by The Joint Commission. | | |
| **Required Actions:**<br>None. | | |
| 12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.<br><br>NCQA CR11—Element A | CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3-4<br>CR-Mechanism for Evaluation of Co State Ops Manual.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP's policy listed the selection criteria for participation in the RMHP provider network and stated that RMHP adopted the quality standards set forth in Colorado's State Operations Manual for State surveys. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.<br><br>NCQA CR11—Element A | CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3-4<br>CR-Mechanism for Evaluation of Co State Ops Manual.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The policy stated that RMHP requires organization providers to attest to having a process for credentialing its practitioners. During the on-site interview, RMHP staff members reported that the RMHP staff had reviewed CDPHE's State Operations Manual for site visits and verified that CDPHE surveyed organizations for credentialing practices. In addition, RMHP recently put in place a process to have organizations' executive directors attest to having credentialing processes in place. The attestations were found in organizational provider files that were assessed after this process was implemented. | | |
| **Required Actions:**<br>None. | | |
| 14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard.<br><br>NCQA CR11—Element A | CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3-4<br>CR-Mechanism for Evaluation of Co State Ops Manual.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Mechanism for Evaluation document stated that the RMHP credentialing team maintained pertinent sections of the State Operations Manual and reviewed it annually to note any modifications and reports to the chief medical officer and ensure ongoing acceptance and adoption of the standards. The | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| on-site review of organizational provider records demonstrated that files included the CDPHE site survey report or evidence of having passed the CDPHE survey printed from the CDPHE Web site. On-site, the RMHP staff provided documentation that it had last reviewed the State Operations Manual on October 22, 2012. | | |
| **Required Actions:**<br>None. | | |
| 15. The Contractor's organizational provider assessment policies and process include assessment of at least the following medical providers:<br>◆ Hospitals.<br>◆ Home health agencies.<br>◆ Skilled nursing facilities.<br>◆ Free-standing surgical centers.<br><br>NCQA CR11—Element B | CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 1 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP's policy included criteria and processes for hospitals, skilled nursing facilities, surgical facilities, and home health agencies. The on-site review of organizational provider files included skilled nursing facilities and home health agencies. | | |
| **Required Actions:**<br>None. | | |
| 16. The Contractor has documentation that it has assessed contracted medical health care (organizational) providers.<br><br>NCQA CR11—Element D | CR-Medicaid Organizational Providers Credentialing Report.pdf<br>CR-Sample Accred Facility Cred File.pdf<br>CR-Sample Non-Accred Facility Cred File.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The on-site review of organization-specific files demonstrated that RMHP documented assessment and reassessment activities for organizational providers with which it contracts. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities.<br><br>NCQA CR12 | CR-Delegated Cred Oversight DEL.2.10.pdf<br>CR-Delegate Oversight Tool-Montrose 2012.pdf<br>CR-Delegate Oversight Tool-Physiotherapy 2012.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>On-site, the RMHP staff reported that two delegates—Montrose Physician Health Organization and Physiotherapy Associates—provided services to Medicaid members. RMHP submitted reports received from both delegates and completed annual audit reports for both. | | |
| **Required Actions:**<br>None. | | |
| 18. The Contractor has a written delegation document with the delegate that:<br>◆ Is mutually agreed upon.<br>◆ Describes the responsibilities of the Contractor and the delegated entity.<br>◆ Describes the delegated activities.<br>◆ Requires at least semiannual reporting by the delegated entity to the Contractor.<br>◆ Describes the process by which the Contractor evaluates the delegated entity's performance.<br>◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations.<br><br>NCQA CR12—Element A | CR-Delegated Cred-Recred Process DEL.1.12.pdf Pg 1-2<br>CR-Delegated Cred Agreement Termination DEL.3.10.pdf<br>CR-Delegated Cred Agreement – Montrose Community Health Plan<br>CR-Delegated Cred Agreement – Physiotherapy Corporation<br><br>Note – All Delegated credentialing agreements were updated to a new template/format in 2012. Delegation to Montrose Community Health Plan initiated May 23, 1997 and Physiotherapy was initiated in April 15, 2003. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP provided copies of each delegation agreement signed by both parties and which included each of the required provisions. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes:<br>◆ A list of allowed use of PHI.<br>◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure.<br>◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards.<br>◆ A stipulation that the delegate will provide members with access to their PHI.<br>◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur.<br>◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends.<br><br>NCQA CR12—Element B | As part of our delegated credentialing agreements, member specific PHI is not shared. | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable |
| **Findings:**<br>Not Applicable. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 20. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement.<br><br>NCQA CR12—Element C | CR-Delegated Cred-Recred Process DEL.1.12.pdf Pg 1 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>Both delegation agreements included the provision that RMHP retains the right to approve, suspend, or terminate practitioners, providers, and sites. During the on-site interview, the RMHP staff reported that when RMHP discovers sanctions based on ongoing monitoring, it acts immediately (with sanction or termination) as appropriate and informs the delegate. | | |
| **Required Actions:**<br>None. | | |
| 21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed.<br><br>NCQA CR12—Element D | CR-Delegated Cred-Recred Process DEL.1.12.pdf Pg 3<br>CR-Delegated Cred Oversight DEL.2.10.pdf Pg 1<br><br>RMHP does not have any delegated agreement in effect for less than 12 months in the Medicaid service area. | ☐ Met<br>☐ Partially Met<br>☐ Not Met<br>☒ Not Applicable |
| **Findings:**<br>Not Applicable. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 22. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect.<br><br>NCQA CR12—Element E | CR-Delegate Annual Oversight Tracking Tool 2012.pdf<br>CR-Delegate Oversight File Review-Montrose 2012.pdf<br>CR-Delegate Oversight File Review-Physiotherapy 2012.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>For the review period, RMHP submitted audit reports that demonstrated a review of both delegates' credentialing files. | | |
| **Required Actions:**<br>None. | | |
| 23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations.<br><br>NCQA CR12—Element F | CR-Delegate Oversight Tool-Montrose 2012.pdf<br>CR-Delegate Oversight Tool-Physiotherapy 2012.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP submitted documentation of having reviewed both delegates' policies and records against NCQA standards during the review period. | | |
| **Required Actions:**<br>None. | | |
| 24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually).<br><br>NCQA CR12—Element G | CR-Delegate Report Tracking Tool Medicaid 2012.pdf<br>CR-Delegate Semi-Annual Report-Montrose 2012.pdf<br>CR-Delegate Semi-Annual Report-Physiotherapy 2012.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP submitted semiannual reports received from both delegates and a tracking spreadsheet that indicated due dates for future semiannual reports. | | |
| **Required Actions:**<br>None. | | |

| Standard VIII—Credentialing and Recredentialing | | |
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| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 25. The Contractor identifies and follows up on opportunities for improvement, if applicable.<br><br>NCQA CR12—Element H | CR-Delegate Annual Oversight Summary Letter-Montrose 2012.pdf<br>CR-Delegate Annual Oversight Summary Letter-Physiotherapy 2012.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP provided communication with Montrose Physician Health Organization that demonstrated use of the corrective action process with that delegate. | | |
| **Required Actions:**<br>None. | | |

| Results for Standard VIII—Credentialing and Recredentialing | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | **Met** | = | 47 | X | 1.00 | = | 47 |
| | **Partially Met** | = | 0 | X | .00 | = | 0 |
| | **Not Met** | = | 0 | X | .00 | = | 0 |
| | **Not Applicable** | = | 2 | X | NA | = | NA |
| **Total Applicable** | | = | 47 | **Total Score** | | = | 47 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 100% |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members.<br>*42CFR438.240*(a)<br>DH Contract: II.I.1<br>RMHP Contract: II.J.1 | Standard X Quality Assessment and Performance Improvement\QI X.1 Corporate QI Program Description 2012_2013.pdf<br><br>Standard X Quality Assessment and Performance Improvement\QI X.1 Corporate QI WorkPlan and Eval 2012_ 021213.xls | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The QI program description (corporate-wide) stated that the QI program conducted systematic monitoring and evaluation of clinical and service-related activities, and acted on opportunities for improvement. Program activities focused on care quality, patient safety, and physician access and availability. The program description stated that the RMHP Board of Directors was accountable for the QI program and had designated the responsibility for oversight of quality programs to the chief medical officer and the chief operating officer. The Quality Improvement Committee (QIC) provides program oversight. The Medical Advisory Council (MAC) and MEAC are subcommittees of the QIC, with responsibility for clinical initiatives and member experience initiatives, respectively. The program description also defined numerous other subcommittees with specific QI functions. The corporate QI work plan described all planned QI activities for the year and included a general description of each activity. The work plan did not delineate activities applicable to specific lines of business (i.e., Medicaid). HSAG recommended that the annual work plan designate which QI activities were applicable to the Medicaid population and specify goals or benchmarks for performance, as appropriate. | | |
| **Required Actions:**<br>None. | | |
| 2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services.<br>*42CFR438.240(b)(3)*<br>DH Contract: II.I.2.e<br>RMHP Contract: II.J.2.e | Standard III Coordination and Continuity of Care\Continuity.Coordination and Transition of Medical Care 2012.doc | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The staff provided samples of utilization data trending reports for monitoring over- and under-utilization. During the on-site interview, the staff described several mechanisms for monitoring over- and under-utilization, including prior authorization and concurrent review activities and monthly monitoring reports of patient days per 1,000 members, readmissions within 30 days, and emergency department visit trends for Medicaid members. Staff members stated that the Healthcare Effectiveness Data and Information Set (HEDIS) performance measures were reviewed monthly to monitor potential under-utilization, and that HEDIS measures were used to generate gaps in care reports. Staff members stated, and a review of QIC meeting minutes verified, that the analysis of utilization trends was reported to the QIC. | | |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Required Actions:**<br>None | | |
| 3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care for persons with special health care needs.<br>*42CFR438.240(b)(4)*<br>DH Contract: II.I.2.d.4<br>RMHP Contract: II.J.2.d.4 | Standard X Quality Assessment and Performance Improvement\QI X.3 Guidelines for Identification and COC - Pediatric.pdf<br><br>Standard X Quality Assessment and Performance Improvement\QI X.3 Guidelines for Identification and COC -Adult.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The corporate QI program description outlined multiple QI monitoring activities that were applicable to all RMHP members. The program description stated that HEDIS measures and the Consumer Satisfaction with Healthcare Providers and Systems (CAHPS) survey were used to gather information about the quality of clinical care and services, including care of persons with special health care needs. During the on-site interview, staff members described several QI activities that were related to members with special health care needs, including a performance improvement project (PIP) related to the integration of behavioral and physical health needs and information-sharing of member assessments and special health care needs with appropriate providers, coordination of waiver benefits with the Department of Human Services, and the screening of members to identify those with special health care needs for referral to the case management program. | | |
| **Required Actions:**<br>None. | | |
| 4. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual report describes:<br>◆ Techniques used by the Contractor to improve performance.<br>◆ The outcome of each performance improvement project.<br>◆ The overall impact and effectiveness of the QAPI program.<br>*42CFR438.240(e)(2)*<br>DH Contract: II.I.2.h<br>RMHP Contract: II.J.h | Standard X Quality Assessment and Performance Improvement\QI X.4 1.QI Program Annual Report 021213.pdf<br><br>Standard X Quality Assessment and Performance Improvement\QI X.4 1.bQI Annual Evaluation Memo QIC.pdf<br><br>Standard X Quality Assessment and Performance Improvement\QI X.4 1.QI Program Annual Report 021213.pdf<br><br>Standard X Quality Assessment and Performance Improvement\QI X.4 8.a2Womens preventive Services.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Findings:**<br>The QI Program Annual Report included a comprehensive assessment of QI work plan objectives applicable to all lines of business, such as a summary analysis of CAHPS data, physician satisfaction data, preventive and disease management HEDIS measures, quality of care concerns, Medicaid PIPs, and clinical practice guidelines adopted. The report included a general description of techniques used to improve performance and highlighted areas of improvement, as well as opportunities for continued improvement. HEDIS measures were documented with benchmark goals and performance by line of business, and an analysis included identified barriers to effective interventions. HSAG recommended that the annual report consistently document recommendations or conclusions related to the results of each QI activity, and clearly delineate the activities applicable to the Medicaid population. The annual report did not include conclusions related to the overall impact of the QI program. During the on-site interview, staff members stated that RMHP was working on a revised version of the annual report that would include a summary of the overall impact of the QI program. | | |
| **Required Actions:**<br>RMHP must include an assessment of the overall impact and effectiveness of the QI program (applicable to Medicaid members) in the annual QI Report. | | |
| 5. The Contractor shall adopt practice guidelines for the following:<br>◆ Perinatal, prenatal, and postpartum care for women.<br>◆ Conditions related to persons with a disability or special health care needs.<br>◆ Well child care.<br><br>DH Contract: II.I.2.a.1<br>RMHP Contract: II.J.2.a.1 | Standard X Quality Assessment and Performance Improvement\QI X.5 AAP Bright Futures Well Child Guideline.pdf<br><br>Standard X Quality Assessment and Performance Improvement\QI X.5 Guidelines for Identification and COC - Pediatric.pdf<br><br>Standard X Quality Assessment and Performance Improvement\QI X.5 Guidelines for Identification and COC -Adult.pdf<br><br>Standard X Quality Assessment and Performance Improvement\QI X.5 Prenatal Guideline_ OB.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>RMHP provided evidence of prenatal and postpartum care clinical practice guidelines and preventive pediatric care guidelines. The clinical guideline tracking chart included approval of clinical guidelines for asthma, adult diabetes, and adult depression. During on-site interviews, the staff provided evidence that the case management program used nationally recognized clinical guidelines for persons with special health care needs. HSAG recommended that RMHP formally adopt these guidelines for special health care needs members as defined in the Clinical Practice Guidelines Policy. | | |
| **Required Actions:**<br>None. | | |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 6. The Contractor ensures that practice guidelines comply with the following requirements:<br>◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.<br>◆ Consider the needs of the Contractor's members.<br>◆ Are adopted in consultation with contracting health care professionals.<br>◆ Are reviewed and updated annually.<br><br>*42CFR438.236(b)*<br>DH Contract: II.I.2.a.2<br>RMHP Contract: II.J.2.a.2 | Standard X Quality Assessment and Performance Improvement\QI X.7 Clinical Guidelines.pdf<br><br>Standard X Quality Assessment and Performance Improvement\CM X.8 Clinical Policy Development Workflow.vsd<br><br>Standard X Quality Assessment and Performance Improvement\CM X.8. Clinical Policy Development.doc<br><br>Standard X Quality Assessment and Performance Improvement\CM X.8. CM Criteria for UM Decisions.doc<br><br>Standard X Quality Assessment and Performance Improvement\CM X.8.2 Clinical Policy Development.doc | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Clinical Practice Guidelines Policy stated that practice guidelines must be from a recognized organization that develops evidence-based practice guidelines or must have been developed with input from board-certified physicians. The policy stated that all guidelines must be relevant to the RMHP population, and are to be reviewed and approved by the medical directors, MPRC, and the MAC. The policy stated that clinical practice guidelines must be reviewed at least every other year. RMHP submitted examples of practice guidelines that were endorsed by nationally recognized professional organizations. The QI program description stated that RMHP adopted clinical practice guidelines for preventive care as well as diagnosis-specific clinical guidelines, and described the process for guideline adoption as outlined in the requirement, with the exception of the requirement for annual review and approval of guidelines. During the on-site interview, staff members described the process of development and update of clinical practice guidelines within the RMHP committee structure. Staff members stated that a previous version of the Clinical Guidelines Policy required that updates occur every year. | | |
| **Required Actions:**<br>RMHP must modify its policies and procedures to ensure that clinical practice guidelines applicable to Medicaid members are reviewed and approved annually. | | |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| 7. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members, at no cost.<br><br>*42CFR438.236(c)*<br>DH Contract: II.I.2.a.3<br>RMHP Contract: II.J.2.a.3 | Standard X Quality Assessment and Performance Improvement\QI X.7 Clinical Guidelines.pdf<br><br>Medicaid Provider Manual\2012 Provider Manual Bookmarked 011113.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Clinical Practice Guidelines Policy stated that clinical practice guidelines would be disseminated to providers and members at no cost. The policy stated that guidelines were disseminated to providers through the RMHP provider Web site and that provider newsletters would notify providers of the availability of clinical practice guidelines and how to access them. The provider tab of the RMHP Web site included the clinical practice guidelines. The RMHP provider manual informed providers that Disease Management Program clinical guidelines were available and how to access them.<br><br>The member handbook did not inform members of the availability of practice guidelines. The member section of the RMHP Web site also did not include access to clinical practice guidelines. During the on-site interview, staff members stated that RMHP incorporated information from clinical practice guidelines into disease management education materials for members, and it distributed mailings to members regarding chronic conditions. HSAG recommended that RMHP inform members of the availability of clinical practice guidelines at no cost and how to access them. | | |
| **Required Actions:**<br>None. | | |
| 8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.<br><br>*42CFR438.236(d)*<br>DH Contract: II.I.2.a.4<br>RMHP Contract: II.J.2.a.4 | The Care Management Department uses Milliman evidence based guidelines, 16th edition or RMHP internally developed Clinical Policies.<br><br>Standard X Quality Assessment and Performance Improvement\CM X.8 Clinical Policy Development Workflow.vsd<br><br>Standard X Quality Assessment and Performance Improvement\CM X.8. Clinical Policy Development.doc<br><br>Standard X Quality Assessment and Performance Improvement\CM X.8. CM Criteria for UM Decisions.doc<br><br>Standard X Quality Assessment and Performance Improvement\CM X.8.2 Clinical Policy Development.doc | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | RMHP can address this further with HSAG reviewers at the on-site interviews. | |

**Findings:**
The Clinical Policy Development Policy described the involvement of the New Technology Assessment and Guidelines (NTAG) Physician Advisory Committee in developing expanded or modified coverage guidelines. Staff members stated that RMHP used Milliman criteria or internally developed clinical polices to make utilization review and benefit determinations. During the on-site interview, staff members described the processes for review and integration of clinical practice guidelines into other operational processes. These were as follows:

- RMHP takes into consideration best practices and new guidelines that are recommended by HealthTeamWorks and are based on community or population-based needs.
- Clinical practice guidelines are reviewed by the RMHP medical director, medical policy managers, and the MPRCs (peer review committees) within the five RMHP regions.
- Clinical practice guidelines are reviewed by the MAC.
- Annual review and approval of the Milliman guidelines coincides with the update of clinical practice guidelines.
- The NTAG committee submits recommendations for the integration of new technology to the MAC annually.
- The Disease Management Program routinely uses clinical practice guidelines as a resource for developing member education materials.
- The clinical practice guidelines guide the consultation with physicians in RMHP's practice transformation program.

**Required Actions:**
None.

| | | |
|---|---|---|
| 9. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data.<br>*42CFR438.242(a)*<br>DH Contract: II.I.2.k.1<br>RMHP Contract: II.J.2.k.1 | Standard X Quality Assessment and Performance Improvement\QI X.9 Data Integration Flowchart.ppt<br>Standard X Quality Assessment and Performance Improvement\Claims 1500 Ben Billing Medicaid Form Online.pdf<br>Standard X Quality Assessment and Performance Improvement\Claims Pharmacy Claim Form.pdf<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 425 Processing.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 Adding Claims to Facets.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | Adding Claims to Facets.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 MDE Reconciliation.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 MDE Reconciliation.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 MDE Resubmit Process.doc<br>Standard X Quality Assessment and Performance Improvement\IA X 8&9 Facets Claims Flow.doc<br>Standard X Quality Assessment and Performance Improvement\IT 8&9 CSV File.doc | |
| **Findings:**<br>The HEDIS data integration flow chart documented the collection of information from multiple claims data sources—as well as treatment data, laboratory data, and immunization data sources—that was maintained in a data warehouse and integrated into the HEDIS reporting database. During the on-site interview, the staff provided an overview of the hardware and software components of the health information system (HIS), which demonstrated collection and integration of data from multiple databases such as claims, member enrollment, customer services, case management, prior authorization, and treatment records. The staff provided several examples of HIS reports that included analysis and integration of data from multiple databases. | | |
| **Required Actions:**<br>None. | | |
| 10. The Contractor collects data on member and provider characteristics and on services furnished to members.<br>*42CFR438.242(b)(1)*<br>DH Contract: II.I.2.k.2<br>RMHP Contract: II.J.2.k.2 | Standard X Quality Assessment and Performance Improvement\Claims 1500 Ben Billing Medicaid Form Online.pdf<br>Standard X Quality Assessment and Performance Improvement\Claims Pharmacy Claim Form.pdf<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 425 Processing.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 Adding Claims to Facets.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 Adding Claims to Facets.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 MDE Reconciliation.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| | MDE Reconciliation.doc<br>Standard X Quality Assessment and Performance Improvement\IA 8&9 MDE Resubmit Process.doc<br>Standard X Quality Assessment and Performance Improvement\IA X 8&9 Facets Claims Flow.doc<br>Standard X Quality Assessment and Performance Improvement\IT 8&9 CSV File.doc | |
| **Findings:**<br>The HEDIS data integration flow chart and the sample claims forms demonstrated that RMHP collects information on services to members through provider claims databases, as well as treatment, pharmacy, laboratory, and immunization databases. The Network Adequacy Report provided evidence of information collected on provider characteristics. The staff provided several reports that demonstrated information collected on services rendered to members. RMHP provided sample reports and case management files that demonstrated the collection of information on member characteristics. During the on-site interview, the RMHP staff stated that member characteristics are collected through enrollment files, with updates based on customer service and case management contacts with members. Staff members also stated that provider characteristics are collected through credentialing and recredentialing applications and are updated through provider interactions with the staff. Provider characteristics are used in the on-line provider directory. Information on services furnished to members is obtained primarily through claims, HEDIS medical record reviews, and case management documentation. | | |
| **Required Actions:**<br>None. | | |
| 11. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include:<br>◆ Member surveys (Consumer Assessment of Healthcare Providers and Systems [CAHPS]).<br>◆ Anecdotal information.<br>◆ Grievance and appeals data.<br>◆ Enrollment and disenrollment information.<br><br>DH Contract: II.H.2.d.1 & 2<br>RMHP Contract: II.J.2.d.1 & 2 | Standard X Quality Assessment and Performance Improvement\QI X.4 1.QI Program Annual Report 021213.pdf<br><br>Standard X Quality Assessment and Performance Improvement\2Q 2013_Medicaid_Grievances_Detail of Other Category.xls<br><br>Standard X Quality Assessment and Performance Improvement\SFY 2012-2013 RMHP Enrollment Disenrollment Report Year by Quarter.xls | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Findings:**<br>The QI program description stated that RMHP administers a number of member satisfaction surveys, including the annual CAHPS survey, annual disease management and complex case management member surveys, and a patient satisfaction with physician survey. The program description stated that the MEAC reviewed survey results and correlated the results with complaints data to identify opportunities for improvement. The annual grievance report trended quarterly member grievances by type (e.g., access and availability, clinical care, and customer service) and the results of grievance investigations. The RMHP Enrollments and Disenrollment Quarterly Report indicated that the majority of Medicaid disenrollments were due to loss of eligibility. The MEAC meeting minutes included a review and discussion of CAHPS results and grievance and appeals trends. The QI Program Annual Report provided a summary analysis of the 2012 CAHPS results and stated that a MEAC review of CAHPS results was pending. HSAG recommended that the analysis of member grievances also be included in the QI annual report.<br><br>During the on-site interview, the staff provided an example Member Experience Dashboard Report that was recently implemented for monthly review by the MEAC. The report included CAHPS data, grievance and appeals data, and enrollment efficiency data, and was specific to Medicaid members. | | |
| **Required Actions:**<br>None. | | |
| 12. The Contractor develops a corrective action plan when members report statistically significant of levels dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported.<br><br>DH Contract: II.H.2.d.3<br>RMHP Contract: II.J.2.d.3 | Standard X Quality Assessment and Performance Improvement\QI X.4 1.QI Program Annual Report 021213.pdf<br><br>Standard X Quality Assessment and Performance Improvement\RMHP Combined CHP+ Report QTR 4 SFY 2011_ 2012.doc | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Grievance Policy and Procedure stated that all grievances were to be documented with regard to the substance, investigation, research, any actions taken, and resolution, and would be tracked in the grievance database. The policy stated that RMHP reviews Medicaid grievance trends at least annually to identify and correct any issues, and it stated that any individual complaints of potential quality of care concerns (QOCCs) were reviewed by the QI department and the medical director for potential peer review and corrective action. The QI program description stated that potential QOCCs identified through adverse event criteria were also individually reviewed and tracked. The program description stated that any clinical quality issue identified through satisfaction surveys was forwarded to the chief medical officer and any service quality issue was forwarded to the chief operating officer.<br><br>During the on-site interview, the staff provided evidence of a QI project initiated by the MEAC to improve the process for resolving member grievances. Staff members stated that targeted provider education was initiated if any trend in grievances was related to a particular provider. Staff members stated and provided evidence that there were no Medicaid QOCCs during the review period that required corrective action. They also confirmed that voluntary disenrollments from the plan were too small to require corrective action. | | |

| Standard X—Quality Assessment and Performance Improvement | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the Health Plan** | **Score** |
| **Required Actions:**<br>None | | |
| 13. The Contractor shall review compliance with the following criteria each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department:<br>◆ Accuracy of all required fields.<br>◆ Completeness of encounter claims submitted.<br>◆ Presence of Medical Record documentation for each encounter claim.<br>*42CFR438.242(b)(2)*<br>DH Contract: II.H.6.c.5.b<br>RMHP Contract: Exhibit I-II.D.5 & 6 | | ☐ Met<br>☒ Partially Met<br>☐ Not Met<br>☐ Not Applicable |
| **Findings:**<br>The Medicaid provider manual outlined the detailed fields and criteria for a clean claim and informed providers that RMHP applied automated clinical edits to each claim to verify coding accuracy. The manual informed providers of the methods for electronically or manually submitting claims and of the required standardized claim forms. The FACETS claims flow document outlined the process to verify eligibility, accuracy, and completeness of claims by claims processing personnel prior to payment of providers. The Medicaid Claims Accuracy and Completeness Audit Report verified that an annual review of the processes for verifying accuracy and completeness of encounter and claims data was performed. The Fraud and Abuse Deterrent Policy outlined the process for sampling and verifying the correct coding of evaluation and management claims codes against medical record documentation to prevent fraud and abuse. During the on-site interview, staff members stated that the monitoring of medical record documentation to verify accuracy of information in encounter claims had not been performed during the audit period. | | |
| **Required Actions:**<br>RMHP must perform and document an audit of a statistically valid sample of Medicaid encounter claims that includes verification of claims information against medical record documentation. | | |

| Results for Standard X—Quality Assessment and Performance Improvement | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 10 | X | 1.00 | = | 10 |
| | Partially Met | = | 3 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | 0 |
| **Total Applicable** | | = | 13 | **Total Score** | | = | 10 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 77% |

The completed record review tools follow this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

# *Appendix B.* Colorado Department of Health Care Policy and Financing
## Credentialing Record Review Tool
## *for* Rocky Mountain Health Plans

| | | | |
|---|---|---|---|
| **Reviewer:** | Barbara McConnell | **Review Period:** | January 1, 2012–December 31, 2012 |
| **Participating Plan Staff Member:** | Terri Trimm | **Date of Review:** | March 19, 2013 |

| SAMPLE | 1 | | 2 | | 3 | | 4 | | 5 | | 6 | | 7 | | 8 | | 9 | | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Provider ID#** | 97493 | | 99286 | | 100076 | | 100707 | | 101684 | | 102764 | | 103790 | | 104663 | | 105585 | | 107192 | |
| **Provider Type (MD, PhD, NP, PA, MSW)** | MD | | OD | | MD | | NP | | NP | | MD | | MD | | MD | | PT | | MD | |
| **Application Date** | 6/8/11 | | 1/20/12 | | 8/18/11 | | 12/19/11 | | 1/30/12 | | 4/28/12 | | 4/24/12 | | 10/22/12 | | 10/25/12 | | 11/19/12 | |
| **Specialty** | Pediatrics | | Optometry | | Internal Med | | Nurse Pract | | Nurse Pract | | Cardio Vas | | OB/GYN | | Ortho | | Phy Therapy | | Plastic Surg | |
| **Credentialing Date (Committee/Medical Director Approval Date)** | 7/25/11 | | 2/13/12 | | 3/19/12 | | 1/16/12 | | 2/13/12 | | 7/9/12 | | 6/25/12 | | 12/17/12 | | 12/17/12 | | 12/17/12 | |
| **Item** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| **Initial Credentialing Verification:** The contractor, using primary sources, verifies that the following are present: | | | | | | | | | | | | | | | | | | | | |
| ♦ A current, valid license to practice (with verification that no State sanctions exist) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ A valid DEA or CDS certificate (if applicable) | NA | | X | | X | | NA | | NA | | X | | X | | X | | NA | | X | |
| ♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ Work history | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ Current malpractice insurance in the required amount (with history of professional liability claims) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ Verification that the provider has not been excluded from federal participation | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ Signed application and attestation | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| **Applicable Elements** | **7** | | **8** | | **8** | | **7** | | **7** | | **8** | | **8** | | **8** | | **7** | | **8** | |
| **Point Score** | **7** | | **8** | | **8** | | **7** | | **7** | | **8** | | **8** | | **8** | | **7** | | **8** | |
| **Percentage Score** | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Total Record Review Score** | | | | | **Total Applicable: 76** | | **Total Point Score: 76** | | **Total Percentage: 100%** | |

**Notes:** Providers #1 (MD), #4 (NP), and #5 (NP) did not have a DEA or CDS certificate. Each file included proof of DEA/CDS for covering physicians.

HSAG HEALTH SERVICES ADVISORY GROUP

# *Appendix B.* Colorado Department of Health Care Policy and Financing
## Recredentialing Record Review Tool
## *for* Rocky Mountain Health Plans

| | | | |
|---|---|---|---|
| **Reviewer:** | Barbara McConnell | **Review Period:** | January 1, 2012–December 31, 2012 |
| **Participating Plan Staff Member:** | Terri Trimm | **Date of Review:** | March 19, 2013 |

| SAMPLE | 1 | | 2 | | 3 | | 4 | | 5 | | 6 | | 7 | | 8 | | 9 | | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Provider ID#** | 19411 | | 27017 | | 53378 | | 57723 | | 69264 | | 74429 | | 79634 | | 85761 | | 0446 | | 1164 | |
| **Provider Type (MD, PhD, NP, PA, MSW)** | MD | | PT | | MD | | MD | | PT | | SLP | | MD | | MD | | PT | | MD | |
| **Application/Attestation Date** | 12/19/12 | | 5/10/12 | | 8/3/12 | | 11/28/12 | | 3/21/11 | | 5/22/12 | | 10/21/10 | | 10/14/11 | | 7/15/10 | | 4/21/12 | |
| **Specialty** | Family Med | | Phys Therapy | | Infect Disease | | Oncology | | Phys Therapy | | Speech Thpy | | Internal Med | | Critical Care | | Phys Therapy | | Family Med | |
| **Last Credentialing/Recredentialing Date** | 7/19/10 | | 10/12/09 | | 12/21/09 | | 5/10/10 | | 8/25/08 | | 2/22/10 | | 4/28/08 | | 6/8/09 | | 4/14/08 | | 10/19/09 | |
| **Recredentialing Date (Committee/Medical Director Approval Date)** | 1/21/13 | | 5/29/12 | | 8/27/12 | | 12/17/12 | | 4/4/11 | | 10/11/12 | | 11/15/10 | | 1/16/12 | | 11/8/10 | | 7/2/12 | |
| **Item** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** | **Yes** | **No** |
| **Recredentialing Verification:** The contractor, using primary sources, verifies that the following are present: | | | | | | | | | | | | | | | | | | | | |
| ♦ A current, valid license to practice (with verification that no State sanctions exist) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ A valid DEA or CDS certificate (if applicable) | X | | NA | | X | | X | | NA | | NA | | X | | X | | NA | | X | |
| ♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ Current malpractice insurance in the required amount (with history of professional liability claims) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ Verification that the provider has not been excluded from federal participation | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ Signed application and attestation | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days) | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| ♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date | X | | X | | X | | X | | X | | X | | X | | X | | X | | X | |
| **Applicable Elements** | **8** | | **7** | | **8** | | **8** | | **7** | | **7** | | **8** | | **8** | | **7** | | **8** | |
| **Point Score** | **8** | | **7** | | **8** | | **8** | | **7** | | **7** | | **8** | | **8** | | **7** | | **8** | |
| **Percentage Score** | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | | **100%** | |
| **Total Record Review Score** | | | | | | | | | **Total Applicable: 76** | | | | **Total Point Score: 76** | | | | **Total Percentage: 100%** | | | |
| **Notes:** | | | | | | | | | | | | | | | | | | | | |

# Appendix C. Site Review Participants for Rocky Mountain Health Plans

Table C-1 lists the participants in the FY 2012–2013 site review of **RMHP**.

| Table C-1—HSAG Reviewers and BHO Participants | |
|---|---|
| **HSAG Review Team** | **Title** |
| Barbara McConnell, MBA, OTR | Director, State and Corporate Services |
| Katherine Bartilotta, BSN | Project Manager |
| **RMHP Participants** | **Title** |
| Matt Cook | Provider Network Management Staff |
| MaryLynn Dittmer | Projects and Compliance Coordinator |
| Sandy Dowd | Care Management |
| Nora Foster | Customer Service |
| Kele Geisler | Provider Network Management |
| Carol Ann Hendrikse | Clinical Manager Care Management |
| Jackie Hudson | Quality Improvement Senior Manager |
| Christy Phost | Case Management Manager |
| David Klemm | Manager Government Programs |
| Mike Luedtke | Staff Attorney |
| Nandan Menon | Chief Technology Officer |
| Marci O'Gara | Director, Customer Service |
| Dale Renzi | Director, Provider Network Management |
| Bethany Smith | Provider Relations Manager |
| Jerry Spomer | Director of Internal Audit |
| Lori Stephenson | Quality Improvement Director |
| Terri Trimm | Credentialing Manager |
| Melissa Treto | Member Benefits Administration Staff |
| Patrick Gordon (via Webinar) | Associate Vice President |
| **Department Observers** | **Title** |
| Teresa Craig (Telephonically) | Contract Manager |
| Russ Kennedy | Quality and Compliance Specialist |
| Jeremy Sax (Telephonically) | Physical Managed Care Contract Specialist |

# Appendix D. Corrective Action Plan Process for FY 2012–2013 for Rocky Mountain Health Plans

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 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 external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting to HSAG and the Department. The health plan will submit the CAP using the template provided.<br><br>For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions. |
| **Step 2** | **Prior approval for timelines exceeding 30 days** |
| | If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing. |
| **Step 3** | **Department approval** |
| | Following review of the CAP, the Department or HSAG will notify the health plan via e-mail whether:<br><br>◆ The plan has been approved and the health plan should proceed with the interventions as outlined in the plan.<br>◆ Some or all of the elements of the plan must be revised and resubmitted. |
| **Step 4** | **Documentation substantiating implementation** |
| | Once the health plan has received Department approval of the CAP, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs. |
| **Step 5** | **Progress reports may be required** |
| | For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP. |

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

The template for the CAP follows.

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| **Standard III—Coordination and Continuity of Care** | | | | | |
| 4. The Contractor implements procedures to provide individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals. | During the on-site interview, the RMHP staff reported that the new member welcome call and needs assessment were conducted only for members identified by the State at enrollment as needing to be engaged in an ongoing course of treatment. Staff members stated that there was not a routine call and needs assessment for all newly enrolled Medicaid members. RMHP must implement a process to ensure that following enrollment, all Medicaid members receive initial screening for special health care needs and qualification for complex case management. | | | | |
| 10. The Contractor:<br>◆ Instructs its participating providers on how to refer a member for | The provider manual did not inform providers of the following wraparound services: inpatient substance abuse | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| wraparound services.<br>◆ Advises participating providers of EPSDT support services that are available through local public health departments.<br>◆ Informs the provider of the availability of the following wraparound services:<br>• Auditory services (children)—HMO covered services include screening, medically necessary ear exams, and audiological testing. Wraparound benefits include hearing aids, auditory training, audiological assessment, and hearing | rehabilitation through Valley View and hospital backup level of care (e.g., subacute care). The provider manual also did not provide information on how providers may refer members for wraparound services or information on the availability of EPSDT support services through the local public health departments. During the on-site interview, RMHP stated that hospital backup level of care is a covered service of RMHP; however, it was not listed in the description of RMHP covered services.<br>RMHP must revise its provider communications to include the complete listing of Medicaid wraparound services, as outlined in the requirement. RMHP must also revise its provider communications to include information on how providers may refer members for wraparound | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| evaluation.<br>• Dental services (children)—comprehensive dental assessment, care, and treatment (age 1 or before).<br>• Drug/Alcohol treatment for pregnant women—assessment and treatment (Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only).<br>• Extraordinary Home Health Services—expanded EPSDT benefit includes any combination of necessary home health services | services, that EPSDT services are available for members through age 20 (currently stated as age 21), and inform providers of the availability of EPSDT support services through the local public health departments. | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| that exceed the maximum allowable per day; and services that must, for medical reasons, be provided at locations other than the child's place of residence.<br>• HCBS services—case management, home modification, electronic monitoring, personal care, and non-medical transportation.<br>• Hospice services—client may continue to receive care not related to the terminal illness from the HMO.<br>• Hospital back-up level of care as set forth in 10 CCR 2505-10, Section 8.470. | | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| • Inpatient substance abuse rehabilitation DRG 936 (Valley View).<br>• Intestinal transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (e.g., liver); coordinated by the Department and HMO case manager (provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai).<br>• Non-emergency transportation to medical appointments—covered services | | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| (through the client's county of residence).<br>• Private duty nursing (nursing services only).<br>• Skilled nursing facility services (skilled nursing and rehabilitation services) if client meets level of care certification. | | | | | |
| 11. The Contractor informs all members aged 20 and under that EPSDT services are available. Information must effectively inform those individuals who are blind or deaf, or who cannot read or understand the English language and must include:<br>◆ The benefits of preventive health care.<br>◆ That services provided under the | The Covered Services and Community Resource sections of the handbook included a listing of some, but not all, of the available EPSDT services, and did not clearly identify that they were EPSDT services. RMHP member materials must inform members of the complete list of services available through the EPSDT program, as defined in the requirement. Specifically, RMHP must address the following omissions: drug and alcohol treatment for pregnant | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| EPSDT program are without cost to the individual.<br>◆ The services available under the EPSDT program and where and how to obtain those services, which include:<br>• Auditory devices (children)—HMO covered services include screening, medically necessary ear exams, and audiological testing. Wraparound benefits include hearing aids, auditory training, audiological assessment, and hearing evaluation.<br>• Dental services (children)—comprehensive dental assessment, | women; inpatient drug rehabilitation at Valley View; intestinal transplants at specific facilities; and hospital backup level of care. RMHP must clarify benefit descriptions and explain additional services available under the Medicaid fee-for-service payment structure, although not covered under RMHP's managed care contract. RMHP must also develop a designated EPSDT section of the member handbook or some other method to clearly define the services available under the EPSDT program and where and how to obtain them. | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| care, and treatment (age 1 or before).<br>• Drug/Alcohol treatment for pregnant women—assessment and treatment (Special Connections Program administered by the Alcohol/Drug Abuse Division, Department of Human Services. Specified treatment centers only).<br>• Extraordinary Home Health Services—expanded EPSDT benefit includes any combination of necessary home health services that exceed the maximum allowable per day; and services that must, for medical | | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| reasons, be provided at locations other than the child's place of residence.<br>• HCBS services—case management: home modification, electronic monitoring, personal care, and non-medical transportation.<br>• Hospice services—client may continue to receive care not related to the terminal illness from the HMO.<br>• Hospital back-up level of care as set forth in 10 CCR 2505-10, Section 8.470.<br>• Inpatient substance abuse rehabilitation DRG 936 (Valley View). | | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| • Intestinal transplants (excluding immunosuppressive medications, which are a covered HMO benefit) covered alone or with other simultaneous organ transplants (e.g., liver); coordinated by the Department and HMO case manager (provided only at three out-of-state facilities: University of Pittsburgh, Jackson Memorial, and Mt. Sinai).<br>• Non-emergency transportation to medical appointments—covered services (through the client's county of residence). | | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| • Private duty nursing (nursing services only).<br>• Skilled nursing facility services (skilled nursing and rehabilitation services) if client meets level of care certification. | | | | | |
| 13. The Contractor provides to members regularly scheduled examinations and evaluations of general physical and mental health, growth, and development, and nutritional status of infants, children, and youth. Screenings must include:<br>◆ Comprehensive health and developmental history.<br>◆ Comprehensive, unclothed physical examination.<br>◆ Appropriate vision | The RMHP provider manual included all of the elements in the requirement except referral to a dentist beginning at one year of age. The manual outlined the intervals for EPSDT well-child exams but did not recommend intervals for the specific screening services. RMHP must correct its provider communications regarding EPSDT screening services to include "referral to a dentist beginning at one year of age." RMHP also must define more specifically the expected intervals for the screening services in both the | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| testing.<br>◆ Appropriate hearing testing.<br>◆ Appropriate laboratory testing.<br>◆ Dental screening services furnished by direct referral to a dentist for children beginning at 1 year of age.<br>◆ If it is determined at the time of screening that immunization is needed, and appropriate, then immunizations must be provided at the time of treatment. | provider manual and the member handbook. | | | | |
| 14. The Contractor has implemented the State's periodicity schedule for screening services and specifies screening services applicable at each stage of the member's life, beginning with | The RMHP provider manual defined the components and time intervals for comprehensive EPSDT well-child exams; however, it did not address screenings (such as hearing and vision) or indicate specific screening intervals | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| neonatal examination, up to the age at which an individual is no longer eligible for EPSDT services. (The Contractor must demonstrate outreach efforts based on established periodicity schedules) | outlined in the State's periodicity schedule. RMHP must revise the provider manual to specifically address recommended screenings as outlined in the State's EPSDT periodicity schedule. | | | | |
| 15. The Contractor maintains policies describing its screening package and the methods used to assure that screening requirements are met. | During on-sight interviews, the staff confirmed that RMHP had not developed a policy describing the EPSDT screening package and methods used to assure that screening requirements were met. Staff members stated that RMHP had not formally adopted the Bright Futures guidelines, but the schedule was used as an internal reference for child wellness and preventive services. RMHP must develop and approve a policy describing its screening package and the methods used to assure that screening requirements are met. RMHP must formally | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| | adopt a periodicity schedule consistent with the State's EPSDT requirements, and clearly communicate expectations regarding EPSDT services to RMHP providers. | | | | |
| **Standard IV—Member Rights and Protections** | | | | | |
| 4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. | Although member rights were listed on the Web site and in the member handbook, information on the Web site was outdated. In addition, information on the Web site directing the member about receiving mental health services was outdated and described the Mental Health Assessment and Services Agency (MHASA) system (outdated since 2005), stating the MHASA for western Colorado was Colorado Health Network.Furthermore, the annual Medicaid enrollment letter (provided on-site) did not inform members of their right to request and | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| | receive a copy of the member handbook on request, as the staff stated on-site that it did. This having been a previous corrective action, HSAG once again recommends that RMHP evaluate its systems and processes for both implementing corrective actions and following through with processes. In order for members to fully understand benefits guaranteed under the Medicaid program and the rights associated with these benefit programs, they must receive accurate and timely information. Conflicting information from various sources is confusing.RMHP must work with its BHO partner to ensure accurate presentation of mental health/behavioral health information on RMHP's Web site. RMHP must update its Web site and develop processes to ensure | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| | that members who choose to use the RMHP Web site receive the most accurate information, and that this information does not conflict with previous hard copy information the member may have received. RMHP must also ensure that members are notified annually of their right to request and receive a copy of the member handbook. | | | | |
| **Standard X—Quality Assessment and Performance Improvement** | | | | | |
| 4. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual report describes:<br>◆ Techniques used by the Contractor to improve performance.<br>◆ The outcome of each performance improvement project. | The annual report did not include conclusions related to the overall impact of the QI program. RMHP must include an assessment of the overall impact and effectiveness of the QI program (applicable to Medicaid members) in the annual QI Report. | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| ◆ The overall impact and effectiveness of the QAPI program. | | | | | |
| 6. The Contractor ensures that practice guidelines comply with the following requirements:<br>◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.<br>◆ Consider the needs of the Contractor's members.<br>◆ Are adopted in consultation with contracting health care professionals.<br>◆ Are reviewed and updated annually. | The QI program description stated that RMHP adopted clinical practice guidelines for preventive care as well as diagnosis-specific clinical guidelines, and described the process for guideline adoption as outlined in the requirement, with the exception of the requirement for annual review and approval of guidelines. RMHP must modify its policies and procedures to ensure that clinical practice guidelines applicable to Medicaid members are reviewed and approved annually. | | | | |
| 13. The Contractor shall review compliance with the following criteria each year by reviewing and documenting at least | During the on-site interview, staff members stated that the monitoring of medical record documentation to verify accuracy of information in | | | | |

| Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP | | | | | |
|---|---|---|---|---|---|
| **Standard and Requirement** | **Required Actions** | **Planned Intervention and Person(s)/Committee(s) Responsible** | **Date Completion Anticipated** | **Training Required/Monitoring and Follow-up Planned** | **Documents to be Submitted as Evidence of Completion** |
| one statistically valid sample of encounter claims submitted to the Department:<br>◆ Accuracy of all required fields.<br>◆ Completeness of encounter claims submitted.<br>◆ Presence of Medical Record documentation for each encounter claim. | encounter claims had not been performed during the audit period. RMHP must perform and document an audit of a statistically valid sample of Medicaid encounter claims that includes verification of claims information against medical record documentation. | | | | |

# Appendix E. Compliance Monitoring Review Activities for Rocky Mountain Health Plans

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

**Table E-1—Compliance Monitoring Review Activities Performed**

| For this step, | HSAG completed the following activities: |
|---|---|
| **Activity 1:** | **Planned for Monitoring Activities** |
| | Before the compliance monitoring review:<br>◆ HSAG and the Department held teleconferences to determine the content of the review.<br>◆ HSAG coordinated with the Department and the health plan to set the dates of the review.<br>◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities.<br>◆ HSAG staff attended Medical Quality Improvement Committee (MQuIC) meetings to discuss the FY 2012–2013 compliance monitoring review process and answer questions as needed.<br>◆ HSAG assigned staff to the review team.<br>◆ Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the health plans were prepared for the compliance monitoring review. |
| **Activity 2:** | **Obtained Background Information From the Department** |
| | ◆ HSAG used the BBA Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the health plan's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tool, and report template.<br>◆ HSAG submitted each of the above documents to the Department for its review and approval.<br>◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific Managed Care regulations or contract requirements.<br>◆ HSAG considered the Department responses when determining compliance and analyzing findings. |
| **Activity 3:** | **Reviewed Documents** |
| | ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the desk review request via e-mail 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 four standards. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested.<br>◆ Documents submitted for the desk review and during the on-site document 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. |

| Table E-1—Compliance Monitoring Review Activities Performed | |
|---|---|
| **For this step,** | **HSAG completed the following activities:** |
| | ◆ 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. |
| **Activity 4:** | **Conducted Interviews** |
| | ◆ 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. |
| **Activity 5:** | **Collected Accessory Information** |
| | ◆ During the on-site portion of the review, 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 of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.) |
| **Activity 6:** | **Analyzed and Compiled Findings** |
| | ◆ Following the on-site portion of the review, HSAG met with health plan staff to provide an overview of preliminary findings.<br>◆ HSAG used the FY 2012–2013 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities.<br>◆ HSAG analyzed the findings and assigned scores.<br>◆ HSAG determined opportunities for improvement based on the review findings.<br>◆ HSAG determined actions required of the health plan to achieve full compliance with Medicaid managed care regulations and associated contract requirements. |
| **Activity 7:** | **Reported Results to the Department** |
| | ◆ HSAG completed the FY 2012–2013 Site Review Report.<br>◆ HSAG submitted the site review report to the health plan and the Department for review and comment.<br>◆ HSAG incorporated the health plan's and Department's comments, as applicable, and finalized the report.<br>◆ HSAG distributed the final report to the health plan and the Department. |