COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2019–2020 Site Review Report

for

Rocky Mountain Health Plans

Region 1

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HSAG HEALTH SERVICES ADVISORY GROUP

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Table of Contents

1. Executive Summary 1-1
Introduction 1-1
Summary of Compliance Results 1-2
Standard I—Coverage and Authorization of Services 1-3
Summary of Strengths and Findings as Evidence of Compliance 1-3
Summary of Findings Resulting in Opportunities for Improvement 1-3
Summary of Required Actions 1-4
Standard II—Access and Availability 1-4
Summary of Strengths and Findings as Evidence of Compliance 1-4
Summary of Findings Resulting in Opportunities for Improvement 1-5
Summary of Required Actions 1-5
Standard VI—Grievances and Appeals 1-6
Summary of Strengths and Findings as Evidence of Compliance 1-6
Summary of Findings Resulting in Opportunities for Improvement 1-7
Summary of Required Actions 1-8

2. Overview and Background 2-1
Overview of FY 2019–2020 Compliance Monitoring Activities 2-1
Compliance Monitoring Site Review Methodology 2-1
Objective of the Site Review 2-2

3. Follow-Up on Prior Year's Corrective Action Plan 3-1
FY 2018–2019 Corrective Action Methodology 3-1
Summary of FY 2018–2019 Required Actions 3-1
Summary of Corrective Action/Document Review 3-1
Summary of Continued Required Actions 3-2

Appendix A. Compliance Monitoring Tool A-1

Appendix B. Record Review Tools B-1

Appendix C. Site Review Participants C-1

Appendix D. Corrective Action Plan Template for FY 2019–2020 ..... D-1

Appendix E. Compliance Monitoring Review Protocol Activities E-1

Appendix F. Focus Topic Discussion F-1

Appendix G. MCO Compliance Review Report G-1

1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposals 2017000265, the Department of Healthcare Policy and Financing (the Department) executed contracts with the Regional Accountable Entities for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The Regional Accountable Entities (RAEs) are responsible for integrating the administration of physical and behavioral healthcare and will manage networks of fee-for-service primary care providers and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). In addition, the **Rocky Mountain Health Plans** (**RMHP**) Region 1 RAE contract incorporates into the RAE a limited managed care initiative for capitated physical health services (managed care organization [MCO]). 42 CFR requires PCCM entities, PIHPs, and MCOs to comply with specified provisions of 42 CFR 438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCM entities, PIHPs, and MCOs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2019–2020 site review activities for **RMHP**. For each of the three standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2018–2019 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials of authorization of services (denials), grievances, and appeals record reviews. Appendix C lists HSAG, RAE, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process that the health plan will be required to complete for FY 2019–2020 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol. Appendix F includes the summary of the focus topic interviews with RAE staff members used to gather information for assessment of statewide trends related to the FY 2019–2020 focus topic selected by the Department. Appendix G includes the compliance monitoring report for the MCO.

Summary of Compliance Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable.* HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

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

Table 1-1—Summary of RAE Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	34	30	27	3	0	4	90%
II. Access and Availability	16	16	16	0	0	0	100%
VI. Grievances and Appeals	35	35	30	5	0	0	86%
Totals	**85**	**81**	**73**	**8**	**0**	**4**	**90%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

Table 1-2 presents the scores for **RMHP** RAE and MCO combined for the denials, grievances, and appeals 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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	90	58	54	4	32	93%
Grievances	60	48	46	2	12	96%
Appeals	60	55	50	5	5	91%
Totals	**210**	**161**	**150**	**11**	**49**	**93%**

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

RMHP RAE submitted a large body of evidence to substantiate compliance with coverage and authorization of services requirements. **RMHP**'s submission included policies, procedures, reports, work plans, tools, manuals, and sample denial and extension letters. HSAG reviewed all submissions and found that the documents illustrated a thorough and comprehensive approach for the review, authorization, and denial of RAE covered services.

RMHP RAE delegated utilization management (UM) functions for behavioral health services to Optum. Policies and procedures addressed **RMHP**'s strategic oversight of all delegated UM activities, including an annual audit and evaluation of all delegated entities and overall performance. The delegation oversight scoring tool and annual oversight report demonstrated monitoring mechanisms and performance compliance for activities such as the initial and continuous prior authorization request process, application of evidence-based criteria, and requesting peer-to-peer review for decisions and review of adverse benefit determinations. Delegated oversight activities also included regular joint operations meetings and required delegate reporting and monitoring of utilization, grievances, and appeals. In instances of substandard performance, **RMHP** had a process to implement a corrective action plan to address and correct areas of concern, including discontinuation of the delegated relationship.

During on-site record reviews, HSAG observed that the notices of adverse benefit determination (NABDs) demonstrated the required content, including the reason for the decision, the member's right to appeal and to request a State review, and the possibility of requesting continued service/benefits pending the resolution of the appeal. **RMHP**'s staff members stated that, in addition to mailing members the NABD, **RMHP** placed a call to each member or the member's designated representative to clearly explain the reason for the adverse benefit determination, to ensure that the decision is clearly understood, and to address any corresponding questions.

RMHP's policies and procedures accurately defined "emergency condition," "emergency services," and "post-stabilization services" consistent with regulatory definitions. In addition, the *RMHP Member Benefit Booklet* clearly defined and explained that both emergency care and post-stabilization care services are covered and do not require a prior authorization. **RMHP**'s *Claims Processing Manual* reiterated that services rendered in an urgent care facility or in the emergency room and all associated services are payable at the claim processor level without review for medical necessity.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

RMHP's *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies included inaccurate information regarding required time frames for standard prior authorization decisions, as well as extended time frames. In addition, one of 10 denial record reviews was *Not Met* for "decision made within required time frame." **RMHP** must correct information in its *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies to accurately address:

- The 10-calendar day time frame for making standard authorization decisions.
- The 14-calendar day time frame for extending a standard or expedited authorization decision.

RMHP must also develop a mechanism to ensure that the required time frames are met.

RMHP demonstrated that the member letter used for UM denials included all the required content and was available in prevalent non-English languages and alternative formats for persons with special needs. However, three of the denial record reviews demonstrated that **RMHP**'s reason for the adverse benefit determination incorporated prior authorization clinical criteria difficult for Medicaid members with limited reading ability to understand. **RMHP** must ensure that the NABD in its entirety is written in language that is easy for a member to understand.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

RMHP submitted a large body of evidence to substantiate compliance with access and availability requirements. **RMHP**'s submission included policies, procedures, reports, analytics, strategic plans, tools, manuals, and directories. HSAG reviewed the submission and found that **RMHP** maintained a network of providers sufficient to cover services to its RAE members. Within its Network Capacity Report, **RMHP** demonstrated the number of primary care and specialist providers available in each county, as well as the ratio of physicians to members living in those respective counties. HSAG reviewed the report and found that the identified provider types met network adequacy time and distance standards for primary care, behavioral health, and specialist providers. In order to further enhance access, **RMHP** implemented use of telemedicine. **RMHP** reported that use of its CareNow and provider telemedicine modalities for urgent care and psychological therapy services has increased significantly over the short time since implementation and **RMHP** expects this trend to continue.

During the on-site interview, **RMHP** confirmed that members were provided access to women's healthcare specialists and second opinions without a referral, which aligned with **RMHP** policies. **RMHP** provided evidence in its 2019 Provider Network Strategic Plan and Access Plan that a sufficient ratio of family planning providers were made available to members. In addition, **RMHP** affirmed that it made out-of-network providers available to members at no cost in situations where there was no

qualified provider within the network. **RMHP** stated that eating disorder specialists were the most referred to out-of-network providers.

RMHP had policies in place that outlined the State's standards for timely access. **RMHP** also published timely access standards in its 2019 Provider Manual to ensure providers were aware of the requirements. **RMHP** informed providers in its 2019 Provider Manual that they may not limit their hours of operation in a manner which is less than what is offered to members of non-publicly financed programs. **RMHP** provided evidence of a member survey used to monitor providers for timely access. During 2019, **RMHP** evaluated timely access by administering the survey annually. During the on-site interview, **RMHP** stated that it would be conducting the survey quarterly in order to garner more responses and improve the quality of member reporting by reducing the lag between the member's appointment and the survey.

RMHP provided a robust array of policies on cultural competency. Within its policies, **RMHP** included provisions for how it addressed the needs of those members with limited English proficiency, diverse cultural and ethnic backgrounds, physical or mental disabilities, differing sexual orientation, or gender identity. During the interview, **RMHP** discussed its provider education series, which addressed topics such as "Bridges Out of Poverty" training and cultural and generational communications. Future topics in the provider education series include: "Bridging the Care for Veterans in Rural Colorado" and "Best Practices for Providing Integrated Care Services for Latino Families."

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VI—Grievances and Appeals

NOTE: Federal requirements related to RAE appeals apply only to RAE behavioral health capitated services. The Department contract requires that regulations related to grievances apply to all RAE members. Findings from the combined Prime and RAE on-site record reviews apply to both the RAE and Prime.

Summary of Strengths and Findings as Evidence of Compliance

RMHP maintained comprehensive policies with thoroughly defined procedures for processing both appeals and grievances. Policies and procedures accurately defined "adverse benefit determination," "appeals," and "grievances" per regulatory language and described that a member or his or her designated representative may file a grievance, appeal, or State fair hearing (SFH). **RMHP**'s *Designation of Representative Policy and Procedure* clearly addressed the process of obtaining a designated representative form from the member when needed. Staff members explained that, if a member or his or her representative contacts **RMHP** concerning a grievance or appeal, **RMHP** promptly sends the designated representative form and follows up with the member in 5 days to remind the member of the need for the form. While **RMHP** will begin processing an appeal when verbally requested by a member, receipt of the designated representative form officially begins the time period for processing an appeal. In addition to assisting members with the designated representative process, staff members explained that the most common forms of assistance offered to members included: providing a verbal explanation of the appeal process, reiterating and clarifying what specifically the member is grieving or appealing, assisting with walk-in requests, and explaining the SFH process. **RMHP**'s Customer Service Department is the initial contact point for members filing grievances or appeals, which are documented in the grievance and appeal data system and forwarded to a grievance and appeal (G&A) coordinator for follow-up and resolution. Staff members explained that other organizational points of contact with the member—e.g., care management staff members—have been trained to recognize, capture, and forward member grievance information to G&A staff members. Grievance coordinators ensure that the grievance is resolved and members are notified of resolution within the required time frames. HSAG found on-site grievance record reviews 100 percent compliant with: acknowledgement letter sent within required time frame, resolution letter sent in required time frame (generally one or two working days), resolved by person not previously involved, and resolution letter easy to understand. **RMHP**'s *Appeals Policy and Procedure* and related documents outlined detailed procedures for accepting, documenting, processing, and providing notice to members regarding an appeal and SFH. Associated timelines for notices to members addressed acknowledgements; standard, expedited, and extended appeals, as well as denial of expedited appeal requests; and extension letters to members. Verbal appeals from members were summarized by staff members and sent to the member to obtain a signed written appeal; however, staff members stated that it is frequently difficult to get members to return the signed appeal and that **RMHP** processes all verbal appeals regardless of receipt of a signed appeal. Any additional information received from the member or designated representative to support the appeal is scanned into the system and forwarded to the appeals coordinator. **RMHP**-contracted medical reviewers make decisions on appeals with input from Optum physician advisor services to ensure that appropriate behavioral health clinical expertise is applied in the decision.

Staff members stated that the **RMHP** medical director may override a decision made by an Optum consultant when local circumstances—i.e., needed level of care or service is not available in the area—are considered. HSAG found on-site appeal record reviews 100 percent compliant with: acknowledgement letter sent within required time frame, resolution letter sent in required time frame, resolved by person not previously involved and with appropriate clinical expertise, and resolution letter includes required content. **RMHP** time-stamped receipt of all appeals and notices to members to ensure that the 72-hour time frame for expedited decisions was met. **RMHP** documented all contract-required information and tracked all grievances and appeals in the Macess software system, including each step in the resolution process. Staff members stated that the G&A staff members manually monitor all time frames daily. **RMHP**'s Provider Manual included extensive information for providers regarding the grievance, appeal, and SFH processes and time frames.

Summary of Findings Resulting in Opportunities for Improvement

While the *Designation of Representative Policy and Procedure* stated that parties to an appeal include the member, the designated representative, or a representative of a deceased member's estate, the *Appeals Policy and Procedure* did not define the parties to an appeal or SFH. HSAG recommends that **RMHP** also include the parties to the appeal in its *Appeals Policy and Procedure.*

While **RMHP**'s professional service agreements list numerous reasons that **RMHP** will not take adverse action against a provider, including assisting members with appeal of a denial of service decision, the provider manual does not clearly specify in the grievance and appeals section that **RMHP** will not take punitive action against a provider for supporting a member's appeal. As the information in the provider service agreements is somewhat obscure, HSAG recommends adding language in the grievance and appeal section of the **RMHP** Provider Manual that clearly states that **RMHP** will not take punitive action against a provider for supporting a member's appeal or requesting an expedited appeal.

HSAG noted that the appeal resolution letter template includes all information pertaining to the member's right to request an SFH and that the template language is used for all appeal resolutions, including those in which the appeal resolution overturns the original adverse benefit determination. Whereas the member's right to an SFH does not apply when the appeal resolution approves the requested service, HSAG suggests that **RMHP** selectively remove the SFH information from appeal resolutions which overturn the original denial, so as not to confuse the member.

RMHP's *Appeals Policy and Procedure* addressed the circumstances for the member to request continued benefits as applicable to both an appeal and an SFH. These circumstances included the criterion "the original period covered by the original authorization has not expired," which applies only to the Contractor level of appeal and not to an SFH. HSAG suggests that **RMHP** consider segregating circumstances for requesting continued benefits during an appeal from the circumstances applicable to an SFH in order to ensure that staff members clearly understand the difference in qualifying criteria. In addition, the criteria for requesting continued benefits include "if the member or designated representative specifically requests extension of services." HSAG cautions that a member's designated

representative may be his or her provider, and that a provider may not request continuation of benefits on behalf of the member.

Summary of Required Actions

RMHP's *Appeals Policy and Procedure* and *Grievance Policy and Procedure* addressed the requirements that individuals involved in making a grievance or appeal decision must not have been involved in the previous level of review and must have appropriate clinical expertise when applicable. However, during on-site record reviews, HSAG identified that one grievance pertaining to treatment by a provider failed to include review by an **RMHP** clinician and referred the member back to the treating provider group to resolve the complaint, thereby, not resolving the member's grievance. **RMHP** must develop a mechanism to ensure that:

- Any grievance regarding treatment by a provider is reviewed and resolved by an **RMHP** clinician with appropriate clinical expertise in treating the member's condition.
- Each member grievance is thoroughly addressed by **RMHP** staff members.

RMHP's *Appeals Policy and Procedure* stated that the content of the member appeal resolution letter must be written in easy to understand language and the template appeal resolution letter demonstrated that the letter was written in language easy for the member to understand. However, HSAG identified in on-site appeal record reviews that in 50 percent of the appeal resolution letters the reason for the appeal decision that was not written in easy to understand language, primarily due to including extensive clinical information excerpted from clinical reviewer criteria. **RMHP** must develop a mechanism to ensure that the reason for the appeal decision in Medicaid member appeal resolution letters simplifies the reason for the decision and is written in language at or near the sixth-grade reading level.

RMHP's *Appeal Policy and Procedure* addressed the circumstances applicable to providing continuation of benefits during an appeal or SFH, although inaccurately stated that the member must file the *appeal* within 10 days of the NABD (the member must request continuation of benefits within 10 days). In addition, the policy defined that a criterion for requesting continued benefits during an SFH included "the original period covered by the original authorization has not expired." This criterion applies only to requesting continuation of benefits during an appeal, not an SFH. Furthermore, the *Appeal Policy and Procedure* inaccurately defined "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue after requested by the member. These inaccuracies were also repeated in the **RMHP** Prime Member Handbook and the **RMHP** Provider Manual. **RMHP** must correct the *Appeal Policy and Procedure* and related documents to:

- Accurately reflect that the member must request continuation of benefits—not file the appeal—within 10 days after the NABD or within 10 days of the notice of appeal resolution, as applicable.
- Clarify that "the original period covered by the original authorization has not expired" does not apply to requesting continued benefits during a SFH.
- Remove "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue during an appeal or SFH.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services; Standard II—Access and Availability; and Standard VI—Grievances and Appeals. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all three standards. In addition, the Department requested that HSAG conduct on-site group interviews with key RAE staff members to explore individual RAE experiences related to one focus topic. The focus topic chosen by the Department for 2019–2020 was *Region-specific Initiatives Related to the Health Neighborhood.*

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met, Partially Met, Not Met, or Not Applicable.* The Department determined that the review period was January 1, 2019, through December 31, 2019. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to each of denials of authorization, grievances, and appeals.

HSAG reviewed a sample of the RAE's administrative records related to RAE denials of authorization, grievances, and appeals to evaluate implementation of applicable federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of denials, grievances, and appeals. For health plans that were contracted by the Department for administration of a RAE and a RAE MCO, HSAG included five records from each of the RAE and the RAE MCO for a total of 10 records. Using a random sampling technique, HSAG selected the samples from all RAE and MCO denial records, all grievance records, and all appeal records that occurred between January 1, 2019, and December 31, 2019. For the record review, the health plan received a score of M (*Met*), NM (*Not Met*), or NA (*Not Applicable*) for each required element. HSAG separately calculated a record review score for each record and an overall record review score. Results of record reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievances and Appeals.

To facilitate the focus topic interviews, HSAG used a semi-structured qualitative interview methodology to explore with RAE staff members information pertaining to the Department's interests related to the focus topic selected. The qualitative interview process encourages interviewees to describe experiences, processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes. Focus topic discussions were not scored. HSAG and the Department collaborated to develop the *Focus Topic Interview Guide*. Appendix F contains the summarized results of the on-site focus topic interviews.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

Objective of the Site Review

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

- The RAE's compliance with federal healthcare regulations and managed care contract requirements in the three areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the RAE into compliance with federal healthcare regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the RAE, as assessed by the specific areas reviewed.
- Possible interventions recommended to improve the quality of the RAE's services related to the standard areas reviewed.
- Information related to the specific focus topic area to provide insight into statewide trends, progress, and challenges in implementing the RAE and ACC programs.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 site review, each RAE 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 RAE 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 RAE and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP** until it completed each of the required actions from the FY 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

Related to member rights and protections, **RMHP** RAE was required to develop provisions for community education regarding advance directives.

Related to member information, **RMHP** RAE was required to:

- Ensure its website is fully readily accessible per Section 508 guidelines.
- Update its provider directories to include whether or not the provider has completed cultural competency training and whether the provider's office has accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.
- Ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 guidelines.

Summary of Corrective Action/Document Review

RMHP RAE submitted a proposed CAP in May 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **RMHP** RAE. **RMHP** RAE submitted initial documents as evidence of completion in September 2019. HSAG and the Department reviewed and approved **RMHP** RAE's documents submitted as evidence of completion and responded to **RMHP** RAE in October 2019.

Summary of Continued Required Actions

RMHP RAE successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* RAE Contract: Exhibit B-2—14.6.2 MCO Contract: Exhibit M-2—14.4.2	Note: Federal requirements only apply to MCOs and PIHPs (behavioral health services of RAEs) unless otherwise noted. **Both RAE and Prime:** *I_UM_Program Description_2019-2020* Page 3, Section II, Paragraph 2: This describes that RMHP's UM Program is designed to ensure that medical services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the Plan. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 22: This describes that as part of its procedure RMHP ensures that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *2019 Provider Manual* Page 89, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the Member. Further, RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* RAE Contract: Exhibit B-2—14.6.4 MCO Contract: Exhibit M-2—14.4.4	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 6-7, Paragraph 24(a): This states that RMHP does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the Member. *2019 Provider Manual* Page 89, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the Member. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose.	**Both RAE and Prime:** *I_UM_Clinical Criteria for UM Decisions* Page 1, Purpose: This describes that RMHP applies objective and evidence-based criteria when determining medical appropriateness (necessity) of health care services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.210(a)(4) RAE Contract: Exhibit B-2—14.6.5, 14.6.5.1–2 MCO Contract: Exhibit M-2— 14.4.5, 14.4.5.1-2	*I_UM_Preauthorization Policy & Procedure* Pages 7-8, Paragraph 24(e)(i) & (ii): This describes that RMHP may place appropriate limits on services on the basis of criteria applied under the State (medical necessity) and for the purpose of utilization control, provided that the services furnished can reasonably be expected to achieve their purpose. *2019 Provider Manual* Page 89, Pre-authorization Policies and Procedures: This states that RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan. **RAE-specific:** N/A **Prime-specific:** N/A	
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3–10-16-104(3)(B)*		*For Information Only (RAE)*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-2—14.6.5.2.1 MCO Contract: Exhibit M-2— 14.4.5.2.1		
5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*	I	*For Information Only (RAE)*
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*		*For Information Only (RAE)*
7. The RAE defines medical necessity for services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Is not experimental or investigational.	**Both RAE and Prime:** *I_UM_Program Description_2019-2020* Page 3, Section II: This describes that RMHP's UM Program is designed to ensure that medical services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the plan. Page 24-25, Section XI: This describes RMHP's use of nationally accepted evidence-based guidelines that span the continuum of care, such as MCG Care Guidelines® and other nationally recognized criteria established by organizations such as the American Academy of Obstetrics, Gynecology or Pediatrics. Use of these criteria ensures that RMHP provides services in accordance with professionally recognized standards for healthcare in the United States.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is not more costly than other equally effective treatment options. *42 CFR 438.210(a)(5)* RAE Contract: Exhibit B-2—2.1.62 MCO Contract: Exhibit M-2— 2.1.69 10 CCR 2505-10 8.076.1.8	*I_UM_Clinical Criteria for UM Decisions* Pages 1-2, Section II: This describes that RMHP applies written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services. Further this states that RMHP clinical policies are sound and based upon analysis of clear, professionally recognized evidence of effectiveness, and are financially responsible. *I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: This provides the definition of "Medical Necessity" that comports with 42 CFR 438.210(a)(5). *2019 Provider Manual* Page 66, Paragraph 2: This describes that a "Medically Necessary" health care good or service will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects, of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. Medical necessity means that a good or service: • Is clinically appropriate in terms of type, frequency, extent, site, and duration; • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Is delivered in the most appropriate setting(s) required by the client's condition; • Is not experimental or investigational; and • Is not more costly than other equally effective treatment options. **RAE-specific:** N/A **Prime-specific:** N/A	
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* RAE Contract: Exhibit B-2—14.8.2 MCO Contract: Exhibit M-2— 14.6.2	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 1, Purpose: This policy addresses the processing of requests for initial and continuing authorization of services. **RAE-specific:** *I_UM_2019_Optum_BH_UM_Program Description_Work Plan* Page 6, Scope of Utilization Management Program: This describes that Optum has a well-structured UM program with a continuum of processes to address requests for initial and continuing authorization of services. **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2019* Page 2, UM 1- Utilization Management Structure: This describes that eviCore has a well-structured UM program with policies that promote utilization decisions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	affecting the health care of Members in a fair, impartial and consistent manner.	
9. The Contractor and its subcontractors have in place and follow written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* RAE Contract: Exhibit B-2—None MCO Contract: Exhibit M-2— None	**Both RAE and Prime:** *I_UM_Clinical Criteria for UM Decisions* This document demonstrates that RMHP applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Pages 5-6, Section VII: This describes how RMHP annually assesses the consistency with which reviewers apply UM criteria in decision making and acts upon opportunities to improve consistency, if applicable. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 24: This provides that the criteria for authorization decisions are applied consistently. **RAE-specific:** *I_UM_2019_Optum_BH_UM_Program Description_Work Plan* Page 32, Clinical Criteria: This demonstrates that Optum uses evidence-based objective criteria that are reviewed at least annually. **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2019*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2, UM 2: Clinical Criteria for Utilization Management Decisions: This demonstrates that eviCore uses evidence-based, objective criteria that are reviewed at least annually.	
10. The Contractor and its subcontractors have in place and follow written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* RAE Contract: Exhibit B-2—14.8.2.5 MCO Contract: Exhibit M-2— 14.6.2.5	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(d)(ii): This describes that RMHP allows discussion with the attending physician, PCP or requesting physician to collect necessary information to make a preauthorization decision. Page 17, Paragraph 35: This describes that RMHP allows a rendering provider to request a peer-to-peer review to discuss an adverse determination. **RAE-specific:** *I_UM_2019_Optum_BH_UM_Program Description_Work Plan* Page 10, Peer Reviewer Determinations and Denials: This describes that Optum will conduct peer review or reconsiderations with a treating physician/practitioner when requested or as applicable for state-specific or contractual requirements. **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2019* Page 2, UM 2: Clinical Criteria for Utilization Management Decisions:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This demonstrates that the eviCore policies include assessment of the individual needs of the Member and consideration of the local delivery system. Input from outside physicians/practitioners with specific expertise is considered.	
11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical or BH needs. *42 CFR 438.210(b)(3)* RAE Contract: Exhibit B-2—14.6.6 MCO Contract: Exhibit M-2— 14.4.6	**Both RAE and Prime:** *I_UM_Appropriate Professionals for CM and Pharmacy* Page 3, Section III: This describes the process for practitioner review of non-behavioral healthcare denials. Pages 4-5, Section IV: This describes the process for practitioner review of behavioral healthcare denials. Page 5, Section V: This describes the process for use of board-certified consultants in instances where RMHP Clinical Pharmacists and Associate Medical Directors do not have clinical expertise in the areas for which services or pharmaceuticals are being requested. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 23: This describes that UM decisions are made by individuals with the knowledge and skills to evaluate working diagnoses and proposed treatment plans for the Member's medical or behavioral health needs. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *42 CFR 438.210(c)* RAE Contract: Exhibit B-2—8.6.1 MCO Contract: Exhibit M-2— 8.7.13.6 10 CCR 2505-10 8.209.4.A.1	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 15–17, Paragraphs 32-34: This describes the procedures that RMHP has in place to notify Members and requesting providers of decisions to deny or modify service authorization requests which may be completed orally or in writing. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* RAE Contract: Exhibit B-2—8.6.6, 8.6.8 MCO Contract: Exhibit M-2— 8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	**Both RAE and Prime:** **Bullet #1:** *I_UM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Preauth TAT's and Notification Requirements* This document is a grid of regulatory timeframes that RMHP follows for notification of preauthorization decisions. The grid indicates that RMHP provides notice of standard authorization decisions within 10 calendar days. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(d)(i): This sets forth the timing for issuing a notice for a standard authorization decision. It indicates that RMHP	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	will make a determination and notify the covered person and the covered person's provider of the determination within 10 calendar days after the receipt of the preauthorization request. **Bullet #2:** *I_UM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Preauth TAT's and Notification Requirements* This document is a grid of regulatory time frames that RMHP follows for notification of expedited preauthorization decisions. *I_UM_Preauthorization Policy & Procedure* Page 11, Paragraph 31(b): This sets forth the process for issuing a notice for an authorization decision no later than 72 hours after receipt of the request for those instances when the Member's condition requires an expedited decision. **RAE-specific:** N/A **Prime-specific:** N/A	
Findings: RMHP's *UM Timeliness of UM Decisions* policy described the process and time frames for making standard and expedited authorization decisions. The policy incorrectly identified the time frame for pre-service non-urgent requests as "up to 15 days" from the date of receipt. In addition, the policy did not		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
specify that the time frame is within "calendar days." The denial record reviews identified that one of 10 records was *Not Met* for "decision made within required time frame."		
Required Actions: RMHP must correct its *UM Timeliness of UM Decisions* policy to accurately address the 10-calendar day time frame for making standard authorization decisions. RMHP must also develop a mechanism to ensure that the required time frames are met.		
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* RAE Contract: Exhibit B-2—8.6.6.1, 8.6.8.1 MCO Contract: Exhibit M-2— 8.6.6.1, 8.6.8.1	**Both RAE and Prime:** *I_UM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(d)(iii), Page 14, Paragraph 31(e)(i)(2): This describes the process for extending the standard or expedited authorization timeframe for up to 14 calendar days when the Member requests an extension or RMHP justifies the need for an extension to the State. **RAE-specific:** N/A **Prime-specific:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: RMHP's *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies described the process for requesting an extension and specified the time frame for a determination to be reached. However, the *UM Timeliness of UM Decisions* policy inaccurately stated that the Contractor extension time frame is within "15 days" from the end of the initial authorization time frame or at the request of the member or provider. In addition, neither the *UM Preauthorization of Services* policy nor the *UM Timeliness of UM Decisions* policy indicated "calendar days" in the extension time frame.		
Required Actions: RMHP must correct information in its *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies to accurately address the additional "14-calendar day" time frame for extending a standard or expedited authorization decision.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* RAE Contract: Exhibit B-2—8.6.1–8.6.1.4 MCO Contract: Exhibit M-2— 8.6.1-8.6.1.4 10 CCR 2505-10 8.209.4.A.1	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 15, Paragraph 32(a): This describes that notification will be provided to a Member in writing in a manner calculated to be understood by the Member, and that the notice will be available in English and prevalent non-English languages spoken by Members throughout the State and available in alternative formats for persons with special needs. **RAE-specific:** *I_UM_Sample RAE Only Denial Letter Adult* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_UM_Sample RAE Only Denial Letter Child* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. **Prime-specific:** *I_UM_Sample Denial Letter Adult Medicaid-CHP* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_UM_Sample Denial Letter Child Medicaid-CHP* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	I_Pharmacy_Sample Denial Letter Medicaid-CHP This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_Pharmacy_Sample QL Denial Letter Medicaid-CHP* This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10.	
Findings: RMHP policies and other submitted evidence demonstrated that template NABDs used for UM denials were written in a language easy to understand and informed the member of the availability of the letter in other languages and alternative formats. However, HSAG found three of 10 denial record reviews were *Not Met* for "correspondence with the member was easy to understand." RMHP incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the adverse benefit determination. The language content would be difficult for a member with a limited reading ability to understand.		
Required Actions: RMHP must ensure that the NABD in its entirety is written in language that is easy for a member to understand.		
16. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due.	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 15-16, Paragraph 32(b)(i-x): This describes the content of notices of action or adverse benefit determination and includes the entire list of regulatory requirements. **RAE-specific:** *I_UM_Sample RAE Only Denial Letter Adult* *I_UM_Sample RAE Only Denial Letter Child* These letter templates demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) **Bullet #1:** Page 1, Paragraph 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. *42 CFR 438.404(b)(1–6)* RAE Contract: Exhibit B-2—8.6.1.5–8.6.1.12 MCO Contract: Exhibit M-2— 8.6.1.5-8.6.1.12 10 CCR 2505-10 8.209.4.A.2	Page 2, Section "How We Made Our Decision" **Bullet #2:** Page 2, Section "How We Made Our Decision" Page 2, Section "Call Us If You Have Questions" **Bullet #3:** Page 2, Section "Call Us If you Have Questions" Page 2, Section "Before You Begin: Know Your Appeal Rights" Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Page 3, Section "How To Ask For An Appeal" Page 5, Section "How To Ask For A Quick Appeal" **Bullet #4:** Page 3, Section "How To Ask For An Appeal" Page 5, Section "How To Ask For A Quick Appeal" **Bullet #5:** Page 2, Section "Before You Begin: Know Your Appeal Rights" Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Page 6, Section "How To Ask For A Formal Hearing" **Bullet #6:** Page 6, Section "How To Ask For A Formal Hearing" **Bullet #7:** Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Page 5, Section "How To Ask For A Quick Appeal" **Bullet #8:** Page 7, Section "Continuing Your Benefits And Services"	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 7, Section "To Continue Receiving Your Benefits and Services During The Appeal, Quick Appeal, Or Formal Hearing Process, You Must:" Pages 7-8, Section "Understanding The Results Of Your Appeal, Quick Appeal, Or Formal Hearing" **Prime-specific:** *I_Pharmacy_Sample Denial Letter Medicaid-CHP* This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) *I_UM_Sample Denial Letter Adult Medicaid-CHP* *I_UM_Sample Denial Letter Child Medicaid-CHP* These letter templates demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) i **Bullet #1:** Page 1, Paragraph 2 Page 2, Section "How We Made Our Decision" **Bullet #2:** Page 2, Section "How We Made Our Decision" Page 2, Section "Call Us If You Have Questions" **Bullet #3:** Page 2, Section "Call Us If You Have Questions" Page 2, Section "Before You Begin: Know Your Appeal Rights" Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Page 3, Section "How To Ask For An Appeal"	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 4-5, Section "How To Ask For A Quick Appeal" **Bullet #4:** Page 3, Section "How To Ask For An Appeal" Pages 4-5, Section "How To Ask For A Quick Appeal" **Bullet #5:** Page 2, Section "Before You Begin: Know Your Appeal Rights" Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Pages 5-6, Section "How To Ask For A Formal Hearing" **Bullet #6:** Pages 5-6, Section "How To Ask For A Formal Hearing" **Bullet #7:** Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Pages 4-5, Section "How To Ask For A Quick Appeal" **Bullet #8:** Page 6, Section "Continuing Your Benefits And Services" Pages 6-7, Section "To Continue Receiving Your Benefits and Services During The Appeal, Quick Appeal, Or Formal Hearing Process, You Must:" Page 7, Section "Understanding The Results Of Your Appeal, Quick Appeal, Or Formal Hearing"	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
17. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits. • A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), (II), and (III)* RAE Contract: None MCO Contract: None		*For Information Only (RAE)*
18. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service.	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 11, Paragraph 31(c)(i-vi): This incorporates the circumstances and timeframes by reference to Section 8.209 of State Medicaid Rules found in 10 CCR 2505-10. **Bullet #1:** Page 3, Paragraph 5: This indicates RMHP must notify the Member at least 10 days before the date of action for termination, suspension,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)* RAE Contract: Exhibit B-2—8.6.3.1, 8.6.5–8.6.8 MCO Contract: Exhibit M-2— 8.6.3.1, 8.6.5-8.6.8 10 CCR 2505-10 8.209.4.A.3	or reduction of previously authorized Medicaid/CHP+-covered services. **Bullet #2:** Page 11, Paragraph 31(c)(ii): This indicates that RMHP provides notices denial of payment at the time of any denial affecting the claim. **Bullet #3:** Page 12, Paragraph 31(d)(i): This indicates that RMHP will make a determination and notify the covered person and the covered person's provider of the determination within 10 calendar days after the receipt of the preauthorization request. **Bullet #4:** Page 14, Paragraph 31(e)(i): This indicates that RMHP will response to expedited service authorization requests within 72 hours of receipt. **Bullet #5:** Page 13, Paragraph 31(d)(iv)(2)(a): This indicates that RMHP will respond to extended service authorization decisions no later than the extension expiration date. **Bullet #6:** Page 14, Paragraph 31(d)(iv)(2)(d): This indicates that if RMHP fails to make a determination within the required time frame, RMHP will notify the	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Member of his/her appeal rights on the date the time frame expires. **RAE-specific:** N/A **Prime-specific:** N/A	
19. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 5: This describes that for reduction, suspension, or termination of previously authorized Health First Colorado (Medicaid)/CHP+-covered services, RMHP notifies the Member at least ten (10) days before the intended effective date of the proposed adverse benefit determination (action). **Bullet #1:** *I_UM_Preauthorization Policy & Procedure* Pages 11-12, Paragraph 31(c)(vi)(1): This describes the exceptions for when RMHP provides notice for reduction, suspension, or termination of a previously authorized Medicaid-covered service on or before the intended effective day of the proposed adverse benefit determination. **Bullet #2:** *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(c)(vi)(2):	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* RAE Contract: Exhibit B-2—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.1.8 MCO Contract: Exhibit M-2— 8.6.3.1-8.6.3.2, 8.6.4.1-8.6.4.1.8 10 CCR 2505-10 8.209.4.A.3 (a)	This describes that if probable Member fraud has been verified, RMHP gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. **RAE-specific:** N/A **Prime-specific:** N/A	
20. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* RAE Contract: Exhibit B-2—8.6.6.2 MCO Contract: Exhibit M-2— 8.6.6.2 10 CCR 2505-10 8.209.4.A.3 (c)(1)	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 12–13, Paragraph 31(d)(iii): This describes that RMHP may choose to request an extension. If an extension is taken, RMHP sends a written notice of the reason for the extension, which specifically describes the required information necessary to complete the request, gives the Member 14 days from the receipt of the notice to provide the specified information, and gives the Member the right to file a grievance if the Member disagrees with the decision to take the extension. **RAE-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: N/A	
21. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* RAE Contract: Exhibit B-2—14.8.6 MCO Contract: Exhibit M-2— 14.6.6	**Both RAE and Prime:** *I_UM_Appropriate Professionals for CM and Pharmacy* Page 5, Section VI: This describes RMHP's Affirmative Statement about Incentives. *I_UM_Program Description_2019-2020* Page 3, Section II: This states that RMHP does not specifically reward practitioners or other individuals for issuing denials of coverage or care and offers no incentives for Pharmacy or UM decision makers to encourage decisions that result in underutilization. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or	**Both RAE and Prime:** *2019 Provider Manual* Page 80, Section – Definition of Emergent Care: Includes the regulatory definition of "emergency medical condition." *I_UM_Emergency Department Services Claim Review Policy*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.33 MCO Contract: Exhibit M-2— 2.1.38	This policy describes that RMHP makes payment for all emergency department services without medical necessity review. *I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: This defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(a)(i-iii): This describes that RMHP will not deny treatment to a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** *RMHP Prime Member Handbook* Pages 12-13: This informs Members about when to use the emergency room, describing the circumstances contained in the regulatory definition of "emergency medical condition" – in plain language.	
23. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.34 MCO Contract: Exhibit M-2— 2.1.39	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: This defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *2019 Provider Manual* Page 80, Definition of Emergent Care: This illustrates that emergency services means covered inpatient and outpatient services furnished by a provider qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 15-16, Emergency Services: This defines emergency services for Members and informs that services for evaluation and stabilization are covered.	
24. The Contractor defines post-stabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.74 MCO Contract: Exhibit M-2— 2.1.83	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* Page 2, Section 4 This contains the regulatory definition of post-stabilization care. *I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: This contains the regulatory definition of post-stabilization care services. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 15, Section – Emergency Services This explains that post-stabilization care to Members, including that these are covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B-2—14.5.6.2.2 MCO Contract: Exhibit M-2— 14.2.1.2.1	**Both RAE and Prime:** *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) Page 1, Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The claims manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph 3(b): This describes that RMHP covers emergency department services by participating and non-participating practitioners and providers. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(a)(i-iii): This describes that preauthorization is not required in medically urgent/emergent situations. *I_UM_Program Description_2019-2020* Page 21, Prospective Review Process Objectives: This states that urgent and emergent services do not require prospective review and all emergency room claims are paid without review through the normal claims payment processes. *2019 Provider Manual* Page 32, Section Access to Care, Paragraph 2:	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This describes that RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 7, Section – Doctors that do not work with RMHP: This informs Members that the requirement for obtaining care from doctors that work with RMHP does not apply to emergency care.	
26. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services.	**Both RAE and Prime:** *I_UM_Emergency Department Services Claim Review Policy* Page 1, Policy (a): This describes that appropriateness of services is assumed based on Prudent Layperson definition. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(a-b): This describes that RMHP will not deny treatment to a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(c)(1)(ii) RAE Contract: Exhibit B-2—14.5.6.2.6 MCO Contract: Exhibit M-2— 14.2.1.2.1.2	• Serious dysfunction of any bodily organ or part. RMHP will not deny treatment if a representative of RMHP instructed the Member to seek emergency services. *2019 Provider Manual* Page 80, Section – Definition of Emergent Care, Paragraph 2: This defines emergent care and describes that RMHP will not deny payment for treatment obtained under the circumstances described in the regulation and contract. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Pages 12, Section – When to use the emergency room: This informs Members about when to use the emergency room, explains the prudent layperson standard, and provides examples of when a person should go to the emergency room. Page 15, Section – Emergency Services: This informs Members that emergency services are covered.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR 438.114(d)(1)* RAE Contract: Exhibit B-2—14.5.7.2.8 MCO Contract: Exhibit M-2— 14.2.1.2.1.3, 14.2.1.4.1	**Both RAE and Prime:** *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph (3)(a).: This states that RMHP makes payment for all emergency department services at a claim processer level without medical necessity review. Appropriateness of services is assumed based on Prudent Layperson definition. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(c-d): This describes that RMHP will not limit what constitutes an emergency based on a list of diagnoses or symptoms. RMHP will not refuse to cover emergency services based upon failure of the emergency room provider, hospital, or fiscal agent to notify the Member's primary care provider or RMHP of the Member's screening and treatment within 10 calendar days of presentation for emergency services. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) Page 1, Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services. The claims manual states that emergency services are allowed (paid for) when rendered in an urgent care facility or in the emergency room. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* RAE Contract: Exhibit B-2—14.5.6.2.9 MCO Contract: Exhibit M-2— 14.2.1.2.1.4	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(e): This describes that RMHP will not hold a Member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) Page 1, Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services. The claims manual states that emergency services are allowed (paid for) when rendered in an urgent care facility or in the emergency room. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 15, Section – Emergency Services: This defines "emergency services" to include services necessary to evaluate, (i.e., screen) and stabilize the Member. It is further explained that RMHP will provide the medically necessary covered care and services needed to the Member to continue to get better, referred to as "post-stabilization". Page 37, Copayment Table: This informs Members that they have no copayment for emergency services provided in an emergency room.	
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* RAE Contract: Exhibit B-2—14.5.6.2.10 MCO Contract: Exhibit M-2— 14.2.1.2.1.5	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(f): This describes that RMHP allows the attending emergency physician, or the provider actually treating the Member, to be responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on RMHP who is responsible for coverage and payment. *2019 Provider Manual* Page 32, Section – Access to Care: This describes that the attending emergency physician or provider actually treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. **RAE-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: *RMHP Prime Member Handbook* Page 15, Section – Emergency Services: This informs Members that the Member's doctor will decide when the Member receiving emergency services is ready for transfer or discharge.	
30. The Contractor is financially responsible for post-stabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* RAE Contract: Exhibit B-2—14.5.6.2.11 MCO Contract: Exhibit M-2— 14.2.1.2.1.6	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 1: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have been pre-approved (prior authorized) by RMHP or its representative. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 10: This describes that RMHP is financially responsible for post-stabilization services that are prior authorized by an in-network provider or RMHP representative, regardless of whether they are provided within or outside of RMHP's network of providers. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further post-stabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* RAE Contract: Exhibit B-2—14.5.6.2.12 MCO Contract: Exhibit M-2— 14.2.1.2.1.7	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 2: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have not been pre-approved (prior authorized) by RMHP or its representative. *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 13(a): This describes that RMHP is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if: RMHP does not respond to a request for pre-approval within 1 hour. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* RAE Contract: Exhibit B-2—14.5.6.2.12 MCO Contract: Exhibit M-2— 14.2.1.2.1.7	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 3: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have not been pre-approved by RMHP or its representative under all of the circumstances set forth in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 13(a-c): This describes that RMHP is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if: RMHP does not respond to a request for pre-approval within 1 hour, RMHP cannot be contacted, or RMHP's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, RMHP gives the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the Member until a plan provider is reached.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
33. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* RAE Contract: Exhibit B-2—14.5.6.2.14 MCO Contract: Exhibit M-2— 14.2.1.2.1.8	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 3(c): This describes that RMHP's financial responsibility for post-stabilization services it has not pre-approved ends when any of the four situations occur as stated in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 13(d)(i-iv): This describes that RMHP's financial responsibility for post-stabilization care services it has not pre-approved ends when: a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care, or the Member is discharged. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. If the member receives post-stabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* RAE Contract: Exhibit B-2—14.5.6.2.13 MCO Contract: Exhibit M-2— 14.2.1.2.1.7.4	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* Page 2, Section 6.0, Paragraph D: This describes that Member liability is limited to an amount no greater than what RMHP would charge the Member if he or she had obtained the services through RMHP. *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 11: This describes that if a Member receives post-stabilization services from a provider outside RMHP's network, RMHP does not charge the Member more than he or she would be charged if he or she had obtained services through an in-network provider. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 16, Section - Emergency Services: This describes that Member costs for post-stabilization care rendered by a non-RMHP provider will be no more than what the Member would have paid if treated by a RMHP provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

RAE Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	27	X	1.00	=	27
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	27
Total Score ÷ Total Applicable						=	90%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE maintains and monitors a PCMP and BH network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Adult mental health providers • Pediatric mental health providers • SUD providers • Psychiatrists • Child psychiatrists • Psychiatric prescribers • Family planning providers The MCO maintains a and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Family planning providers • Gerontologists • Internal medicine providers • Physician specialists	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* Pages 18-23, Provider Type Counts: The Network Adequacy Plan is an annual contract deliverable to the Department that describes how the provider network is maintained, monitored, and incentivized to provide adequate access to quality services for RAE and Prime Members. *II_ R1NetworkRptQ1FY1920.xls* The Network Report is a quarterly contract deliverable to the Department for network adequacy reporting. This is the spreadsheet component of the report. See BehavioralHealthProviders_Tab1 and BehavioralHealthProviders_Tab2 for child psychiatrist and psychiatric prescriber data. *2019 Provider Manual* Page 94, Provider Rights and Responsibilities: This describes that RMHP recommends that providers have a policy and/or procedure that documents how they ensure effective communication with Members with limited English proficiency. It also urges provider's offices and/or facilities to accommodate people with disabilities and/or special health care needs. **RAE-specific:** *II_2020 RAE Provider Directory*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.206(b)(1) RAE Contract: Exhibit B-2—9.5.1.1, 9.5.1.3 MCO Contract: Exhibit M-2— 9.4.1.1, 9.4.1.3.	This illustrates providers who are able to serve Members with limited English proficiency as well as if they are handicap accessible. **Prime-specific:** *II_ R1NetworkRptQ1FY1920.xls* We report on Prime specialists on the *PhysHealthProvs_PrimeSPC* tabs. This includes gerontologists or internal medicine providers. *II_2019 Prime Provider Directory* This illustrates providers who are able to serve Members with limited English proficiency as well as if they are handicap accessible.	
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language.	**Both RAE and Prime:** *II_PNM_2017&2018 Availability of Practitioner Analysis* Pages 5-12, RAE/Prime data and analysis. This document uses data from GeoAccess reports to monitor network adequacy to ensure that providers are sufficient in number and accessibility based on current regulatory standards for distance and Member/Provider ratios for all provider networks. In addition this document describes the ability and option to utilize telemedicine. **Bullet #1:** *II_R1NetworkAdequacyPlnFY19-20* Page 15, Process for Monitoring and Assuring Network Sufficiency:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* RAE Contract: Exhibit B-2—9.1.4, 9.1.5, 9.1.7.1, 9.5.1.2, 9.5.1.4-6 MCO Contract: Exhibit M-2— 9.4.1.1-6, 9.4.1.9	This describes that RMHP considers anticipated Medicaid enrollment. **Bullet #2:** *II_R1NetworkAdequacyPlnFY19-20* Page 16: This describes the expected utilization of services, by taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the RMHP's service area. **Bullet #3:** *II_ R1NetworkRptQ1FY1920.xls* [Throughout report] This demonstrates the numbers, types, and specialties of network providers required to furnish the contracted Medicaid services. **Bullet #4:** *II_ R1NetworkRptQ1FY1920.xls* See the "Summary" tab for the number of network providers accepting/not accepting new Medicaid Members. *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to Providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and provide relevant information to Members. **The tools ask providers to report whether they are accepting new Medicaid Members.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_PNM_Provider Directory Screenshot Examples RAE* *II_PNM_Provider Directory Screenshot Examples Prime* Pages 1- 3: These screenshots from the RMHP online provider directory indicate whether a provider is accepting new Members. *II_CDPE_2020 RAE Resource Guide* Pages 44-48, Tier Demonstration Criteria: This details expectations of practices by Tier as it relates to Medicaid access within the PCMP office. Higher Tier practices must be completely open to Medicaid patients. This document is geared toward RAE PCMPs which includes CHP and Prime providers. **Bullet #5:** *II_CI_Oct2019_RAE_PRIME_BH_GeoAccess* [Throughout report] This demonstrates the geographic location of behavioral health providers in relationship to where Medicaid Members live, considering	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	distance, travel time, and means of transportation used by Members. *II_CI_Oct2019_RAE_PRIME_PH_GeoAccess* [Throughout report] This demonstrates the geographic location of physical health providers in relationship to where Medicaid Members live, considering distance, travel time, and means of transportation used by Members. **Bullet #6:** *II_R1NetworkAdequacyPlnFY19-20* Page 27, Members with Limited English Proficiency and Illiteracy: This describes that RMHP has identified providers with the capability to communicate with Members who have limited-English-proficiency or in their preferred language. *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The tools ask providers to report their Language Capabilities for Member communication needs.**	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_PNM_Provider Directory Screenshot Examples RAE* *II_PNM_Provider Directory Screenshot Examples Prime* Pages 7 – 9: These screenshots from the RMHP online provider directory demonstrate that RMHP informs Members of the types of languages spoken by the provider and/or staff. *II_PNM_2018 RMHP Provider Language Analysis* See pages 2-3 and 6 for Medicaid (RAE & Prime combined) data and analysis. This document uses data from GeoAccess reports to monitor providers' ability to accommodate the linguistic needs and preferences of Members. **Bullet #7:** *II_R1NetworkAdequacyPlnFY19-20* Page 28, Members Living with Physical Disabilities or Needing Reasonable Accommodation: This describes the ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Members with physical or mental disabilities.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool: The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tool include provider's ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Members with physical disabilities.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_PNM_Provider Directory Screenshot Examples RAE* *II_PNM_Provider Directory Screenshot Examples Prime* Pages 4 – 6: These screenshots from the RMHP online provider directory demonstrate that RMHP informs Members of the accessibility of a provider's office for people with physical disabilities. *2019 Provider Manual* Page 94, Provider Rights and Responsibilities: This demonstrates that RMHP urges providers to ensure that their offices and/or facilities are able to	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	accommodate people with disabilities and/or special health care needs. **Bullet #8:** *II_R1NetworkAdequacyPlnFY19-20* Page 16, Access to Care: This describes the Network Advisory Committee recommendations for providers to utilize telemedicine when travel is difficult or prohibited for the Member. *II_R1NetworkRptQ1FY1920.doc* Pages 4-5: This describes the availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *II_CDPE_RAE Resource Guide* Page 29, CareNow: Virtual Care Platform: This describes RMHP's virtual care program that allows Members to connect to a doctor or therapist through their computer or mobile device. CareNow is available at no cost to RMHP RAE, Prime and CHP+ Members *II_CI_CareNow Webpage* This document contains a link to and screenshot of the CareNow webpage on RMHP.org. This webpage informs Members about how CareNow can be used as an alternative to health care visits.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: See above **Prime-specific:** See above	
3. The Contractor ensures that its RAE and MCO PCMP provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes The MCO provider network also complies with the following additional time and distances standards: • Specialists—adult and pediatric: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals:	**Both RAE and Prime:** *II_CI_Oct2019_RAE_PRIME_PH_GeoAccess* The physical health (PH) Geo Access report evaluates the availability of physical health providers in the network by examining time and distance standards. Includes: Adult Primary Care Providers, Pediatric Primary Care Providers, and OBGYN Providers. *2019 Provider Manual* Pages 27 -28: Informs providers of the RAE and Prime network time and distance standards. *2020 Provider Manual* Pages 27 -28: Informs providers of the RAE & Prime network time and distance standards. *II_PNM_P&P Practitioner Availability and Accessibility* This P&P describes how RMHP maintains an effective organizational process for monitoring network adequacy, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* RAE Contract: Exhibit B-2—9.4.7 MCO Contract: Exhibit M-2—9.3.8	*II_PNM_2017&2018 Availability of Practitioner Analysis* Pages 6-9, This report shows the provider to Member ratio and distance/drive time RAE and Prime requirements for: adult primary care, pediatrics, OB/GYN and other various specialties. **RAE-specific:** N/A **Prime-specific:** *II_CI_Oct2019_RAE_PRIME_PH_GeoAccess* The physical health (PH) Geo Access report evaluates the availability of physical health providers in the network by examining time and distance standards. Includes: Prime Adult Specialists and Prime Pediatric Specialists.	
4. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes	**Both RAE and Prime:** See below. **RAE-specific:** *II_CI_Oct2019_RAE_PRIME_BH_GeoAccess* The behavioral health (BH) Geo Access report evaluates the availability of behavioral health providers in the network by examining time and distance standards. Includes: Adult Mental Health Providers, Pediatric Mental Health Providers, Adult	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Mental health providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B2—9.4.10.1)* *42 CFR 438.206(a); 438.68(b)* RAE Contract: Exhibit B-2—9.4.9 MCO Contract: Exhibit M-2— 9.3.8	Psych Prescriber Providers, Pediatric Psych Prescriber Providers, and Substance Use Disorder Providers *2019 Provider Manual* Pages 27-28: This informs providers of the RAE and Prime Member/Provider ratios as well as time and distance standards. *II_PNM_P&P Practitioner Availability and Accessibility* This P&P describes how RMHP maintains an effective organizational process for monitoring network adequacy, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues. *II_PNM_2017&2018 Availability of Practitioner Analysis* Page 10-11: This shows the provider to Member ratio and distance/drive time RAE and Prime requirements for psychiatry and marriage and family therapy.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* RAE Contract: Exhibit B-2—9.2.7 MCO Contract: Exhibit M-2— 9.2.8.3.2	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* Page 17, Women's Health: This describes direct access for women's health within the network. *2019 Provider Manual* Page 66, Paragraph 4: This describes how RMHP provides female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services and is in addition to the Member's designated source of primary care if that source is not a women's health care specialist. *II_CM_P&P_Direct Access for OBGYN Care* This policy describes that RMHP provides for a female Member to have direct access to a contracting obstetrician or gynecologist (OB/GYN) for her reproductive and gynecological care, and that the OB/GYN may serve as the woman's primary care provider. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 8, Care for pregnancy and other health care for women: This describes direct access within the network for women's health care.	
6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* RAE Contract: Exhibit B-2—9.7.6 MCO Contract: Exhibit M-2— 9.3.13	**Both RAE and Prime:** *II_CM_Second Opinions_Out-of-Network Services* Page 1, Policy: This explains that RMHP provides for a second opinion from an in-network provider or arranges for the Member to obtain a second opinion outside the network at no cost to the Member. *2019 Provider Manual* Page 109, RMHP Prime and CHP+ Members: This shows that RMHP covers one second opinion per medical condition without a referral. *2020 Provider Manual* Pages 108-109, Section – It is your right, Bullet 11: This informs providers that Members can get a second opinion with no referral and at no cost to the Member. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 21 Second Opinion: This informs Members that second opinions are covered without copayment and explains how to obtain one.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 37 Copayment Chart: This informs Members that second opinions are covered without copayment.	
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* RAE Contract: Exhibit B-2—14.6.1.1 MCO Contract: Exhibit M-2— 9.3.10	**Both RAE and Prime:** *2019 Provider Manual* Page 67, Out-of-Network/Out-of-Plan Services: This informs providers of out-of-network/out-of-plan services available to Members in a timely manner at the in-network benefit level. *II_CM_Second Opinions_Out-of-Network Services* Page 2, Services Not Available in Network This explains that if the RMHP network is unable to provide necessary covered services, RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. **RAE-specific:** N/A **Prime-specific:** *II_R1NetworkAdequacyPlnFY19-20* Pages 14-15, Out-of-Network/Out-of-Plan Services: This explains that if the RMHP network is unable to provide necessary covered services, RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* RAE Contract: Exhibit B-2—14.7.11.1 MCO Contract: Exhibit M-2— None	**Both RAE and Prime:** *2019 Provider Manual* Page 67, Out-of-Network/Out-of-Plan Services: This informs providers that out-of-network/out-of-plan services are available to members at the in-network benefit level. *II_CM_Second Opinions_Out-of-Network Services* Page 2, Services Not Available in Network: This explains that RMHP will coordinate payment with out-of-network providers to ensure that the cost to the Member is no greater than it would be if the services were furnished in-network. **RAE-specific:** N/A **Prime-specific:** *II_R1NetworkAdequacyPlnFY19-20* Page 14, Out-of-Network/Out-of-Plan Services: This describes how Members may receive out-of-network services upon approval, at the in-network benefit level.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* RAE Contract: Exhibit B-2— 9.5.1.1, 9.5.1.3.10	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* Pages 18 and 23, Provider Type tables: This demonstrates that the RMHP RAE and Prime networks include family planning participating providers that ensure timely access to covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
MCO Contract: Exhibit M-2— 9.4.1.3.4	**RAE-specific:** N/A **Prime-specific:** N/A	
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care (RAE only): – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request. • Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. (RAE only) *42 CFR 438.206(c)(1)(i)* RAE Contract: Exhibit B1—9.4.13 MCO Contract: Exhibit M-2— 9.3.9.1	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* Pages 25-27: This describes Emergency BH care, urgent care and non-urgent care standards information. Page 18, Paragraph 2: This describes that Members may not be placed on waiting lists for initial routine services. *2019 Provider Manual* Pages 30-31, RAE Appointment Wait Time Standards: This lists the RAE and Prime Appointment Wait Time Standards that demonstrate RMHP's guidelines and standards around emergency behavioral care, urgent care, non-urgent symptomatic care, well care visits within 30 days after the request, outpatient follow up appointments, and explains that Members will not be placed on waiting lists for initial routine services. *2020 Provider Manual* Pages 30-31, RAE Appointment Wait Time Standards: This lists the RAE and Prime appointment wait time requirements that include specifics for behavioral	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	health services and explains that Members may not be placed on waiting lists for initial routine behavioral health Services. *II_PNM_Revised Appointment Availability Analysis 2019* This report describes RMHP access to service and wait time standards. It reviews how Member surveys are sent annually to ensure that appointment availability is sufficient. RMHP is considering conducting these surveys quarterly in 2020. Pages 23-24, Qualitative Analysis: This describes the results from the Member survey relating to the standards for timely access to care and services. **RAE-specific:** N/A **Prime-specific:** N/A	
11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care.	**Both RAE and Prime:** **Bullet #1:** *2019 Provider Manual* Page 66, Paragraph 1, RMHP Prime/CHP+ Members: This informs providers that they may not limit their hours of operation in a manner which is less than is offered to Members of non-publicly-financed programs.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.206(c)(1)(ii) RAE Contract: Exhibit B-2—9.4.2–9.4.4 MCO Contract: Exhibit M-2— 9.3.2-9.3.4	*2020 Provider Manual* Page 66: This section describes that RMHP highly recommends providers to have minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. *II_PNM_Physicians Medical Services Agreement* Pages 5-6, Section A, Medical Services to Covered Persons: This states that providers arranges such time provisions required by any Health Care Plan which is offered by RME to covered persons in the service area. (Due to the numerous lines of business we offer we must write the agreements in general terms to meet all contractual obligations.) Page 15, Section DD, Non-discrimination – Publicly Finance Programs: This provider contract template describes that providers may not discriminate against any covered person enrolled in a publicly financed program, including limiting the hours of operation. **Bullet #2:** *II_R1NetworkAdequacyPlnFY19-20* Page 23: This shows the count of providers offering after-hours and weekend appointment availability *II_R1NetworkRptQ1FY1920.xls* All tabs have identification of providers offering after-hours appointment availability information.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tools include Appointment Availability questions for extended hours on evenings and weekends.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. **Bullet #3:** *II_R1NetworkRptQ1FY1920.doc* Pages 3-4, CareNow information: CareNow is a no-cost, chat-based program that allows RMHP RAE, Prime and CHP+ Members to message, send photos, or video chat with a doctor or therapist anywhere the Internet can be accessed. *II_CI_CareNow Webpage* This document contains a link to and screenshot of the CareNow webpage on RMHP.org. CareNow can be used by Members as an alternative to emergency department visits for after-hours urgent care. *II_CDPE_RAE Resource Guide* Page 29, CareNow: Virtual Care Platform:	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This describes RMHP's virtual care program that allows Members to connect to a doctor or therapist through their computer or mobile device. CareNow is available at no cost to RMHP RAE, Prime and CHP+ Members. *II_PNM_Spring_Summer Provider Newsletter 2019* Page 8: This includes news about CareNow, a tool that can be used by RAE, Prime and CHP+ Members as an alternative to emergency department visits for after-hours urgent care. **RAE-specific:** N/A **Prime-specific:** *See Above*	
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* RAE Contract: Exhibit B-2—9.4.6 MCO Contract: Exhibit M-2— 9.3.7	**Both RAE and Prime:** *II_PNM_Physicians Medical Services Agreement* Page 15, Section AA - 24-Hour Coverage: This describes the requirement for providers to provide or arrange for 24-hour coverage for emergency medical services. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* RAE Contract: Exhibit B-2—9.5.1.8 MCO Contract: Exhibit M-2— 9.4.1.8	**Both RAE and Prime:** *II_PNM_P&P Appointment Availability Surveys* This P&P describes how RMHP maintains an effective organizational process for monitoring appointment scheduling and wait times, through the use of member surveys, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues if applicable. *II_PNM_Patient Appointment Wait Time Survey* The Appointment Wait Time Surveys are sent annually to Members as a mechanism to ensure compliance with access by network providers, which includes behavioral health providers (prescribing and non-prescribing); primary care providers; and specialists (high-volume & high-impact). *2019 Provider Manual* Page 23, Access to Care: This describes how RMHP maintains quality standards to identify, evaluate, and remedy problems relating to access of care. It also identifies RMHPs targets (goals) for Member/provider ratios, time and distance drive time standards as well as appointment wait time standards. *II_CDPE_2020 RAE Resource Guide* Pages 44-48, Tier Demonstration Criteria, Supporting Documentation/Assessment:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This details expectations of practices by Tier as it relates to Medicaid access within the PCMP practice. Higher Tier practices must be completely open to Medicaid patients. Practices must show empanelment and continuity of care for Members within their care teams. Practices must regularly deliver care in alternative formats to meet the needs of the patient population. This also describes assessment criteria related to follow up appointment standards for hospital and emergency room discharges. This document also describes the Value Based Contracting Review Committee (VBCRC) process for evaluating providers participating in RMHPs Tiering Program. This document refers to RAE PCMPs which includes CHP and Prime providers. *II_CPDE_VBCRC Charter* Page 1: The Value Based Contracting Review Committee (VBCRC) Charter details the aim, scope and general structure of the committee that evaluates practices in value based contracts with RMHP for compliance with contractual expectations and requirements. This committee evaluates practices in Tiers 1, 2, & 3. *II_CPDE_VBCRC Process* Page 2 – 4: This details how the Value Based Contracting Review Committee (VBCRC) evaluates practices in value based contracts with RMHP as it relates to contractual	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	expectations and requirements. Specifically, this document details the frequency of review as well as how practices are notified if there is failure to comply with any requirements and a corrective action plan is implemented. *II_CDPE_RAE PCMP Tiering & Attribution Analysis* This analysis demonstrates that 116/198 (59%) of RAE PCMPs and 40/56 (71%) of Prime PCMPs are evaluated within the VBCRC process for the Value Based Payment Tiering Program. This accounts for 76% of the attributed RAE Member population and 90% of the attributed Prime Member population. *II_CI_Region 1 BH Focus Group Report* This is the final report from the behavioral health focus groups that RMHP conducted throughout the region in Spring 2019, in partnership with the Colorado Cross-Disability Coalition. Focus group participants, made up of both providers and clients, reported their experiences with access to care/network gaps. Follow-up community meetings were held to discuss the report findings and next steps in Fall 2019. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* RAE Contract: Exhibit B-2—7.2.1–7.2.6 MCO Contract: Exhibit M-2— 7.2.1-7.2.6	**Both RAE and Prime:** The following documents illustrate that RMHP delivers services to Members in a culturally competent manner to all Members. *COMBINED_1557Notice_ MLIS (Medicaid CHP+)* RMHP's notice of nondiscrimination provides for meaningful access and effective communication and includes protections for those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. *II_CM_CM & UM Communication Policy and Procedure* Page 1 – 2: This describes RMHP's commitment to meaningful and effective communication. *II_CM_Culturally Sensitive Services* This P&P describes RMHP's care management approach to addressing culturally sensitive and diverse Member populations, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. **Bullet #1:** *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tools include Staff Training elements.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_CM_CM & UM Communication Policy and Procedure* Page 2: This describes that RMHP ensures written materials that are critical to obtaining services are available in prevalent non-English languages. ***Bullet #2:*** *2019 Provider Manual* Page 107: This describes cultural competency and provides direction to providers about where and how to complete cultural competency training. *II_CI_Culturally Responsive Care Online Resources for Providers* This screenshot lists the links to Culturally Responsive Care resources on the RMHP.org website that providers can access for further training.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CI_R1PracSupportFY19-20 Page 9: This describes Disability Competent Care trainings that RMHP offers to providers. *II_QI_RMHP 2018 Annual Cultural and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of Members and the actions RMHP takes to meet those needs. Page 8: This includes information about staff training that addresses special needs, cultural competency and health disparities as well as diversity and inclusion training. *II_CI_Disability Competent Care Training Slides for MFHC 04-30-19* This is the slide deck for the Disability Competent Care training that Julie Reiskin with the Colorado Cross-Disability Coalition provided on RMHP's behalf to Mountain Family Health Centers (MFHC) providers on 4/30/19. These trainings are available to RMHP providers upon request and asking the question about training on the Provider Attributes Survey prompted MFHC's request. *II_CI_Disability Competent Care Training for MFHC 04-30-19_Evaluations* These are the evaluation forms from MFHC providers for the Disability Competent Care training that Julie	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Reiskin with the Colorado Cross-Disability Coalition provided on RMHP's behalf to Mountain Family Health Centers providers on 4/30/19. ***Bullet #2:*** *II_CPDE_Cultural and Generational Communication Presentation* The Practice Transformation team at RMHP hosted an Advanced Practice Learning Collaborative in November 2019 which included a presentation on Cultural and Generational Communication. Over 100 participants from PCMP's across Region 1 attended. ***Bullet #3:*** *II_CM_Culturally Sensitive Services* Page 3, Section 5.0, Paragraph 4: This demonstrates that RMHP Care Management staff participate in efforts to identify Members whose cultural norms and practices may affect their access to health care. These efforts include health education or newsletter articles. *II_CM_Cultural and Linguistic Assessment* This document reflects RMHP's approach to identify Members who have cultural norms and practices that may affect their access to healthcare. *II_QI_RMHP 2018 Annual Cultural and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Members and the actions RMHP takes to meet those needs. Page 11, Analysis: This describes RMHP's response related to cultural norms and practices that were found to impact Member's access to care. ***Bullet #4:*** *II_CM_CM & UM Communication Policy and Procedure* Pages 4 – 5: This describes translation, interpreter, and auxiliary services that RMHP has available to communicate with members. *II_CM_Culturally Sensitive Services* Page 3, Section 5.0, Paragraph 1: This explains how RMHP facilitates culturally and linguistically appropriate care and outreach to members with diverse cultural and ethnic backgrounds for prevention, health education and treatment for diseases prevalent to those groups. *II_QI_RMHP 2018 Annual Cultural and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of Members and the actions RMHP takes to meet those needs. Page 1:	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This describes that RMHP offers language assistance services in over 200 languages through interpretation and translation vendors. *II_CDPE_2020 RAE Resource Guide* Page 29, Supplemental Resources for Patient Care, Rural Interpreting Service Project (RISP): This describes the availability for providers to use RISP services when providing care to Members who are deaf, hard of hearing, or deafblind in rural areas at no cost. *II_PNM_Spring Provider Newsletter* Page 4: The newsletter provides information about the Rural Interpreting Services Project (RISP), a free resource for providers who may need language assistance services for deaf, hard of hearing or deafblind patients. **RAE-specific:** N/A **Prime-specific:** See Above	
15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* RAE Contract: Exhibit B-2—9.1.4.5, 9.1.7.1, 9.5.1.2	**Both RAE and Prime:** *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
MCO Contract: Exhibit M-2—9.1.5.5, 9.4.1.2	asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tools include a provider's ability to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical disabilities.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_PNM_ Standards for Practitioner Office Sites* This P&P describes how RMHP maintains an effective organizational process for monitoring the quality and safety of clinical care and services provided to Members. **RAE-specific:** N/A **Prime-specific:** See above	
16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Adequacy Report is submitted to the State quarterly.	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* This annual report provides an overview of RMHP's RAE and Prime Provider Network and Access Plan. It is submitted annually to the Department of Health Care Policy and Finance. *II_R1NetworkRtpQ1FY1920.xls* *II_ R1NetworkRptQ1FY1920.doc*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.207(b) RAE Contract: Exhibit B-2—9.5.1–9.5.4 MCO Contract: Exhibit M-2— 9.4.1-9.4.4	This quarterly report is 2 parts; a quantitative report in an Excel spreadsheet and a narrative report in a Word document. This comprehensive report provides Member/Provider ratios and time and distance reporting according to contract standards and is submitted to the Department quarterly. **RAE-specific:** N/A **Prime-specific:** N/A	

RAE Results for Standard II—Access and Availability							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	16	**Total Score**		=	16
Total Score ÷ Total Applicable						=	100%

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* RAE Contract: Exhibit B2—8.1 MCO Contract: Exhibit M-2— 8.1 10 CCR 2505-10—8.209.1	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *VI_CS_Notice of Appeal Resolution* *VI_CS_Process for Accepting Appeal or Grievance* The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service.	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 16, Section VII, Paragraph A-G: This defines "Adverse Benefit Determination." **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities). *42 CFR 438.400(b)* RAE Contract: Exhibit B2—2.1.3 MCO Contract: Exhibit M-2— 2.1.3 10 CCR 2505-10—8.209.2.A		
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* RAE Contract: Exhibit B2—2.1.5 MCO Contract: Exhibit M-2— 2.1.5 10 CCR 2505-10—8.209.2.B	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 16, Section VI: This defines "appeal" as a review by RMHP of an adverse benefit determination. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* Contract: Exhibit B2—2.1.42, 8.6.6.2 MCO Contract: Exhibit M-2— 2.1.47, 8.6.6.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.(i)	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 15-16, Section V: *VI_CS_Grievance Policy and Procedure* Page 6, Section 5.0 - Definitions: In both documents, grievance is defined as a verbal or written expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to quality of care or services provided, aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by RMHP to make an authorization decision. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).* *42 CFR 438.402(c)* RAE Contract: Exhibit B2—8.5.1, 8.5.3, 8.7.1, 8.7.15.1, 8.7.5 MCO Contract: Exhibit M-2— 8.5.1, 8.7.5, 8.7.15.1,	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 3.0, Paragraph III: This indicates that a Member or their designated representative may file grievances. Page 2, Section 4.0, Paragraph IV: This states that RMHP must obtain authorization in writing from the Member or his/her designated client representative (DCR), including a treating health care professional, to represent his or her interests related to grievances. *VI_CS_Appeals Policy and Procedure* Page 2, Section I, Paragraph C: This indicates that procedures for authorized representatives to appeal on a Member's behalf are outlined in the "Designation of Representatives" Process. Page 11-12, Section XI: This states that the Member or their DCR may request a State Fair Hearing. *VI_CS_Process Designation of Representatives* Page 1, Section 3.0, Paragraph 2: This states that a Member, or a designated client representative acting on behalf of a Member with the Member's written consent, or the legal representative of a deceased Member's estate, may file a grievance, a health plan-level appeal, and may request a State Fair hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-free numbers that have adequate TTY/TDD and interpreter capability. *42 CFR 438.406(a)* RAE Contract: Exhibit B2—8.3 MCO Contract: Exhibit M-2— 8.3 10 CCR 2505-10 8.209.4.C	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 1-2, Section 4.0, Subsection I, Paragraph B: This explains how RMHP assists Members in completing any forms required, putting verbal requests, including requests for a State fair hearing, into writing and taking other procedural steps. *VI_CS_Grievance Policy and Procedure* Page 2, Section 4.0, General Information paragraph: This explains how RMHP assists Members with completing any forms or completing other procedural steps. *COMBINED_1557Notice_MLIS (Medicaid CHP+) Tagline and Notice of Nondiscrimination* This document is sent with all significant Member communications, including with all appeals and grievances Member mailings. Page 1: The Notice of Nondiscrimination states that RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge, including auxiliary aids and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	services, free language assistance services, qualified interpreters and more. **RAE-specific:** N/A **Prime-specific:** N/A	
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* RAE Contract: Exhibit B2—8.5.4, 8.7.4 MCO Contract: Exhibit M-2— 8.5.3, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 4, Section IV, Paragraph C: This describes the requirements for the grievances and appeals reviewers/decision-makers. The Medical Director and the clinical consultant must not have been involved in the initial decision or be the subordinate of the medical director involved in the initial review. The reviewer or consultant must have the appropriate clinical expertise in treating the Member's condition or disease. *VI_CS_Grievance Policy and Procedure* Pages 4-5, Section I, Bullet 3: This indicates that RMHP ensures that individuals who make decisions on grievances are individuals who were not involved in any aspect of the circumstances or decision-making that led to the grievance nor a subordinate of any individual who was involved, and have the appropriate clinical expertise in treating the Member's condition or disease.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
Findings: RMHP's *Appeals Policy and Procedure* and *Grievance Policy and Procedure* stated these requirements almost verbatim. While all appeal record reviews confirmed the appeal decision was made by a person with appropriate clinical expertise, one record that involved a grievance about the member's clinical treatment was not reviewed by an RMHP clinician, but rather referred the member back to the treating provider group—subject of the grievance—to resolve the issue.		
Required Actions: RMHP must develop a mechanism to ensure that any grievance regarding treatment by a provider is reviewed and resolved by an RMHP clinician with appropriate clinical expertise in treating the member's condition.		
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* RAE Contract: Exhibit B2—None MCO Contract: Exhibit M-2—None	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 4, Section IV, Paragraph C(4): This states that the individuals who make decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* RAE Contract: Exhibit B2—8.5.3 MCO Contract: Exhibit M-2— 8.5.3 10 CCR 2505-10—8.209.5.D	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 4.0-General Information: This lists the ways that RMHP accepts grievances, both orally and in writing. *VI_CS_Process for Accepting Appeal or Grievance* This document describes the process that Customer Service Representatives follow to accept Member grievances orally by phone. *VI_CS_Complaints and Appeals Routing* Page 2, Section 6.0: This explains how Customer Service Representatives receive grievances by phone or email. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* RAE Contract: Exhibit B2—8.5.3 MCO Contract: Exhibit M-2— 8.5.3 10 CCR 2505-10—8.209.5.A	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 4.0-General Information: States that Members or their designated representative can file grievances at any time. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* RAE Contract: Exhibit B2—8.1 MCO Contract: Exhibit M-2— 8.1 10 CCR 2505-10 8.209.5.B	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 3, Section V: This states that acknowledgment letters are sent to Members within two working days. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1) and (d)(1)* RAE Contract: Exhibit B2—8.5.5, 7.2.7.3, 7.2.7.5 MCO Contract: Exhibit M-2— 8.5.4, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 5, Section I, Paragraph 3: This states that RMHP must respond to a grievance within 15 working days from the date of receipt, or as expeditiously as the Member's health condition requires. Page 3, Section VI: This describes that the reviewer's resolution must be in language that is easily understandable. It must provide a rationale in sufficient detail that may be easily understood by the Member. *VI_CS_ Grievance Resolution Template RAE-PRIME* This template is used to provide notice to the Member of the disposition/resolution of their grievance. They are in a format and include standard language that can be easily understood by Members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. RAE Contract: Exhibit B2—8.1 MCO Contract: Exhibit M-2— 8.1 10 CCR 2505-10 8.209.5.G	**Both RAE and Prime:** *VI_CS_ Grievance Resolution Template RAE-PRIME* This template includes the disposition /resolution process and the date it was completed. **RAE-specific:** N/A **Prime-specific:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The *Grievance Policy and Procedure* and on-site record reviews confirmed the required content of the grievance resolution letter. However, HSAG noted one grievance record in which RMHP's resolution did not address the member's complaint regarding provider treatment and inappropriately referred the member back to the provider to resolve the issue.		
Required Actions: RMHP must develop a mechanism to ensure that each member grievance is thoroughly addressed by RMHP staff members.		
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* RAE Contract: Exhibit B2—None MCO Contract: Exhibit M-2—None	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *VI_CS_Notice of Appeal Resolution*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VI_CS_Process for Accepting Appeal or Grievance The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. The documents indicate that there is only one level of appeal with the health plan for RAE and Prime Members. Members are provided clear instructions about how to request a State Fair Hearing after exhausting RMHP's appeal process, or if RMHP fails to adhere to the required timeframes for processing appeals. **RAE-specific:** N/A **Prime-specific:** N/A	
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* RAE Contract: Exhibit B2—8.7.5.1 MCO Contract: Exhibit M-2— 8.7.5.1 10 CCR 2505 10 8.209.4.B	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* Page 1, Member Appeal Submission: This indicates the 60 calendar day time frame Members have to submit an appeal. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* RAE Contract: Exhibit B2—8.7.5.2 MCO Contract: Exhibit M-2— 8.7.5.2 10 CCR 2505-10 8.209.4.F	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 1, Section I, Paragraph A(4): This indicates that appeals will be accepted verbally. Page 3, Section II, Paragraph A(1): This explains how verbal appeals are acknowledged and describes the process for obtaining a written, signed appeal of an oral request. *VI_ CS_Verbal Appeal Acknowledgment Template* This template explains to Members what RMHP believes to be the reason for the appeal, and indicates that the Member can sign and return the letter if they agree that RMHP understands what they are appealing. This notice also explains that the Member must sign and return the letter. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* RAE Contract: Exhibit B2—8.1, 8.7.2 MCO Contract: Exhibit M-2— 8.1 10 CCR 2505-10 8.209. 4.D	**Both RAE and Prime:** *VI_CS_MD,CHP Timelines* This document indicates the time frame to acknowledge receipt of a standard appeal. *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	These letter templates are used to provide written acknowledgement of verbal and written appeals and are sent within two working days of receipt of standard appeals. **RAE-specific:** N/A **Prime-specific:** N/A	
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* RAE Contract: Exhibit B2—8.7.6, 8.7.7, 8.7.11 MCO Contract: Exhibit M-2— 8.7.6, 8.7.7, 8.7.11 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 3, Section II, Paragraph A: This explains that verbal inquiries are treated as appeals. Page 3, Section II, Paragraph A(1): This describes the procedure for confirming a standard appeal in writing and that written confirmation is not required for an expedited appeal. *VI_CS_Process Designation of Representatives* Page 1, Section 3.0(2): This explains that the Member, the Member's designated representative or the legal representative of a deceased Member's estate are the parties to the appeal. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.) • The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* RAE Contract: Exhibit B2—8.7.8–8.7.10 MCO Contract: Exhibit M-2— 8.7.8-8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 3, Section II.A.2: This explains how RMHP gives Members an opportunity to submit further evidence, including in cases of expedited resolution where time is limited. **RAE-specific:** *VI_Health First Colorado Member Handbook* This handbook, which can be accessed via a link on the RMHP and Health First Colorado websites, provides information regarding the appeals process. **Prime-specific:** *RMHP Prime Member Handbook* Page 39-40, Section – Appeals and Grievances: This describes that Members are informed how they will receive information about how to access their appeal file and that they may provide more information about their appeal to RMHP either in person, by telephone, or in writing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that:	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 5-6, Section V: This describes the expedited review process. Page 6, Section V, Paragraph B(3): This states that punitive action will not be taken against a provider for requesting an expedited appeal or supporting a Member's appeal.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* RAE Contract: Exhibit B2—8.7.14.2.1, 8.7.12 MCO Contract: Exhibit M-2— 8.7.14.2.1, 8.7.12 10 CCR 2505-10 8.209.4.Q-R	*VI_PNM_Physicians Medical Services Agreement* Page 22, Section 7, Paragraph G. Limitations on Adverse Actions: This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. *VI_PNM_Professional Services Agreement* Pages 23-24, Section 7, Paragraph G. Limitations on Adverse Actions: This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. *VI_PNM_Hospital Services Agreement* Page 25, Section 8, Paragraph G. Limitations on Adverse Actions: This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.410(c)* RAE Contract: Exhibit B2—8.7.14.2.2 MCO Contract: Exhibit M-2— 8.7.14.2.2 10 CCR 2505-10 8.209.4.S	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 6, Section V, Paragraph B (1): This describes that if RMHP denies a request for expedited resolution, it will transfer the appeal decision to the standard time frame and will make reasonable efforts to give the Member verbal notice followed by written notice of the denial within two calendar days. *VI_CS_Appeals Policy and Procedure* Page 6, Section V, Paragraph B (4): This describes that the Member has the right to file a grievance if he or she disagrees with the decision not to expedite the appeal. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member.	**Both RAE and Prime:** **Bullet 1 –** *VI_CS_MD,CHP Timelines* This document provides timeframes for appeals process and decisions. **Bullet 2 –** *VI_CS_Appeals Policy and Procedure*	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(b)(2) *42 CFR 438.408(d)(2)* *42 CFR 438.10* RAE Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 MCO Contract: Exhibit M-2— 8.7.14.1, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	Page 5, Section IV, Paragraph D: This describes the content of appeal resolution letters, including that they must be in a format and language that is easily understood by the Member. *VI_CS_Notice of Appeal Resolution* This template provides the standard text contained in a notice of appeal resolution and demonstrates that the content is in a format and language that may be easily understood by the Member. **RAE-specific:** N/A **Prime-specific:** N/A	
Findings: RMHP's *Appeals Policy and Procedures* and associated time frames for notifying the member of appeal resolution accurately addressed these requirements. On-site record reviews demonstrated compliance with the required 10-working day time frame. However, 50 percent of the record reviews included language not easy for the member to understand, largely due to including extensive clinical information excerpted from clinical reviewer criteria in the description of the reason for the appeal decision.		
Required Actions: RMHP must develop a mechanism to ensure that the reason for the appeal decision in appeal resolution letters sent to Medicaid members simplifies the reason for the decision and is written in language at or near the sixth-grade reading level.		
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution.	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* This document describes that the timeframe for resolving an expedited appeal is within 72 hours of receipt. *VI_CS_Appeals Policy and Procedure*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(b)(3) and (d)(2)(ii) RAE Contract: Exhibit B2—8.7.14.2.3, 8.7.14.2.6 MCO Contract: Exhibit M-2— 8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	Page 6, Section V, Paragraph B (2): This describes that RMHP will make reasonable efforts to provide oral notice to the Member of the expedited resolution. **RAE-specific:** N/A **Prime-specific:** N/A	
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* RAE Contract: Exhibit B2—8.7.14.2, 8.7.14.2.4, 8.5.6 MCO Contract: Exhibit M-2— 8.5.6, 8.7.14.2, 8.7.14.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 7-8, Section VI, Paragraph H (1): This explains the circumstances under which RMHP will extend the time frames for resolution of both expedited and standard appeals. *VI_CS_Grievance Policy and Procedure* Page 5, Section I: This explains the circumstances under which RMHP will extend the time frame for resolution of a grievance. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires. *42 CFR 438.408(c)(2)* RAE Contract: Exhibit B2—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 MCO Contract: Exhibit M-2— 8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 7-8, Section VI, Paragraph H (1): This explains that if RMHP extends the time frame, reasonable efforts will be made to give the Member prompt oral notice of the delay and the Member will be given written notice of the reason for the delay within two calendar days, informing the Member that they may file a grievance if they disagree with the decision. Further, this P&P explains that the appeal will be resolved as expeditiously as the Member's health condition requires and no later than the date the extension expires. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request.	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 5, Section IV, Paragraph M: This describes the information that must be included in the notice of appeal resolution. *VI_CS_Notice of Appeal Resolution* This template illustrates that the notices of appeal resolution contains the required language.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* RAE Contract: Exhibit B2—8.7.14.3, 8.7.14.4 MCO Contract: Exhibit M-2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	**RAE-specific:** N/A **Prime-specific:** N/A	
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* RAE Contract: Exhibit B2—8.7.15.1–8.7.15.2 MCO Contract: Exhibit M-2—8.7.15.1-8.7.15.2 10 CCR 2505-10 8.209.4.N and O	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 11-12, Section XI, Paragraph A.: This explains that the Member or their DCR may request a State fair hearing within 120 days from the date of the notice of resolution. The P&P also explains that a Member is deemed to have exhausted the appeal process and may request a State fair hearing if RMHP does not adhere to the notice and timing requirements. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 41, Paragraph 2: Members are informed they may request a State fair hearing within 120 calendar days from the date of the notice of resolution and that if RMHP does not	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	adhere to the notice and timing requirements, the Member may request a State fair hearing.	
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* RAE Contract: Exhibit B2—8.7.15.3 MCO Contract: Exhibit M-2— 8.7.15.3	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section XI, Paragraph D: This explains that RMHP, as well as the Member and his or her representative, participate in the State Fair Hearing. *VI_CS_Process Designation of Representatives* Page 1, Section 3, Paragraph 2: This explains that a representative of a deceased Member's estate is considered a party to a State Fair Hearing. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination.	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section XII: This describes the policy for continuation of benefits during the appeal process. *VI_CS_Notice of Appeal Resolution* Page 2, How to Ask for your Services to Continue During a State Fair Hearing:	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. * *This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.)* *42 CFR 438.420(a) and (b)* RAE Contract: Exhibit B2—8.7.13.1 MCO Contract: Exhibit M-2—8.7.13.1 10 CCR 2505-10 8.209.4.T	This Member notice describes the continuation of benefits policy while RMHP appeal and State fair hearing are pending. **RAE-specific:** N/A **Prime-specific:** N/A	

Findings:
RMHP's *Appeal Policy and Procedure* addressed the circumstances applicable to providing continuation of benefits during an appeal or SFH, although inaccurately stated that the member must file the *appeal* within 10 days of the NABD (the member must request *continuation of benefits* within 10 days but may still file appeal up to 60 days following the NABD). In addition, the policy defined that a criterion for requesting continued benefits during an SFH included "the original period covered by the original authorization has not expired." This criterion applies only to requesting continuation of benefits during an appeal, not an SFH (in the case of a SFH, the member must have previously requested that benefits be continued during the appeal and must again request they be continued during the SFH). These inaccuracies were repeated in the RMHP Prime Member Handbook and the RMHP Provider Manual.

Required Actions:
RMHP must correct the *Appeal Policy and Procedure* and related documents to accurately reflect that the member must request continuation of benefits—not file the appeal—within 10 days after the NABD or within 10 days of the notice of appeal resolution, as applicable. In addition,

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RMHP must revise its documents to clarify that "the original period covered by the original authorization has not expired" does not apply to requesting continued benefits during an SFH.		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* RAE Contract: Exhibit B2—8.7.13.2 MCO Contract: Exhibit M-2— 8.7.13.2 10 CCR 2505-10 8.209.4.U	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section XII, Paragraph F (1-3): This describes how long benefits are continued while an appeal or State Fair Hearing is pending and the events that must occur before benefits can be discontinued. **RAE-specific:** N/A **Prime-specific:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: RMHP's *Appeal Policy and Procedure* addressed each of these circumstances but also included "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue. Whereas this stipulation applies to the ability to initially request continued benefits during an appeal, it is not an applicable criterion once continuation of benefits have been requested by the member.		
Required Actions: RMHP must revise its *Appeal Policy and Procedure* and related documents to remove "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue during an appeal or SFH.		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* RAE Contract: Exhibit B2—8.7.13.3 MCO Contract: Exhibit M-2— 8.7.13.3 10 CCR 2505-10 8.209.4.V	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section XII, Paragraph G (1): This describes the Member's responsibility for the cost of continued services if the appeal decision is adverse to the Member. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* RAE Contract: Exhibit B2—8.7.13.4 MCO Contract: Exhibit M-2— 8.7.13.4 10 CCR 2505-10 8.209.4.W	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 13, Section XII, Paragraph G (3): This describes RMHP's responsibility for effectuating the State hearing decision if it reverses RMHP's decision to deny, limit or delay services that were not furnished while the appeal was pending. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424(b)* RAE Contract: Exhibit B2—8.7.13.5 MCO Contract: Exhibit M-2— 8.7.13.5 10 CCR 2505-10 8.209.4.X	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, XII, Paragraph G (2): This describes that RMHP must pay for services when the State fair hearing officer reverses a decision to deny authorization of services and the Member received the disputed services while the appeal was pending. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed.	**Both RAE and Prime:** **Bullet #1:** *VI_CS_Appeals Policy and Procedure* Page 2, Section I, Paragraph G.: This describes the records of appeals that RMHP maintains. *VI_CS_Grievance Policy and Procedure* Page 4, Section XII: This describes the records of grievances that RMHP maintains. **Bullet #2:** *VI_CI_Quarterly Grievance and Appeals Report Submission*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* RAE Contract: Exhibit B2—8.9.1–8.9.1.6 MCO Contract: Exhibit M-2— 8.9.1-8.9.1.6 10 CCR 2505-10 8.209.3.C	This document shows evidence of quarterly submissions of the Grievance and Appeals report to the Department. **RAE-specific:** N/A **Prime-specific:** N/A	
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member.	**Both RAE and Prime:** *VI_PNM._Physician(s) Medical Services Agreement* Page 12, Section 2, Paragraph T. Expressing Disagreement: Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or requested in written form. Page 12, Section 2, Paragraph S. Compliance, Cooperation and Participation in RME's Policies and Procedures: Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *VI_PNM_Professional Services Agreement* Pages 12-13,Section 2, Paragraph Q. Expressing Disagreement:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.414 *42 CFR 438.10(g)(xi)* RAE Contract: Exhibit B2—8.4 MCO Contract: Exhibit M-2— 8.4 10 CCR 2505-10 8.209.3.B	Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 12, Section 2, Paragraph P. Compliance, Cooperation and Participation in RME's Policies and Procedures: Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *VI_PNM_Hospital Services Agreement* Page 15, Section 2, Paragraph W. Expressing Disagreement: Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 15, Section 2, Paragraph V. Compliance, Cooperation and Participation in RME's Policies and Procedures: Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. **RAE-specific:**	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	N/A **Prime-specific:** *2019 Provider Manual* Pages 53-55, Appeals and Grievances: This describes the Appeals and Grievances process for Prime.	

RAE Results for Standard VI—Grievances and Appeals							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	5	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	30
Total Score ÷ Total Applicable						=	86%

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Denials Record Review Tool
for Rocky Mountain Health Plans RAE and Prime

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 3, 2020
Reviewer:	Erika Bowman, BA, CPC
Participating Plan Staff Member(s):	Sandy Dowd, Matthew Cook, Jan Valencia, Tiffany Kikta, Amber Davis, Christy Hunt, Zach Kareus, and Lisa Nelson

Requirements	File 1	File 2	File 3	File 4	File 5
Member ID	****	****	****	****	****
Date of initial request	01/22/19	2/7/19	2/21/19	4/15/19	05/24/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	CL	NR	NR
(Standard [S], Expedited [E], or Retrospective [R])	E	S	R	E	S
Date notice of adverse benefit determination (NABD) sent	1/23/19	2/13/19	3/5/19	4/16/19	5/24/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	1	6	NA	1	0
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	M	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	M	M	M	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M	NA	M	M
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	M	M	M	M	M
Total Applicable Elements	**6**	**6**	**5**	**6**	**6**
Total Met Elements	**6**	**6**	**5**	**6**	**6**
Score (Number Met / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**100%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Requirements	File 6	File 7	File 8	File 9	File 10
Member ID	****	****	****	****	****
Date of initial request	1/24/19	3/7/19	4/23/19	5/24/19	5/13/19
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	CL
(Standard [S], Expedited [E], or Retrospective [R])	E	E	S	S	R
Date notice of adverse benefit determination (NABD) sent	1/28/19	3/8/19	4/26/19	5/28/19	6/1/19
Notice sent to provider and member? (M or NM)*	M	M	M	M	M
Number of days for decision/notice	4	1	3	4	NA
Notice sent within required time frame? (M or NM) (S = 10 Cal days after; E = 72 hours after; T = 10 Cal days before)*	NM	M	M	M	M
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (M, NM, or NA)*	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (M, NM, or NA)*	NA	NA	NA	NA	NA
NABD includes required content? (M or NM)*	M	M	M	M	M
Authorization decision made by qualified clinician? (M, NM, or NA)*	M	M	M	M	NA
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (M, NM, or NA)*	NA	NA	NA	NA	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (M or NM)*	M	M	M	M	M
Was correspondence with the member easy to understand? (M or NM)*	M	NM	NM	NM	M
Total Applicable Elements	**6**	**6**	**6**	**6**	**5**
Total Met Elements	**5**	**5**	**5**	**5**	**5**
Score (Number Met / Number Applicable) = %	**83%**	**83%**	**83%**	**83%**	**100%**

***** = Reference Denial Record Review Instructions for Corresponding Requirement in Compliance Monitoring Tool
M = Met, **NM** = Not Met, **NA** = Not Applicable, **Cal** = Calendar, **Y** = Yes, **N** = No (Yes and No = not scored—informational only)

**** = Redacted Member ID

Comments:

File 6: This was a new expedited service request. RMHP did not send the Prime NABD within the required time frame of 72 hours. Notice was sent in four days.

File 7: This was a new service request. RMHP's NABD incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the authorization denial. The language content used in the NABD sent to the member would not be easy to understand.

File 8: This was a new service request. RMHP's NABD incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the authorization denial. The language content used in the NABD sent to the member would not be easy to understand.

File 9: This was a new service request. RMHP's NABD incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the authorization denial. The language content used in the NABD sent to the member would not be easy to understand.

Total Record Review Score*	Total Applicable Elements: 58	Total Met Elements: 54	Total Record Review Score: 93%

* Only requirements with an "*" in the tool were used to calculate the score. The total record review score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Rocky Mountain Health Plans RAE and Prime

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 3, 2020
Reviewer:	Kathy Bartilotta
Participating Health Plan Staff Member(s):	Marci O'Gara, Rhonda Michaelson, Sue Baker, James Schneider

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	OMIT	M ☐ N ☐ N/A ☐			M ☐ N ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐	M ☐ N ☐ N/A ☐
Comments: This was not a member grievance. It was a provider complaint about a fee-for-service (FFS) payment. This record was omitted.										
2	****	3/11/19	M ☐ N ☐ N/A ☒	3/13/19	2w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: This member was complaining about denial of Medicaid eligibility. Resolution letter was sent on 3/13/19; no acknowledgement letter was required. The member was referred to the county Department of Human Services with contact information. The grievance was not clinical.										
3	****	4/2/19	M ☐ N ☐ N/A ☒	4/4/19	2w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: The member was complaining about no receipt of ID card from the Department. Resolution letter was sent on 4/4/19; no acknowledgement letter was required. The grievance was not clinical.										
4	****	5/15/19	M ☐ N ☐ N/A ☒	5/16/19	1w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Resolution letter was sent on 5/16/19; no acknowledgement letter was required. Member complained that provider billed RMHP too much for services. The grievance was not clinical.										
5	****	6/29/19	M ☒ N ☐ N/A ☐	7/16/19	12w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Acknowledgement sent 6/28/19. Member complained about receiving bills from provider. RMHP contacted provider and informed member that billing would be discontinued by provider. The grievance was not clinical.										
6	****	9/11/19	M ☒ N ☐ N/A ☐	9/13/19	2w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Both an acknowledgement and a resolution letter were sent on 9/13/19. Member was complaining about clinical care. Per policy, customer service (CS) staff members automatically send clinical complaints to the quality peer review committee for resolution. Resolution letter informed member that the complaint was sent to quality review and that results of the peer review process were confidential.										
7	****	9/28/19	M ☒ N ☐ N/A ☐	10/1/19	1w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Both an acknowledgement and a resolution letter were sent on 10/1/19. Member was complaining about clinical care. Per policy, CS staff members automatically send clinical complaints to the quality peer review committee for resolution. Resolution letter informed member that the complaint was sent to quality review and that results of the peer review process were confidential.										

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Grievance Record Review Tool
for Rocky Mountain Health Plans RAE and Prime

1	2	3	4	5	6	7	8	9	10	11
File #	Member ID #	Date Grievance Received	Acknowledgement Sent Within 2 Working Days	Date of Written Disposition	# of Days to Notice	Resolved and Notice Sent in Time Frame*	Decision Maker Not Previous Level	Appropriate Level of Expertise (If Clinical)	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
8	****	10/16/19	M ☒ N ☐ N/A ☐	10/18/19	2w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Both an acknowledgement and a resolution letter were sent on 10/18/19. The member was complaining about no receipt of ID card from the Department. The grievance was not clinical.										
9	****	11/6/19	M ☒ N ☐ N/A ☐	11/8/19	2w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☒ N/A ☐	M ☐ N ☒ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Both an acknowledgement and a resolution letter were sent on 11/8/19. The member was complaining about verbally abusive treatment by the behavioral health clinician. The RMHP resolution letter directed the member back to the therapist provider group to resolve the problem, which did not address the member's concern and also inappropriately referred the member back to the person that was the subject of the grievance. As this was a clinical concern, the grievance should have been reviewed by an RMHP clinician.										
10	****	12/10/19	M ☒ N ☐ N/A ☐	12/12/19	2w	M ☒ N ☐	M ☒ N ☐ N/A ☐	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Both an acknowledgement and a resolution letter were sent on 12/12/19. The member was dissatisfied because his or her clinician had left the Department's FFS network. The resolution letter explained the provider's choice of contracting with the provider network and offered to assist the member with finding another provider. The grievance was not clinical.										
OS 1	****	2/15/19	M ☐ N ☐ N/A ☒	12/19/19	4w	M ☒ N ☐	M ☐ N ☐ N/A ☒	M ☐ N ☐ N/A ☒	M ☒ N ☐ N/A ☐	M ☒ N ☐ N/A ☐
Comments: Resolution letter was sent on 12/19/19; no acknowledgement letter was required. The member was confused about RMHP's multiple plans (i.e., lines of business). The CS staff member explained the multiple plans to the member. There was no previous decision-maker. The grievance was not clinical.										
Do not score shaded columns below.										
Column Subtotal of Applicable Elements			**6**			**10**	**9**	**3**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**6**			**10**	**9**	**2**	**9**	**10**
Percent Compliant (Divide Met by Applicable)			**100%**			**100%**	**100%**	**67%**	**90%**	**100%**

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

Total Applicable Elements	**48**
Total Compliant (Met) Elements	**46**
Total Percent Compliant	**96%**

* Grievance timeline for resolution and notice sent is 15 working days (unless extended).
**Grievance resolution letter required content includes (1) results of the disposition/resolution process and (2) the date the disposition/resolution process was completed.
**** = Redacted Member ID

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2019–2020 Appeals Record Review Tool
for Rocky Mountain Health Plans RAE and Prime

Review Period:	January 1, 2019–December 31, 2019
Date of Review:	March 3, 2020; March 4, 2020
Reviewer:	Kathy Bartilotta, Gina Stepuncik
Participating Health Plan Staff Member(s):	Marci O'Gara, Rhonda Michaelson, Sue Baker, Nacole Johnson, James Schneider

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
1	****	7/10/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	7/30/19	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: While the original appeal request was received 7/10/19 and acknowledged, a designated representative form was required and was received on 7/16/19 to start the valid appeal processing time frame. The resolution letter was sent 10 working days following receipt of designated representative form. The reason for the appeal decision used the clinical terms "suicidal ideation" and "homicidal ideation" from clinical criteria that would not be easily understood by the member.											
2	****	7/25/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	8/8/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The acknowledgement letter was sent on 7/29/19. This was an appeal of an administrative claim denial for out-of-network services. As the appeal was not based on a clinical reason, no clinical expertise was required in making the appeal decision (scored N/A).											
3	****	7/29/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	8/7/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The acknowledgement letter was sent on 7/31/19. This was an appeal of an administrative claim denial for a non-covered Medicaid benefit. As the appeal was not based on a clinical reason, no clinical expertise was required in making the appeal decision (scored N/A).											
4	****	9/25/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/9/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The acknowledgement letter was sent on 9/27/19. The appeal decision was made by the medical director with consultation from Optum behavioral health expertise. The text description of the reason for the appeal decision was borderline for ease of understanding.											
5	****	9/26/19	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	10/4/19	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: This was an expedited appeal request; no acknowledgement letter was required. The expedited appeal request was denied and the member was notified of denial on 9/27/19. The description of the reason for the appeal decision included extensive clinical information not easy for the member to understand.											
6	****	7/9/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	7/23/19	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The acknowledgement letter was sent on 7/11/19. The description of the reason for the appeal decision included extensive clinical information not easy for the member to understand.											
7	****	7/12/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☐ N ☐ N/A ☒	Yes ☐ No ☒	Yes ☐ No ☒	7/24/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The acknowledgement letter was sent on 7/16/19. This was an appeal of an administrative claim denial. As the appeal was not based on a clinical reason, no clinical expertise was required in making the appeal decision (scored N/A).											

Appendix B. Colorado Department of Health Care Policy and Financing FY 2019–2020 Appeals Record Review Tool for Rocky Mountain Health Plans RAE and Prime

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID #	Date Appeal Received	Acknowledgment Sent Within 2 Working Days	Decision Maker Not Previous Level	Decision Maker Has Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Notice Sent Within Time Frame*	Resolution Letter Includes Required Content**	Resolution Letter Easy to Understand
8	****	7/25/19	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐ N/A ☐	Yes ☒ No ☐	Yes ☐ No ☒	7/26/19	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: This was an expedited appeal; no acknowledgement letter was required. The files were time-stamped to ensure that expedited decisions were made within 72 hours. The resolution letter included language above the sixth-grade reading level.											
9	****	8/6/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	8/27/19	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The acknowledgement letter was sent to the member with the designated representative form. The designated representative form was received on 8/13/19 to start the valid appeal processing time frame. The resolution letter was sent 10 working days following receipt of the designated representative form.											
10	****	8/22/19	M ☒ N ☐ N/A ☐	M ☒ N ☐	M ☒ N ☐ N/A ☐	Yes ☐ No ☒	Yes ☐ No ☒	8/29/19	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: The acknowledgement letter was sent to the member with the designated representative form. The designated representative form was received on 8/27/19 to start the valid appeal processing time frame. The appeal was overturned two days following receipt of the designated representative form. Although the appeal resolution approved the requested service, the resolution letter included the State fair hearing information, which would be confusing to the member.											
Do not score shaded columns below.											
Column Subtotal of Applicable Elements			**8**	**10**	**7**				**10**	**10**	**10**
Column Subtotal of Compliant (Met) Elements			**8**	**10**	**7**				**10**	**10**	**5**
Percent Compliant (Divide Met by Applicable)			**100%**	**100%**	**100%**				**100%**	**100%**	**50%**

Key: M = Met; N = Not Met
N/A = Not Applicable
Yes; No = Not scored—information only

Total Applicable Elements	**55**
Total Compliant (Met) Elements	**50**
Total Percent Compliant	**91%**

***Appeal resolution letter time frame** does not exceed 10 working days from the day the health plan receives the appeal (unless expedited—three calendar days; or unless extended—+14 calendar days).

****Appeal resolution letter required content** includes (1) the result of the resolution process; (2) the date the resolution was completed; (3) if the appeal is not resolved wholly in favor of the member, the right to request a State fair hearing and how to do so; (4) if the appeal is not resolved wholly in favor of the member, the right to request that benefits/services continue while the hearing is pending, and how to make that request.

**** = Redacted Member ID

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2019–2020 site review of **RMHP**.

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

HSAG Review Team	Title
Erika Bowman	Project Manager
Gina Stepuncik	Associate Director
Kathy Bartilotta	Associate Director
Sarah Lambie (telephonic)	Project Manager II
RMHP Participants	**Title**
Amber Davis	Claims Supervisor
Angela Nottingham	Quality Improvement Intervention Developer
Billie Bemis	Clinical Manager, RMHP Optum
Brandee Hewitt	Quality Improvement Specialist
Carol Plock	Executive Director, Health District, Northern Colorado
Carrie Baumann	Projects and Compliance Specialist
Cathy Morehouse	Staff Auditor, Internal Audit
Chelsea Watkins	Clinical Informatics Supervisor, Clinical Program Development
Christy Hunt	Claims Production Manager
Cris Matoush	Regional Crisis System Coordinator
Dale Renzi	Director of Provider Network Management
David Mok-Lamme	Health Information Technology and Data Analytics Director
Elsa Inman	Link Program Coordinator and Hospital Transformation Program (HTP) Lead, Mercy Medical Center
Eve Presler	Care Management, Manager Special Populations and Training
Greg Coren	Western Slope Provider Relations Manager and Provider Network Manager
James Schneider	Supervisor, Customer Service
Jan Valencia	Registered Nurse (RN), Pre-Authorization
Jeremiah Fluke	Prime Contract Manager and Quality Improvement Analyst
Jerry Spomer	Director of Internal Audit, Member Benefit Administration and Member Enrollment and Billing
Jessie Neitzer	Quality, Risk, and Compliance Officer, Montrose Memorial Hospital
Jill Bystol	Quality Assurance Compliance Coordinator

RMHP Participants	Title
Judy Rodriguez	Social Caseworker Manager, Larimer County Department of Human Services (DHS)
Kathryn Jantz	Accountable Health Communities Model Director
Kellee Beckworth	Senior Project Manager, HTP, University of Colorado Health
Kendra Peters	CHP+ Contract Manager and RAE Program Operation Support
Kevin Fitzgerald	Chief Medical Officer
Kila Watkins	Manager, RN Care Management
Kim Brown	Director of Clinical Program Development and Evaluation (CDPE)
Louisa Wren	RAE Health Neighborhood and Community Program Manager
Marci O'Gara	Senior Director of Business Operations
Marjorie Chamenoy	Community Integration, Quality Analyst
Matt Dodson	Director, Archuleta County, DHS
Matthew Cook	Director, Claims Operations
Maura Cameron	Director of Quality Improvement
Meg Taylor	RAE Program Officer, Region 1
Nacole Johnson	Customer Service Process Analyst
Nicole Konkoly	RAE Network Relations Manager
Patrick Gordon	Chief Executive Officer, RMHP
Rhonda Michaelson	Supervisor, Customer Service
Sally Henry	AHCM, Project Coordinator
Sandy Dowd	Director of Care Coordination
Sheila Worth	Medical Strategic Initiatives Administrator
Stephanie Monahan	Executive Director, Northwest Colorado Community Health Partnership
Sue Baker	Manager, Customer Service
Tiffany Kikta	Director, Utilization Management
Tim Sherman	Director, Legal and Regulatory Affairs
Violet Willett	Manager, Care Management Northern Colorado Team
Will Hays	Chief Operating Officer, Hilltop Community
Zach Kareus	Clinical Pharmacist, Pharmacy Department
Department Observers	**Title**
Jeff Jaskunas	CHP+ MCO & SMCN Contract and Program Manager—HCPF
Liana Major	Program Specialist—HCPF
Megan Comer	Program Administrator—HCPF
Russ Kennedy	Quality & Compliance Specialist—HCPF

Appendix D. Corrective Action Plan Template for FY 2019–2020

If applicable, the RAE 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 RAE 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 RAE must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table D-2—FY 2019–2020 Corrective Action Plan for RMHP RAE and Prime

Standard I—Coverage and Authorization of Services—RAE and Prime		
Requirement	**Findings**	**Required Action**
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* RAE Contract: Exhibit B-2—8.6.6, 8.6.8 MCO Contract: Exhibit M-2— 8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	RMHP's *UM Timeliness of UM Decisions* policy described the process and time frames for making standard and expedited authorization decisions. The policy incorrectly identified the time frame for pre-service non-urgent requests as "up to 15 days" from the date of receipt. In addition, the policy did not specify that the time frame is within "calendar days." The denial record reviews identified that one of 10 records was *Not Met* for "decision made within required time frame."	RMHP must correct its *UM Timeliness of UM Decisions* policy to accurately address the 10-calendar-day time frame for making standard authorization decisions. RMHP must also develop a mechanism to ensure that the required time frames are met.

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

Standard I—Coverage and Authorization of Services—RAE and Prime		
Requirement	**Findings**	**Required Action**
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* RAE Contract: Exhibit B-2—8.6.6.1, 8.6.8.1 MCO Contract: Exhibit M-2— 8.6.6.1, 8.6.8.1	RMHP's *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies described the process for requesting an extension and specified the time frame for a determination to be reached. However, the *UM Timeliness of UM Decisions* policy inaccurately stated that the Contractor extension time frame is within "15 days" from the end of the initial authorization time frame or at the request of the member or provider. In addition, neither the *UM Preauthorization of Services* policy nor the *UM Timeliness of UM Decisions* policy indicated "calendar days" in the extension time frame.	RMHP must correct information in its *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies to accurately address the additional "14-calendar day" time frame for extending a standard or expedited authorization decision.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard I—Coverage and Authorization of Services—RAE and Prime		
Requirement	**Findings**	**Required Action**
15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* RAE Contract: Exhibit B-2—8.6.1–8.6.1.4 MCO Contract: Exhibit M-2— 8.6.1-8.6.1.4 10 CCR 2505-10 8.209.4.A.1	RMHP policies and other submitted evidence demonstrated that template NABDs used for UM denials were written in a language easy to understand and informed the member of the availability of the letter in other languages and alternative formats. However, HSAG found three of 10 denial record reviews were *Not Met* for "correspondence with the member was easy to understand." RMHP incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the adverse benefit determination. The language content would be difficult for a member with a limited reading ability to understand.	RMHP must ensure that the NABD in its entirety is written in language that is easy for a member to understand.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals—RAE and Prime		
Requirement	**Findings**	**Required Action**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* RAE Contract: Exhibit B2—8.5.4, 8.7.4 MCO Contract: Exhibit M-2— 8.5.3, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	RMHP's *Appeals Policy and Procedure* and *Grievance Policy and Procedure* stated these requirements almost verbatim. While all appeal record reviews confirmed the appeal decision was made by a person with appropriate clinical expertise, one record that involved a grievance about the member's clinical treatment was not reviewed by an RMHP clinician, but rather referred the member back to the treating provider group—subject of the grievance—to resolve the issue.	RMHP must develop a mechanism to ensure that any grievance regarding treatment by a provider is reviewed and resolved by an RMHP clinician with appropriate clinical expertise in treating the member's condition.

Standard VI—Grievances and Appeals—RAE and Prime		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals—RAE and Prime		
Requirement	**Findings**	**Required Action**
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed. RAE Contract: Exhibit B2—8.1 MCO Contract: Exhibit M-2— 8.1 10 CCR 2505-10 8.209.5.G	The *Grievance Policy and Procedure* and on-site record reviews confirmed the required content of the grievance resolution letter. However, HSAG noted one grievance record in which RMHP's resolution did not address the member's complaint regarding provider treatment and inappropriately referred the member back to the provider to resolve the issue.	RMHP must develop a mechanism to ensure that each member grievance is thoroughly addressed by RMHP staff members.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals—RAE and Prime		
Requirement	**Findings**	**Required Action**
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* RAE Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 MCO Contract: Exhibit M-2— 8.7.14.1, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	RMHP's *Appeals Policy and Procedures* and associated time frames for notifying the member of appeal resolution accurately addressed these requirements. On-site record reviews demonstrated compliance with the required 10-working day time frame. However, 50 percent of the record reviews included language not easy for the member to understand, largely due to including extensive clinical information excerpted from clinical reviewer criteria in the description of the reason for the appeal decision.	RMHP must develop a mechanism to ensure that the reason for the appeal decision in appeal resolution letters sent to Medicaid members simplifies the reason for the decision and is written in language at or near the sixth-grade reading level.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

Standard VI—Grievances and Appeals—RAE and Prime		
Requirement	**Findings**	**Required Action**
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals—RAE and Prime		
Requirement	**Findings**	**Required Action**
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. * *This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for*	RMHP's *Appeal Policy and Procedure* addressed the circumstances applicable to providing continuation of benefits during an appeal or SFH, although inaccurately stated that the member must file the *appeal* within 10 days of the NABD (the member must request *continuation of benefits* within 10 days but may still file appeal up to 60 days following the NABD). In addition, the policy defined that a criterion for requesting continued benefits during an SFH included "the original period covered by the original authorization has not expired." This criterion applies only to requesting continuation of benefits during an appeal, not an SFH (in the case of a SFH, the member must have previously requested that benefits be continued during the appeal and must again request they be continued during the SFH). These inaccuracies were repeated in the RMHP Prime Member Handbook and the RMHP Provider Manual.	RMHP must correct the *Appeal Policy and Procedure* and related documents to accurately reflect that the member must request continuation of benefits—not file the appeal—within 10 days after the NABD or within 10 days of the notice of appeal resolution, as applicable. In addition, RMHP must revise its documents to clarify that "the original period covered by the original authorization has not expired" does not apply to requesting continued benefits during an SFH.

Standard VI—Grievances and Appeals—RAE and Prime		
Requirement	**Findings**	**Required Action**
previously authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* RAE Contract: Exhibit B2—8.7.13.1 MCO Contract: Exhibit M-2—8.7.13.1 10 CCR 2505-10 8.209.4.T		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard VI—Grievances and Appeals—RAE and Prime		
Requirement	**Findings**	**Required Action**
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* RAE Contract: Exhibit B2—8.7.13.2 MCO Contract: Exhibit M-2— 8.7.13.2 10 CCR 2505-10 8.209.4.U	RMHP's *Appeal Policy and Procedure* addressed each of these circumstances but also included "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue. Whereas this stipulation applies to the ability to initially request continued benefits during an appeal, it is not an applicable criterion once continuation of benefits have been requested by the member.	RMHP must revise its *Appeal Policy and Procedure* and related documents to remove "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue during an appeal or SFH.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard VI—Grievances and Appeals—RAE and Prime		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the RAE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the three standards and on-site activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the RAE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The RAEs also submitted lists of denials of authorization of services (denials), grievances, and appeals that occurred between January 1, 2019, and December 31, 2019 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the RAE's key staff members to obtain a complete picture of the RAE's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG reviewed a sample of administrative records to evaluate denials, grievances, and appeals. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with RAE staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2019–2020 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. • HSAG analyzed the findings. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the Department**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the RAE and the Department for review and comment. • HSAG incorporated the RAE's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the RAE and the Department.

Appendix F. Focus Topic Discussion

Overview of FY 2019–2020 Focus Topic Discussion

For the FY 2019–2020 site review process, the Department requested that HSAG conduct open-ended on-site interviews with RAE staff members to gather information on each RAE's experience regarding *Region-specific Initiatives Related to the Health Neighborhood.* Focus topic interviews were designed to obtain a better understanding of the infrastructure and strategies the RAEs have implemented/are implementing to actively build, support, and monitor Health Neighborhood providers, particularly those serving members with complex health needs ("impactable populations"). HSAG collaborated with the Department to develop an interview guide to facilitate discussions and gather similar information from each RAE. Information gathered during the interviews will be analyzed in the FY 2019–2020 RAE Aggregate Report to determine and document statewide trends related to RAE region-specific activities to integrate with and build Health Neighborhoods. This section of the report contains a summary of the focus topic discussion for **RMHP**.

Infrastructure and Strategies

RMHP described its concept of the Health Neighborhood as concentric circles of the continuum of healthcare providers and community organizations, with the core consisting of the primary care and behavioral health providers, surrounded by the Health Neighborhood providers—i.e., hospitals, substance use providers, home health, hospice, pharmacy, specialists, oral health, long-term services and supports (LTSS), crisis system—and further surrounded by community support organizations—i.e., schools, public health agencies, human services agencies, churches, criminal justice entities, Area Agency on Aging, recreational facilities, and other community organizations. Due to the vast geography, diverse populations, and widely varying resources in **RMHP**'s largely rural and mountain RAE region, **RMHP** has adopted a community-based strategy in executing its numerous Health Neighborhood initiatives. **RMHP** considers a community-oriented model essential to success, as local organizations and providers tend to work together to focus on concerns and strategies related to the health of populations in the communities they serve. **RMHP** has generally identified six county-based "communities" within its region—Larimer County Community (eastern slope); Northwest Colorado Community (five-county area bordering Utah and Wyoming); Western Mountain Community (four counties); Mesa County Community (western slope's most populated county); Midwestern Colorado Community (five counties); Southwest Colorado Community (six-county area bordering Utah, Arizona, and New Mexico). From its inception, **RMHP** implemented nine community-based integrated care coordination teams (ICCTs) to be the "boots on the ground" interface with members, providers, and community leadership initiatives throughout the region. Coinciding with implementation of the RAE, **RMHP** developed ongoing region-wide leadership initiatives with Health Neighborhood partners such as: Reunion Health—a collaboration among regional Federally Qualified Health Centers and Community Mental Health Centers (CMHCs) and the RAE to address the unique needs of low-income populations; the Executive Partnership Board Committee—a collaboration of the Department of Human

Services (DHS), Health District of Northern Larimer County, Signal Management Services Organization, hospitals, and the RAE to represent entities other than Reunion Health partners; and the regional Performance Improvement Advisory Committee—a collaboration of members, providers, community organizations, and agencies for diverse community involvement and feedback to the RAE. **RMHP** used a variety of data sources—GeoAccess mapping, member and provider surveys, focus groups, and population health analysis—to identify access to care issues and identify needs of specific subpopulations in the region—e.g., age groups, ethnicity, members with disabilities, members in foster care, members with severe and persistent mental illness (SPMI). These data sources guide both the RAE and collaborative Health Neighborhood partners in improving access issues, including provider network development and administrative processes, care coordination priorities, and benefit expansion needs (e.g., SUD services).

RMHP has both convened and organized Health Neighborhood initiatives as well as joined existing collaborative partnerships throughout the region. **RMHP** participates in multiple Health Neighborhood initiatives simultaneously. Many initiatives are stimulated by stakeholder feedback or stakeholder interests in getting the RAE to support data needs of consortiums or providing expertise or resources for implementation—i.e., care coordination. **RMHP**'s motivation and priority-setting for participation in Health Neighborhood initiatives may be: data-driven (e.g., population health data analysis, key performance indicators (KPIs), utilization data monitoring), politically-driven, partnership-driven (e.g., members, stakeholders, and community input), opportunities for more efficient use of collaborative resources, or grant and contract opportunities that align with regional needs (e.g., Single Entry Point [SEP] contract, Crisis Services contract, Accountable Health Communities, Larimer County "Supported Families, Stronger Communities"). Region 1 Health Neighborhood initiatives are not solely focused on collaboration among providers; many initiatives are driven through stakeholder interests in improving population health through improved access to services that address the social determinants of health (SDOH).

<u>Examples of RAE-stimulated initiatives include:</u>

- Whole Family Care—collaborative of Region 1 pediatric practices
- Child Welfare and Human Services—RAE, Larimer DHS, and Office of Behavioral Health (OBH) implementation of county-level collaboratives to support the Family First Prevention Services Act and Child Mental Health Treatment Act
- Behavioral Health (BH) Focus Groups (members, providers, stakeholders)—conducted region-wide to identify BH access issues
- Latino Initiatives—working with Latino population to better understand barriers to healthcare and social programs
- Accountable Health Communities Model (AHCM)—community-based infrastructure for addressing social needs through social needs screening, care coordination, and community alignment
- CareNow—member access to doctor or therapist through mobile devices
- RecRx—eight contracted recreational facility providers to improve health of members
- Crisis Services contract (Mesa County)—new **RMHP** contract
- SEP contract (Mesa County)—new **RMHP** contract

Examples of established community partnerships in which **RMHP** participates:

- Northwest Colorado Community Health Alliance
- West Mountain Region Health Alliance
- Eagle County Total Health Alliance (Vail Health)
- Yampa Valley Well Being Consortium—northwest Colorado regional health issues
- Southwest Colorado Regional Behavioral Health Coalition—BH needs, training, and workforce development
- Collaborative Management Program and Interagency Oversight Groups—17 organizations addressing high-risk youth
- Hospital Transformation Programs (HTPs)—25 hospitals throughout the region
- Bridging Communication Group—deaf and hard of hearing advocacy; Rural Interpreting Services Pilot
- Stronger Families, Stronger Communities (Larimer County)—preventing child maltreatment and child welfare involvement

Further details on several of these initiatives are described in the sections below.

Improving Access to Specialist Providers

In addition to analysis of Experience of Care and Health Outcomes (ECHO) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[F-1] surveys and RAE network adequacy reports, **RMHP** has used the following sources to garner information regarding access to specialists: BH focus groups; Colorado Health Access Survey; primary care medical provider (PCMP) feedback; care coordinator input; Member Advisory Council input; member appeals and grievances; and quarterly surveys of BH, PCMP, and Prime specialist providers (includes access limits for Medicaid or members with disabilities). While the RAE contracts with BH specialists and **RMHP** Prime contracts with medical specialists (whereby **RMHP** has access to Prime specialist and BH data), all other specialists for RAE members are contracted through the Department and the Department maintains the utilization data applicable to specialists. Therefore, **RMHP** works through its PCMPs to impact referrals to specialists and reduce barriers to access. Through **RMHP**'s Practice Transformation Program (PTP), with tiered performance goals and financial incentives for PCMPs, **RMHP** requires that PCMPs establish written care compacts with specialists. In addition, **RMHP** has extended its PTP to pilot a specialty program in which referral management is a priority. However, **RMHP** encourages more face-to-face collaborative processes between primary care and specialist providers as a more effective means to achieve higher-value care compacts. To target access issues identified by PCMPs, **RMHP** cited examples of leveraging relationships between PCMPs and Prime-contracted specialists—specifically St Mary's Hospital neurology practice and gastrointestinal (GI) specialist groups—to improve referrals to select specialty

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

groups that are in limited supply in the region and overwhelmed with referrals. **RMHP** hosted learning collaboratives with specialist attendance to collectively create care agreements specific to managing appropriate referrals to GI and Neurology—including prior interventions that can be implemented in primary care practices. Neurologists educated primary care providers on their headache/migraine referral guidelines. In addition, to reduce the number of no-shows for specialist appointments, care coordinators offer to accompany members to appointments and/or assist members with coordinating non-emergent medical transportation (NEMT), when necessary. Through the CareNow telehealth modality, members may access mental health or physical health practitioners telephonically for assessment and advise and to be connected to ongoing services. Staff members reported that tracking of CareNow usage data shows increasing use of this modality by members; however, due to BH and SUD confidentiality requirements, BH therapists can only share limited information with PCMPs.

While influence over medical specialists is limited by the structure of the RAE, **RMHP** provided several specific examples of monitoring and interventions related to access to BH services:

- Due to significant expansion of the RAE BH independent provider network (IPN), **RMHP** has been tracking overall trends in the number of outpatient psychotherapy visits (compared to the behavioral health organization) and noted a 63.7 percent increase in utilization; in addition, the average number of psychotherapy visits per member within the IPN has increased 37.8 percent. Rise in the overall costs of outpatient services has been offset by a simultaneous decline in BH inpatient costs. Staff members stated that, while these data might indicate a positive response to increased access to needed BH services, the data have also stimulated **RMHP** to further evaluate the question, "How much increased utilization is expected with improved access versus what may be potential overutilization?" To that end, **RMHP** also used data to identify that the number of outpatient therapy visits varied significantly among individual providers and, therefore, recently implemented pre-authorization requirements for 60-minute psychotherapy after 12 visits.
- **RMHP** has also used data to monitor inpatient utilization trends for each of the four regional CMHCs and found that three of the four CMHCs have experienced steadily decreasing inpatient utilization while one CMHC has experienced comparatively higher inpatient trends. Due to the fact that the one CMHC with higher utilization is associated with the new inpatient facility opened in Mesa County, **RMHP** is working with its Reunion Health Partners to further explore and gain understanding of reasons for variations, including the potential impact of increased access to previously unavailable resources to meet pent up demand. Reunion Health partners also attempted to reduce CMHC appointment "no shows," including implementing programs for same-day access to services, which was unsuccessful in reducing member "no-show" rates.
- **RMHP** conducted region-wide focus groups with members, providers, and community stakeholders, which identified access issues related to: availability and timeliness of private provider and CMHC appointments, especially for those with the greatest BH needs; failures of the Medicaid NEMT system; no meaningful connection with the LTSS system for clients with autism and brain injury; ongoing problems with Medicaid eligibility; and on-going use of emergency room care as the provider for BH crisis services. **RMHP** reconvened focus group participants in local communities throughout the region to analyze results and develop interventions. The RAE collaborated with partner organizations to obtain the Crisis Services contract for the region, as well as the SEP

contract. These contracts are anticipated to offer additional opportunities to work with Health Neighborhood providers.

RMHP stated that significant barriers exist to improving RAE member access to specialists in Region 1, including: the overall lack of specialists located in rural areas (most medical specialists in the region are concentrated in Mesa County), and the fact that many specialists are not willing to accept Medicaid members due to insufficient Medicaid reimbursement and corresponding high demand by all payors. Due to limited access to medical specialist utilization data for RAE members, data monitoring and tracking of overall access to medical specialty care is challenging.

Collaborative Initiatives with Hospitals

The State's HTP is **RMHP**'s largest hospital partner initiative. Region 1 has 25 independent hospitals, widely dispersed geographically and many of which are smaller rural facilities. **RMHP** is working with each hospital or small alliances of hospitals to assist in and support hospitals in choosing their Department performance measures and designing initiatives to improve those measures. Staff members stated that some of the larger health systems, such as UCHealth and SCL Health, desire consistency of measures across their hospitals. Hospitals have expressed frustration that the Department's list of optional measures duplicate hospital activities and initiatives that have been in place for some time. Whereas RAE participation and data are required to address some of the HTP measures and initiatives, **RMHP**'s role is to share available data to contribute to improvement in hospitals' performance measures, share in analysis of community needs assessments to drive HTP community partner initiatives, and participate as a partner in those initiatives, where indicated.

Hospitals and the RAE have focused on efforts to consolidate work and take advantage of already completed work. Hospital and RAE care coordinators in local communities have convened to determine how to reduce the burden on care coordinators. Mutual hospital/RAE care coordination strategies include providing hospitals access to **RMHP**'s Essette care management system and providing the RAE care coordinators access to hospitals' Epic electronic record systems to enhance communications and promote shared care planning. Sufficient information technology resources and data-sharing concerns have been barriers in fully implementing this strategy. Centura Hospital in Durango described that the RAE assisted in finalizing HTP performance measures to ensure that measures align with its community needs assessment. Centura Hospital then reached out to additional hospitals in close proximity to understand and identify commonly shared concerns and to determine how to collectively leverage limited resources in the area. To that end, one of the HTP initiatives was to build a collaborative discharge planning process to connect discharged Medicaid members to a RAE local care coordinator to address members' ongoing needs. Staff members stated that this process was not effectively in place prior to the HTP. UCHealth partners described objectives similar to Centura's and described its history of working with the RAE to analyze community health information, identify measures, and involve community partners in initiatives. Anticipated outcomes of HTP collaboration include improved health outcomes for members and reduction in duplication of services. However, all HTP collaborative initiatives are in the implementation or pre-implementation phase and will require time to produce measurable outcomes.

Examples of additional **RMHP** collaborative hospital initiatives include:

- Contracting with Craig Hospital to perform care coordination for complex RAE members.
- Contracting with hospitals to do AHCM screening for SDOH, with the RAE facilitating warm handoff of referrals, workflow training and support, and data feedback. Barriers include motivating hospitals to adopt screening to improve population health through SDOH.
- Facilitating hospital admit, discharge, and transfer data feeds to the RAE and from West Springs BH hospital to PCMPs through the health information exchange (HIE).

Other Health Neighborhood Initiatives

RMHP has modified its care coordination stratification model to align with the Department's definition of "impactable" populations. **RMHP** used RAE and Department claims data to identify members associated with each tier and align members with appropriate interventions as follows:

- Tier One—complex members with over $25,000 in healthcare costs or emerging needs (e.g., medication compliance issues, SUD diagnosis, more than 12 annual ED visits, more than three annual hospitalizations, BH inpatient admission, high SDOH needs), members of special populations (e.g., foster care, high-risk pregnancy, SPMI), and members on Department of Corrections or Colorado Overutilization Program lists. Each individual member in Tier One receives direct outreach by an **RMHP** care coordinator to complete a detailed needs assessment and develop an extended care coordination plan. **RMHP** identified that approximately 7 percent of members are associated with Tier One.
- Tier Two—members with less than $25,000 in costs but flagged for specific chronic conditions or members of special populations (as defined in Tier One) to be managed through "condition management" programs. **RMHP** analyzed member data to identify the most prevalent of these conditions in the RAE population and has developed condition management care programs for the four most prevalent conditions—anxiety disorders, chronic pain, depression, and hypertension—as well as special population groups. Community-based ICCTs manage these programs and align members with appropriate education or care coordination interventions. **RMHP** identified that approximately 30 percent of members are categorized as Tier Two.
- Tier Three—members with low costs and no flag for chronic conditions who are provided prevention supports and resources through **RMHP** mailings or PCMP education. **RMHP** identified that over 60 percent of members align with Tier Three.

RMHP has defined Tier One or Tier Two members as impactable populations. **RMHP** has newly-developed member outreach programs for chronic conditions and special populations and has strategically aligned ICCTs with specific outreach campaigns. In addition, through **RMHP**'s tiered PTP, higher tiered (Tier One or Tier Two) advanced PCMP practices perform care management for members with complex needs and members with designated chronic conditions. **RMHP** reported that approximately 60 percent of members with complex needs and/or need for chronic condition management are attributed to Tier One or Tier Two practices. **RMHP**'s impactable population

stratification data also drive Health Neighborhood initiatives and activities. **RMHP** provided the following examples:

- The DOC initiative in Larimer County places RAE care coordinators on-site at both a DOC halfway house and the county parole office to connect members to providers, services, and needed medications.
- For the SUD population, **RMHP** is supporting an increased number of physicians to receive medication assisted treatment (MAT) training. Care coordinators are meeting with members receiving MAT treatment to thoroughly assess member needs. **RMHP** is sending care coordinators to methadone clinics to connect members with other provider treatments, as needed.
- **RMHP** coordinates wrap-around services for members through Community Centered Boards, SEPs, OBH, and hospital case conferences.

RMHP recently performed analysis of the correlation between utilization and the cost of care for members assessed as needing SDOH services (e.g., housing, transportation, food resources) and found that: transportation needs most consistently drive elevated ED visits, inpatient admissions, and overall costs of care; and food insecurity increases the prevalence of anxiety, depression, or an SUD diagnosis. Outcome measures of impactable population strategies include: comparing cost-of-care and utilization data before and after implementation of condition management or special population programs, HEDIS measures, SDOH cost measures, and monitoring care coordination ratios and resource costs.

RMHP described additional Health Neighborhood initiatives, including:

- Contributing **RMHP** resources to support several housing initiatives for the homeless population, specifically: contracting to provide RAE care coordination for members associated with the Grand Junction Housing Authority, purchasing a home for transitioning members from homelessness to long-term housing, and providing RAE care coordinators to support UnitedHealthcare's "Housing and Health" program.
- Partnering with Latino Initiatives to: gather focus group and key informant interview data to better understand and address barriers to healthcare and social programs in the Latino community, as well as risk factors that impact mental health and substance use; implement the Family Adelante curriculum—risk reduction BH prevention program—in Larimer County; and recruit additional Spanish-speaking providers for the RAE network.
- Partnering with the Collaborative Care Program and Interagency Oversight Groups (State-funded program to address services for youth involved in multiple provider or social systems) to collaborate with 17 organizations through community-based **RMHP** coordinators, provide RAE insight regarding barriers to obtaining services, and contribute care coordination for wraparound services in individual care plans.
- Contracting with the Northwest Colorado Community Health Partnership (NCCHP) to identify and manage population health issues in a five-county area. NCCHP partners with other community organizations that provide food, housing, and transportation to address overriding issues, such as directing resources to develop additional food resources. At the individual member level, each county has employed two care coordinators who work collaboratively with embedded hospital and

other provider care coordinators to arrange services for members. **RMHP** reported that the NCCHP initiative has been very successful.

- Working with the Yampa Valley Well-Being Consortium to strengthen the relationship between Routt and Moffat counties and achieve the following objectives: leverage the limited resources of the area for maximum benefit (e.g., Supplemental Nutrition Assistance Program (SNAP), reduced school lunch programs), increasing member care focused on helping members thrive (e.g., immunizations, well-child care), and creating an environment in which individual community members feel comfortable and safe asking others for assistance (i.e., if eligible for benefits, why not accessing). The consortium has identified that lack of BH resources is a distinct need, and that additional resources and special funding is needed to address the various needs of the area. The RAE is providing data to support the work of the consortium—e.g., Health Resources and Services Administration grant application—and assisting in aligning activities with population health protocols for managing chronic health conditions.

RMHP noted that measures of effectiveness of Health Neighborhood partnerships must be driven by the objectives of each initiative. While the RAE contributes measurable data to support each initiative when possible, outcome measures are multifaceted and often longitudinal—i.e., population health outcomes—and may require extended time to be realized.

What the Department Can Do

RMHP offered the following observations and recommendations pertaining to access to specialty care:

- The Health Neighborhood KPI—care compacts with specialists—is not a valid measure of either Health Neighborhood outcomes or specialty care access. Each RAE must determine with its partners the valid measures of access to care and specific Health Neighborhood initiatives; many outcome measures will require longitudinal and long-term tracking.
- The Department may want to explore mechanisms to stimulate specialists to relocate to certain areas of the State, and/or to increase telehealth options for providing access to specialists in rural or other limited resource areas.
- The Department might consider structuring PCMP and specialist interactions statewide (and reimburse time spent by providers) to share information on alleviating unnecessary referrals.
- The Department might pursue hospital commitments through the HTP to improve Medicaid access to specialists.

RMHP offered the following recommendations related to HTP measures:

- Align hospital measures with potentially avoidable cost measures
- Ensure that RAE and hospital KPIs are focusing on the same targeted outcomes (including BH measures)

RMHP offered the following recommendations pertaining to statewide development of the health infrastructure:

- Design a statewide initiative to break down silos among State agencies including siloed funding, access to data through a shared database, and alignment of financial incentives and inducements among agencies.
- Facilitate focus on SDOH through HIE technology to exchange member social needs information; also enhance HTP objectives to include SDOH.
- Create a statewide priority to enhance sharing of BH and SUD information among RAEs and providers through the HIE.
- Increase discussions on broad BH needs within the State, such as: carefully examine capacity issues and priorities (e.g., beds vs. housing), explore increased funding opportunities, and coordinate with the Governor's BH Task Force to ensure alignment with recommendations of the task force and provide input to ensure task force recommendations are representative of all populations.

COLORADO
Department of Health Care Policy & Financing

Appendix G:
Fiscal Year 2019–2020 Site Review Report
for
Rocky Mountain Health Plans
Region 1 Managed Care Initiative

May 2020

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

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix G: Table of Contents

1. Executive Summary 1-1
Introduction 1-1
Summary of Compliance Results 1-2
Standard I—Coverage and Authorization of Services 1-3
Summary of Strengths and Findings as Evidence of Compliance 1-3
Summary of Findings Resulting in Opportunities for Improvement 1-3
Summary of Required Actions 1-4
Standard II—Access and Availability 1-4
Summary of Strengths and Findings as Evidence of Compliance 1-4
Summary of Findings Resulting in Opportunities for Improvement 1-5
Summary of Required Actions 1-5
Standard VI—Grievances and Appeals 1-6
Summary of Strengths and Findings as Evidence of Compliance 1-6
Summary of Findings Resulting in Opportunities for Improvement 1-7
Summary of Required Actions 1-8

2. Overview and Background 2-1
Overview of FY 2019–2020 Compliance Monitoring Activities 2-1
Compliance Monitoring Site Review Methodology 2-1
Objective of the Site Review 2-2

3. Follow-Up on Prior Year's Corrective Action Plan 3-1
FY 2018–2019 Corrective Action Methodology 3-1
Summary of FY 2018–2019 Required Actions 3-1
Summary of Corrective Action/Document Review 3-1
Summary of Continued Required Actions 3-2

Appendix G1. Compliance Monitoring Tool G-1

1. Executive Summary

Introduction

In accordance with its authority under Colorado Revised Statute 25.5-1-101 et seq. and pursuant to Request for Proposals 2017000265, the Department of Healthcare Policy and Financing (the Department) executed contracts with the Regional Accountable Entities for the Accountable Care Collaborative (ACC) program, effective July 1, 2018. The Regional Accountable Entities (RAEs) are responsible for integrating the administration of physical and behavioral healthcare and will manage networks of fee-for-service primary care providers and capitated behavioral health providers to ensure access to care for Medicaid members. Per the Code of Federal Regulations, Title 42 (42 CFR)—federal Medicaid managed care regulations published May 6, 2016—RAEs qualify as both Primary Care Case Management (PCCM) entities and Prepaid Inpatient Health Plans (PIHPs). In addition, the **Rocky Mountain Health Plans** (**RMHP**) Region 1 RAE contract incorporates into the RAE a limited managed care initiative for capitated physical health services (managed care organization [MCO]), applicable to a designated service area within the region. 42 CFR requires PCCMs, PIHPs, and MCOs to comply with specified provisions of 42 CFR 438—managed care regulations—and requires that states conduct a periodic evaluation of their PCCMs, PIHPs, and MCOs to determine compliance with federal Medicaid managed care regulations published May 6, 2016. The Department has elected to complete this requirement for the RAEs by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the fiscal year (FY) 2019–2020 site review activities for the **RMHP** Region 1 limited managed care initiative—**RMHP Prime**. For each of the three standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the FY 2019–2020 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the FY 2018–2019 site review activities. Appendix G1 contains the compliance monitoring tool for the review of the MCO standards.

Summary of Compliance Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score.

Table 1-1 presents the scores for **RMHP Prime** for each of the standards. Findings for all requirements are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix G1—Compliance Monitoring Tool.

Table 1-1—Summary of MCO Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
I. Coverage and Authorization of Services	34	30	27	3	0	4	90%
II. Access and Availability	16	15	15	0	0	1	100%
VI. Grievances and Appeals	35	35	30	5	0	0	86%
Totals	**85**	**80**	**72**	**8**	**0**	**5**	**90%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements from the standards in the compliance monitoring tool.

Table 1-2 presents the scores for **RMHP RAE** and **RMHP Prime** combined for the denials, grievances, and appeals 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

Record Reviews	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score* (% of Met Elements)
Denials	90	58	54	4	32	93%
Grievances	60	48	46	2	12	96%
Appeals	60	55	50	5	5	91%
Totals	**210**	**161**	**150**	**11**	**49**	**93%**

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

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

RMHP Prime submitted a large body of evidence to substantiate compliance with coverage and authorization of services requirements. **RMHP**'s submission included policies, procedures, reports, work plans, tools, manuals, and sample denial and extension letters. HSAG reviewed all submissions and found that the documents illustrated a thorough and comprehensive approach for the review, authorization, and denial of Prime covered services.

RMHP Prime delegated utilization management (UM) functions for advanced imaging services, genetic testing, and chiropractor services to eviCore healthcare. Policies and procedures addressed **RMHP**'s strategic oversight of all delegated UM activities, including an annual audit and evaluation of all delegated entities and overall performance. The delegation oversight scoring tool and annual oversight report demonstrated monitoring mechanisms and performance compliance for activities such as the initial and continuous prior authorization request process, application of evidence-based criteria, and requesting peer-to-peer review for decisions and review of adverse benefit determinations. Delegated oversight activities also included regular joint operations meetings and required delegate reporting and monitoring of utilization, grievances, and appeals. In instances of substandard performance, **RMHP** had a process to implement a corrective action plan to address and correct areas of concern, including discontinuation of the delegated relationship.

During on-site record reviews, HSAG observed that the notices of adverse benefit determination (NABDs) demonstrated the required content, including the reason for the decision, the member's right to appeal and to request a State review, and the possibility of requesting continued service/benefits pending the resolution of the appeal. **RMHP**'s staff members stated that, in addition to mailing members the NABD, **RMHP** placed a call to each member or the member's designated representative to clearly explain the reason for the adverse benefit determination, to ensure that the decision is clearly understood, and to address any corresponding questions.

RMHP's policies and procedures accurately defined "emergency condition," "emergency services," and "post-stabilization services" consistent with regulatory definitions. In addition, the *Prime Member Benefit Booklet* clearly defined and explained that both emergency care and post-stabilization care services are covered and do not require a prior authorization. **RMHP**'s *Claims Processing Manual* reiterated that services rendered in an urgent care facility or in the emergency room and all associated services are payable at the claim processor level without review for medical necessity.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

RMHP's *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies included inaccurate information regarding required time frames for standard prior authorization decisions, as well as extended time frames. In addition, one of 10 denial record reviews was *Not Met* for "decision made within required time frame." **RMHP** must correct information in its *UM Timeliness of UM Decisions* and *UM Preauthorization of Services* policies to accurately address:

- The 10-calendar day time frame for making standard authorization decisions.
- The 14-calendar day time frame for extending a standard or expedited authorization decision.

RMHP must also develop a mechanism to ensure that the required time frames are met.

RMHP demonstrated that the member letter used for UM denials included all the required content and was available in prevalent non-English languages and alternative formats for persons with special needs. However, three of the denial record reviews demonstrated that **RMHP**'s reason for the adverse benefit determination incorporated clinical criteria directly from the provider prior authorization form, which would be difficult for Medicaid members with limited reading ability to understand. **RMHP** must ensure that the NABD in its entirety is written in language that is easy for a member to understand.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

RMHP submitted a large body of evidence to substantiate compliance with access and availability requirements. **RMHP**'s submission included policies, procedures, reports, analytics, strategic plans, tools, manuals, and directories. HSAG reviewed the submission and found that **RMHP** maintained a network of providers sufficient to cover services to its Prime MCO members. Within its Network Capacity Report, **RMHP** demonstrated the number of primary care and specialist providers available in each county, as well as the ratio of physicians to members living in those respective counties. HSAG reviewed the report and found that, while most primary care and specialist provider types met network adequacy time and distance standards in most areas, **RMHP** had experienced challenges with obstetrician and gynecologist access in some rural and frontier counties. During the on-site interview, **RMHP** discussed these challenges and strategies to improve access; however, for the most part, the providers required to completely meet network adequacy ratios do not exist in these communities. **RMHP** has continued to work to address access ratios that are less than 100 percent. For example, **RMHP** implemented use of telemedicine for urgent care and psychological therapy services. **RMHP** reported that use of its CareNow and provider telemedicine modalities has increased significantly over the short time since implementation and **RMHP** expects this trend to continue.

During the on-site interview, **RMHP** confirmed that members were provided access to women's healthcare specialists and second opinions without a referral, which aligned with **RMHP** policies.

RMHP provided evidence in its 2019 Provider Network Strategic Plan and Access Plan that a sufficient ratio of family planning providers were made available to members. In addition, **RMHP** affirmed that it made out-of-network providers available to members at no cost in situations where there was no qualified provider within the network. **RMHP** stated that eating disorder specialists were the most referred to out-of-network providers.

RMHP had policies in place that outlined the State's standards for timely access. **RMHP** also published timely access standards in its 2019 Provider Manual to ensure providers were aware of the requirements. **RMHP** informed providers in its 2019 Provider Manual that they may not limit their hours of operation in a manner which is less than what is offered to members of non-publicly financed programs. **RMHP** provided evidence of a member survey used to monitor providers for timely access. During 2019, **RMHP** evaluated timely access by administering the survey annually. During the on-site interview, **RMHP** stated that it would be conducting the survey quarterly in order to garner more responses and improve the quality of member reporting by reducing the lag between the member's appointment and the survey.

RMHP provided a robust array of policies on cultural competency. Within its policies, **RMHP** included provisions for how it addressed the needs of those members with limited English proficiency, diverse cultural and ethnic backgrounds, physical or mental disabilities, differing sexual orientation, or gender identity. During the interview, **RMHP** discussed its provider education series, which addressed topics such as "Bridges Out of Poverty" training and cultural and generational communications. A topic planned for the May 2020 provider education series is "Best Practices for Providing Integrated Care Services for Latino Families."

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement for this standard.

Summary of Required Actions

HSAG identified no required actions for this standard.

Standard VI—Grievances and Appeals

NOTE: Federal requirements related to MCO appeals apply to Prime physical health capitated services. Regulations related to grievances apply to all Prime and RAE members. Findings from the combined Prime and RAE on-site record reviews apply to both Prime and the RAE.

Summary of Strengths and Findings as Evidence of Compliance

RMHP maintained comprehensive policies with thoroughly defined procedures for processing both appeals and grievances. Policies and procedures accurately defined "adverse benefit determination," "appeals," and "grievances" per regulatory language and described that a member or his or her designated representative may file a grievance, appeal, or State fair hearing (SFH). **RMHP**'s *Designation of Representative Policy and Procedure* clearly addressed the process of obtaining a designated representative form from the member when needed. Staff members explained that, if a member or his or her representative contacts **RMHP** concerning a grievance or appeal, **RMHP** promptly sends the designated representative form and follows up with the member in 5 days to remind the member of the need for the form. While **RMHP** will begin processing an appeal when verbally requested by a member, receipt of the designated representative form officially begins the time period for processing an appeal. In addition to assisting members with the designated representative process, staff members explained that the most common forms of assistance offered to members included: providing a verbal explanation of the appeal process, reiterating and clarifying what specifically the member is grieving or appealing, assisting with walk-in requests, and explaining the SFH process. **RMHP**'s Customer Service Department is the initial contact point for members filing grievances or appeals, which are documented in the grievance and appeal data system and forwarded to a grievance and appeal (G&A) coordinator for follow-up and resolution. Staff members explained that other organizational points of contact with the member—e.g., care management staff members—have been trained to recognize, capture, and forward member grievance information to G&A staff members. Grievance coordinators ensure that the grievance is resolved and members are notified of resolution within the required time frames. HSAG found on-site grievance record reviews 100 percent compliant with: acknowledgement letter sent within required time frame, resolution letter sent in required time frame (generally one or two working days), resolved by person not previously involved, and resolution letter easy to understand. **RMHP**'s *Appeals Policy and Procedure* and related documents outlined detailed procedures for accepting, documenting, processing, and providing notice to members regarding an appeal and SFH. Associated timelines for notices to members addressed acknowledgements, standard, expedited, and extended appeals, as well as denial of expedited appeal requests, and extension letters to members. Verbal appeals from members were summarized by staff members and sent to the member to obtain a signed written appeal; however, staff members stated that it is frequently difficult to get members to return the signed appeal and that **RMHP** processes all verbal appeals regardless of receipt of a signed appeal. Any additional information received from the member or designated representative to support the appeal is scanned into the system and forwarded to the appeals coordinator. **RMHP**-contracted medical reviewers make decisions on appeals with input from Optum physician advisor services to ensure that appropriate clinical expertise is applied in the decision. Staff members stated that the **RMHP** medical director may override a decision made by an Optum consultant when

local circumstances—i.e., needed level of care or service is not available in the area—are considered. HSAG found on-site appeal record reviews 100 percent compliant with: acknowledgement letter sent within required time frame, resolution letter sent in required time frame, resolved by person not previously involved and with appropriate clinical expertise, and resolution letter includes required content. **RMHP** time-stamped receipt of all appeals and notices to members to ensure that the 72-hour time frame for expedited decisions was met. **RMHP** documented all contract-required information and tracked all grievances and appeals in the Macess software system, including each step in the resolution process. Staff members stated that the G&A staff members manually monitor all time frames daily. **RMHP**'s Provider Manual included extensive information for providers regarding the grievance, appeal, and SFH processes and time frames.

Summary of Findings Resulting in Opportunities for Improvement

While the *Designation of Representative Policy and Procedure* stated that parties to an appeal include the member, the designated representative, or a representative of a deceased member's estate, the *Appeals Policy and Procedure* did not define the parties to an appeal or SFH. HSAG recommends that **RMHP** also include the parties to the appeal in its *Appeals Policy and Procedure.*

While **RMHP**'s professional service agreements list numerous reasons that **RMHP** will not take adverse action against a provider, including assisting members with appeal of a denial of service decision, the provider manual does not clearly specify in the grievance and appeals section that **RMHP** will not take punitive action against a provider for supporting a member's appeal. As the information in the provider service agreements is somewhat obscure, HSAG recommends adding language in the grievance and appeal section of the **RMHP** Provider Manual that clearly states that **RMHP** will not take punitive action against a provider for supporting a member's appeal or requesting an expedited appeal.

HSAG noted that the appeal resolution letter template includes all information pertaining to the member's right to request an SFH and that the template language is used for all appeal resolutions, including those in which the appeal resolution overturns the original adverse benefit determination. Whereas the member's right to an SFH does not apply when the appeal resolution approves the requested service, HSAG suggests that **RMHP** selectively remove the SFH information from appeal resolutions which overturn the original denial, so as not to confuse the member.

RMHP's *Appeals Policy and Procedure* addressed the circumstances for the member to request continued benefits as applicable to both an appeal and an SFH. These circumstances included the criterion "the original period covered by the original authorization has not expired," which applies only to the Contractor level of appeal and not to an SFH. HSAG suggests that **RMHP** consider segregating circumstances for requesting continued benefits during an appeal from the circumstances applicable to an SFH in order to ensure that staff members clearly understand the difference in qualifying criteria. In addition, the criteria for requesting continued benefits include "if the member or designated representative specifically requests extension of services." HSAG cautions that a member's designated representative may be his or her provider, and that a provider may not request continuation of benefits on behalf of the member.

Summary of Required Actions

While all appeal record reviews confirmed the appeal decision was made by a person with appropriate clinical expertise, one record that involved a grievance about a member's clinical treatment was not reviewed by an **RMHP** clinician, but rather referred the member back to the treating provider group—subject of the grievance—to resolve the issue. In addition, the grievance resolution letter did not address the member's specific complaint. **RMHP** must:

- Develop a mechanism to ensure that any grievance regarding treatment by a provider is reviewed and resolved by an **RMHP** clinician with appropriate clinical expertise in treating the member's condition.
- Develop a mechanism to ensure that each member grievance is specifically and thoroughly addressed by **RMHP** staff members.

Appeal record reviews demonstrated that 50 percent of the record reviews included language not easy for the member to understand, largely due to including extensive clinical information excerpted from clinical reviewer criteria in the description of the reason for the appeal decision. **RMHP** must develop a mechanism to ensure that the reason for the appeal decision in appeal resolution letters sent to Medicaid members simplifies the reason for the decision and is written in language at or near the sixth-grade reading level.

RMHP's *Appeal Policy and Procedure* addressed the circumstances applicable to providing continuation of benefits during an appeal or SFH, although inaccurately stated that the member must file the *appeal* within 10 days of the NABD (the member must request *continuation of benefits* within 10 days). In addition, the policy defined that a criterion for requesting continued benefits during an SFH included "the original period covered by the original authorization has not expired." This criterion applies only to requesting continuation of benefits during an appeal, not an SFH. These inaccuracies were repeated in the **RMHP** Prime Member Handbook and the **RMHP** Provider Manual. **RMHP** must correct the *Appeal Policy and Procedure* and related documents to accurately reflect that the member must request continuation of benefits—not file the appeal—within 10 days after the NABD or within 10 days of the notice of appeal resolution, as applicable. In addition, **RMHP** must revise its documents to clarify that "the original period covered by the original authorization has not expired" does not apply to requesting continued benefits during an SFH.

RMHP's *Appeal Policy and Procedure* included "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue during an appeal or SFH. Whereas this stipulation applies to the ability to initially request continued benefits during an appeal, it is not an applicable criterion once continuation of benefits have been requested by the member. **RMHP** must revise its *Appeal Policy and Procedure* and related documents to remove "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue during an appeal or SFH.

2. Overview and Background

Overview of FY 2019–2020 Compliance Monitoring Activities

For the FY 2019–2020 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services; Standard II—Access and Availability; and Standard VI—Grievances and Appeals. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated for the limited managed care initiative (MCO) through review of all three standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met, Partially Met, Not Met, or Not Applicable.* The Department determined that the review period was January 1, 2019, through December 31, 2019. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key RAE and MCO personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to each of denials of authorization, grievances, and appeals. While the RAE and MCO managed care requirements were reviewed simultaneously on-site, HSAG delineated results for each product line into individual separate reports. However, required corrective actions for the MCO are the responsibility of the RAE and are incorporated into Appendix D of the RAE Region 1 report.

HSAG reviewed a sample of the RAE and MCO administrative records related to denials of authorization, grievances, and appeals to evaluate implementation of applicable federal and State healthcare regulations. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records (to the extent that a sufficient number existed) for each of denials, grievances, and appeals. For health plans that were contracted by the Department for administration of both the RAE and MCO for the RAE region, HSAG included five records from each of the RAE and the MCO for a total of 10 records applicable to both the RAE and the MCO. Using a random sampling technique, HSAG selected the samples from all RAE and Prime denial records, all RAE and Prime grievance records, and all RAE and Prime appeal records that occurred between January 1, 2019, and December 31, 2019. For the record review, the health plan received a score of M (*Met*), NM (*Not Met*), or NA (*Not Applicable*) for each required element. HSAG separately calculated a record review score for each record and an overall record review score. Results of record

reviews were considered in the review of applicable requirements in Standard I—Coverage and Authorization of Services and Standard VI—Grievances and Appeals.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] The three standards chosen for the FY 2019–2020 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, Standard X—Quality Assessment and Performance Improvement, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment.

Objective of the Site Review

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

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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 5, 2019.

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

FY 2018–2019 Corrective Action Methodology

As a follow-up to the FY 2018–2019 site review, each MCO 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 MCO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the MCO and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP Prime** until it completed each of the required actions from the FY 2018–2019 compliance monitoring site review.

Summary of FY 2018–2019 Required Actions

For FY 2018–2019, HSAG reviewed Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

Related to member rights and protections, **RMHP Prime** was required to develop provisions for community education regarding advance directives.

Related to member information, **RMHP Prime** was required to:

- Ensure its website is fully readily accessible per Section 508 guidelines.
- Update its provider directories to include whether or not the provider has completed cultural competency training and whether the provider's office has accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.
- Ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 guidelines.

Summary of Corrective Action/Document Review

RMHP Prime submitted a proposed CAP in May 2019. HSAG and the Department reviewed and approved the proposed plan and responded to **RMHP Prime**. **RMHP Prime** submitted initial documents as evidence of completion in September 2019. HSAG and the Department reviewed and approved **RMHP Prime**'s documents submitted as evidence of completion and responded to **RMHP Prime** in October 2019.

Summary of Continued Required Actions

RMHP Prime successfully completed the FY 2018–2019 CAP, resulting in no continued corrective actions.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. *42 CFR 438.210(a)(3)(i)* RAE Contract: Exhibit B-2—14.6.2 MCO Contract: Exhibit M-2—14.4.2	Note: Federal requirements only apply to MCOs and PIHPs (behavioral health services of RAEs) unless otherwise noted. **Both RAE and Prime:** *I_UM_Program Description_2019-2020* Page 3, Section II, Paragraph 2: This describes that RMHP's UM Program is designed to ensure that medical services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the Plan. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 22: This describes that as part of its procedure RMHP ensures that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *2019 Provider Manual* Page 89, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the Member. Further, RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* RAE Contract: Exhibit B-2—14.6.4 MCO Contract: Exhibit M-2—14.4.4	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 6-7, Paragraph 24(a): This states that RMHP does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the Member. *2019 Provider Manual* Page 89, Paragraph 3: This states that RMHP will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness or condition of the Member. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor may place appropriate limits on services— • On the basis of criteria applied under the Medicaid State plan (such as medical necessity). • For the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose.	**Both RAE and Prime:** *I_UM_Clinical Criteria for UM Decisions* Page 1, Purpose: This describes that RMHP applies objective and evidence-based criteria when determining medical appropriateness (necessity) of health care services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.210(a)(4) RAE Contract: Exhibit B-2—14.6.5, 14.6.5.1–2 MCO Contract: Exhibit M-2— 14.4.5, 14.4.5.1-2	*I_UM_Preauthorization Policy & Procedure* Pages 7-8, Paragraph 24(e)(i) & (ii): This describes that RMHP may place appropriate limits on services on the basis of criteria applied under the State (medical necessity) and for the purpose of utilization control, provided that the services furnished can reasonably be expected to achieve their purpose. *2019 Provider Manual* Page 89, Pre-authorization Policies and Procedures: This states that RMHP may place appropriate limits on services so long as the limits allow for the services furnished to reasonably be expected to achieve their purpose and are in accordance with the State plan. **RAE-specific:** N/A **Prime-specific:** N/A	
4. The Contractor may place appropriate limits on services for utilization control, provided that any financial requirement or treatment limitation applied to mental health or substance use disorder (SUD) benefits in any classification is no more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to members (whether or not the benefits are furnished by the same Contractor). *HB19-1269: Section 3–10-16-104(3)(B)*		*For Information Only (RAE)*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-2—14.6.5.2.1 MCO Contract: Exhibit M-2— 14.4.5.2.1		
5. The Contractor must ensure that the diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health (BH) service. *HB19-1269: Section 12—25.5-5-402(3)(h)*		*For Information Only (RAE)*
6. The Contractor covers all medically necessary covered treatments for covered BH diagnoses, regardless of any co-occurring conditions. *HB19-1269: Section 12—25.5-5-402(3)(i)*		*For Information Only (RAE)*
7. The RAE defines medical necessity for services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Is not experimental or investigational.	**Both RAE and Prime:** *I_UM_Program Description_2019-2020* Page 3, Section II: This describes that RMHP's UM Program is designed to ensure that medical services rendered to Members are medically necessary and appropriate, cost-effective, and in conformance with the benefits of the plan. Page 24-25, Section XI: This describes RMHP's use of nationally accepted evidence-based guidelines that span the continuum of care, such as MCG Care Guidelines® and other nationally recognized criteria established by organizations such as the American Academy of Obstetrics, Gynecology or Pediatrics. Use of these criteria ensures that RMHP provides services in accordance with professionally recognized standards for healthcare in the United States.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is not more costly than other equally effective treatment options. *42 CFR 438.210(a)(5)* RAE Contract: Exhibit B-2—2.1.62 MCO Contract: Exhibit M-2— 2.1.69 10 CCR 2505-10 8.076.1.8	*I_UM_Clinical Criteria for UM Decisions* Pages 1-2, Section II: This describes that RMHP applies written, evidence-based criteria to evaluate the medical appropriateness of medical and behavioral healthcare services. Further this states that RMHP clinical policies are sound and based upon analysis of clear, professionally recognized evidence of effectiveness, and are financially responsible. *I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: This provides the definition of "Medical Necessity" that comports with 42 CFR 438.210(a)(5). *2019 Provider Manual* Page 66, Paragraph 2: This describes that a "Medically Necessary" health care good or service will, or is reasonably expected to, prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects, of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. Medical necessity means that a good or service: • Is clinically appropriate in terms of type, frequency, extent, site, and duration; • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Is delivered in the most appropriate setting(s) required by the client's condition; • Is not experimental or investigational; and • Is not more costly than other equally effective treatment options. **RAE-specific:** N/A **Prime-specific:** N/A	
8. The Contractor and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)(1)* RAE Contract: Exhibit B-2—14.8.2 MCO Contract: Exhibit M-2— 14.6.2	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 1, Purpose: This policy addresses the processing of requests for initial and continuing authorization of services. **RAE-specific:** *I_UM_2019_Optum_BH_UM_Program Description_Work Plan* Page 6, Scope of Utilization Management Program: This describes that Optum has a well-structured UM program with a continuum of processes to address requests for initial and continuing authorization of services. **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2019* Page 2, UM 1- Utilization Management Structure: This describes that eviCore has a well-structured UM program with policies that promote utilization decisions	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	affecting the health care of Members in a fair, impartial and consistent manner.	
9. The Contractor and its subcontractors have in place and follow written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR 438.210(b)(2)(i)* RAE Contract: Exhibit B-2—None MCO Contract: Exhibit M-2— None	**Both RAE and Prime:** *I_UM_Clinical Criteria for UM Decisions* This document demonstrates that RMHP applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Pages 5-6, Section VII: This describes how RMHP annually assesses the consistency with which reviewers apply UM criteria in decision making and acts upon opportunities to improve consistency, if applicable. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 24: This provides that the criteria for authorization decisions are applied consistently. **RAE-specific:** *I_UM_2019_Optum_BH_UM_Program Description_Work Plan* Page 32, Clinical Criteria: This demonstrates that Optum uses evidence-based objective criteria that are reviewed at least annually. **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2019*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2, UM 2: Clinical Criteria for Utilization Management Decisions: This demonstrates that eviCore uses evidence-based, objective criteria that are reviewed at least annually.	
10. The Contractor and its subcontractors have in place and follow written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR 438.210(b)(2)(ii)* RAE Contract: Exhibit B-2—14.8.2.5 MCO Contract: Exhibit M-2— 14.6.2.5	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(d)(ii): This describes that RMHP allows discussion with the attending physician, PCP or requesting physician to collect necessary information to make a preauthorization decision. Page 17, Paragraph 35: This describes that RMHP allows a rendering provider to request a peer-to-peer review to discuss an adverse determination. **RAE-specific:** *I_UM_2019_Optum_BH_UM_Program Description_Work Plan* Page 10, Peer Reviewer Determinations and Denials: This describes that Optum will conduct peer review or reconsiderations with a treating physician/practitioner when requested or as applicable for state-specific or contractual requirements. **Prime-specific:** *I_UM_eviCore_Delegation_Oversight_Summary_2019* Page 2, UM 2: Clinical Criteria for Utilization Management Decisions:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This demonstrates that the eviCore policies include assessment of the individual needs of the Member and consideration of the local delivery system. Input from outside physicians/practitioners with specific expertise is considered.	
11. The Contractor ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the member's medical or BH needs. *42 CFR 438.210(b)(3)* RAE Contract: Exhibit B-2—14.6.6 MCO Contract: Exhibit M-2— 14.4.6	**Both RAE and Prime:** *I_UM_Appropriate Professionals for CM and Pharmacy* Page 3, Section III: This describes the process for practitioner review of non-behavioral healthcare denials. Pages 4-5, Section IV: This describes the process for practitioner review of behavioral healthcare denials. Page 5, Section V: This describes the process for use of board-certified consultants in instances where RMHP Clinical Pharmacists and Associate Medical Directors do not have clinical expertise in the areas for which services or pharmaceuticals are being requested. *I_UM_Preauthorization Policy & Procedure* Page 6, Paragraph 23: This describes that UM decisions are made by individuals with the knowledge and skills to evaluate working diagnoses and proposed treatment plans for the Member's medical or behavioral health needs. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor notifies the requesting provider and gives the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *42 CFR 438.210(c)* RAE Contract: Exhibit B-2—8.6.1 MCO Contract: Exhibit M-2— 8.7.13.6 10 CCR 2505-10 8.209.4.A.1	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 15–17, Paragraphs 32-34: This describes the procedures that RMHP has in place to notify Members and requesting providers of decisions to deny or modify service authorization requests which may be completed orally or in writing. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor adheres to the following time frames for making standard and expedited authorization decisions: • For standard authorization decisions—as expeditiously as the member's condition requires and not to exceed 10 calendar days following the receipt of the request for service. • If the provider indicates, or the Contractor determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than 72 hours after receipt of the request for service. *42 CFR 438.210(d)(1–2)* RAE Contract: Exhibit B-2—8.6.6, 8.6.8 MCO Contract: Exhibit M-2— 8.6.6, 8.6.8 10 CCR 2505-10 8.209.4.A.3(c)	**Both RAE and Prime:** **Bullet #1:** *I_UM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Preauth TAT's and Notification Requirements* This document is a grid of regulatory timeframes that RMHP follows for notification of preauthorization decisions. The grid indicates that RMHP provides notice of standard authorization decisions within 10 calendar days. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(d)(i): This sets forth the timing for issuing a notice for a standard authorization decision. It indicates that RMHP	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	will make a determination and notify the covered person and the covered person's provider of the determination within 10 calendar days after the receipt of the preauthorization request. **Bullet #2:** *I_UM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Preauth TAT's and Notification Requirements* This document is a grid of regulatory time frames that RMHP follows for notification of expedited preauthorization decisions. *I_UM_Preauthorization Policy & Procedure* Page 11, Paragraph 31(b): This sets forth the process for issuing a notice for an authorization decision no later than 72 hours after receipt of the request for those instances when the Member's condition requires an expedited decision. **RAE-specific:** N/A **Prime-specific:** N/A	
Findings: RMHP's *UM Timeliness of UM Decisions* policy described the process and time frames for making standard and expedited authorization decisions. The policy incorrectly identified the time frame for pre-service non-urgent requests as "up to 15 days" from the date of receipt. In addition, the policy did not specify that the time frame is within "calendar days." The denial record reviews identified that one of 10 records was *Not Met* for "decision made within required time frame."		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Required Actions: RMHP must correct its *UM Timeliness of UM Decisions* policy to accurately address the 10-calendar day time frame for making standard authorization decisions. RMHP must also develop a mechanism to ensure that the required time frames are met.		
14. The Contractor may extend the time frame for making standard or expedited authorization decisions by up to 14 additional calendar days if: • The member or the provider requests an extension, or • The Contractor justifies a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(i–ii) and (d)(2)(ii)* RAE Contract: Exhibit B-2—8.6.6.1, 8.6.8.1 MCO Contract: Exhibit M-2— 8.6.6.1, 8.6.8.1	**Both RAE and Prime:** *I_UM_Timeliness of UM Decisions* This document demonstrates that RMHP follows regulated timeframes for timeliness of health care UM decisions. *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(d)(iii), Page 14, Paragraph 31(e)(i)(2): This describes the process for extending the standard or expedited authorization timeframe for up to 14 calendar days when the Member requests an extension or RMHP justifies the need for an extension to the State. **RAE-specific:** N/A **Prime-specific:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: RMHP's *UM Timeliness of UM Decisions* and *Utilization Management Preauthorization of Services* policies described the process for requesting an extension and specified the time frame for a determination to be reached. However, the *UM Timeliness of UM Decisions* policy inaccurately stated that the Contractor extension time frame is within "15 days" from the end of the initial authorization time frame or at the request of the member or provider. In addition, neither the *UM Preauthorization of Services* policy nor the UM *Timeliness of UM Decisions* policy indicated "calendar days" in the extension time frame.		
Required Actions: RMHP must correct information in its UM *Timeliness of UM Decisions* and *UM Preauthorization of Services* policies to accurately address the additional "14-calendar day" time frame for extending a standard or expedited authorization decision.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
15. The notice of adverse benefit determination must be written in language easy to understand, available in prevalent non-English languages in the region, and available in alternative formats for persons with special needs. *42 CFR 438.404(a)* *42 CFR 438.10 (c)* RAE Contract: Exhibit B-2—8.6.1–8.6.1.4 MCO Contract: Exhibit M-2— 8.6.1-8.6.1.4 10 CCR 2505-10 8.209.4.A.1	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 15, Paragraph 32(a): This describes that notification will be provided to a Member in writing in a manner calculated to be understood by the Member, and that the notice will be available in English and prevalent non-English languages spoken by Members throughout the State and available in alternative formats for persons with special needs. **RAE-specific:** *I_UM_Sample RAE Only Denial Letter Adult* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_UM_Sample RAE Only Denial Letter Child* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. **Prime-specific:** *I_UM_Sample Denial Letter Adult Medicaid-CHP* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_UM_Sample Denial Letter Child Medicaid-CHP* This medical letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_Pharmacy_Sample Denial Letter Medicaid-CHP*	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10. *I_Pharmacy_Sample QL Denial Letter Medicaid-CHP* This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.10.	
Findings: RMHP policies and other submitted evidence demonstrated that template NABDs used for UM denials were written in a language easy to understand and informed the member of the availability of the letter in other languages and alternative formats. However, HSAG found three of 10 denial record reviews were *Not Met* for "correspondence with the member was easy to understand." RMHP incorporated clinical criteria language directly from its provider prior authorization forms to describe the reason for the adverse benefit determination. The language content would be difficult for a member with a limited reading ability to understand.		
Required Actions: RMHP must ensure that the NABD in its entirety is written in language that is easy for a Medicaid member to understand.		
16. The notice of adverse benefit determination must explain the following: • The adverse benefit determination the Contractor has made or intends to make. • The reasons for the adverse benefit determination, including the right of the member to be provided upon request (and free of charge), reasonable access to and copies of all documents and records relevant to the adverse benefit determination (includes medical necessity criteria and strategies, evidentiary standards, or processes used in setting coverage limits). • The member's right to request one level of appeal with the Contractor and the procedures for doing so. • The date the appeal is due.	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 15-16, Paragraph 32(b)(i-x): This describes the content of notices of action or adverse benefit determination and includes the entire list of regulatory requirements. **RAE-specific:** *I_UM_Sample RAE Only Denial Letter Adult* *I_UM_Sample RAE Only Denial Letter Child* These letter templates demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) **Bullet #1:** Page 1, Paragraph 2 Page 2, Section "How We Made Our Decision"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member's right to request a State fair hearing after receiving an appeal resolution notice from the Contractor that the adverse benefit determination is upheld. • The procedures for exercising the right to request a State fair hearing. • The circumstances under which an appeal process can be expedited and how to make this request. • The member's rights to have benefits/services continue (if applicable) pending the resolution of the appeal, how to request that benefits continue, and the circumstances (consistent with State policy) under which the member may be required to pay the cost of these services. *42 CFR 438.404(b)(1–6)* RAE Contract: Exhibit B-2—8.6.1.5–8.6.1.12 MCO Contract: Exhibit M-2— 8.6.1.5-8.6.1.12 10 CCR 2505-10 8.209.4.A.2	**Bullet #2:** Page 2, Section "How We Made Our Decision" Page 2, Section "Call Us If You Have Questions" **Bullet #3:** Page 2, Section "Call Us If you Have Questions" Page 2, Section "Before You Begin: Know Your Appeal Rights" Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Page 3, Section "How To Ask For An Appeal" Page 5, Section "How To Ask For A Quick Appeal" **Bullet #4:** Page 3, Section "How To Ask For An Appeal" Page 5, Section "How To Ask For A Quick Appeal" **Bullet #5:** Page 2, Section "Before You Begin: Know Your Appeal Rights" Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Page 6, Section "How To Ask For A Formal Hearing" **Bullet #6:** Page 6, Section "How To Ask For A Formal Hearing" **Bullet #7:** Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Page 5, Section "How To Ask For A Quick Appeal" **Bullet #8:** Page 7, Section "Continuing Your Benefits And Services"	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 7, Section "To Continue Receiving Your Benefits and Services During The Appeal, Quick Appeal, Or Formal Hearing Process, You Must:" Pages 7-8, Section "Understanding The Results Of Your Appeal, Quick Appeal, Or Formal Hearing" **Prime-specific:** *I_Pharmacy_Sample Denial Letter Medicaid-CHP* This pharmacy letter template demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) *I_UM_Sample Denial Letter Adult Medicaid-CHP* *I_UM_Sample Denial Letter Child Medicaid-CHP* These letter templates demonstrates that RMHP meets the language and format requirements of 42 CFR 438.404(b) i **Bullet #1:** Page 1, Paragraph 2 Page 2, Section "How We Made Our Decision" **Bullet #2:** Page 2, Section "How We Made Our Decision" Page 2, Section "Call Us If You Have Questions" **Bullet #3:** Page 2, Section "Call Us If You Have Questions" Page 2, Section "Before You Begin: Know Your Appeal Rights" Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Page 3, Section "How To Ask For An Appeal"	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Pages 4-5, Section "How To Ask For A Quick Appeal" **Bullet #4:** Page 3, Section "How To Ask For An Appeal" Pages 4-5, Section "How To Ask For A Quick Appeal" **Bullet #5:** Page 2, Section "Before You Begin: Know Your Appeal Rights" Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Pages 5-6, Section "How To Ask For A Formal Hearing" **Bullet #6:** Pages 5-6, Section "How To Ask For A Formal Hearing" **Bullet #7:** Page 3, Section "Can I Get Help With My Appeal, Quick Appeal, Or Formal Hearing?" Pages 4-5, Section "How To Ask For A Quick Appeal" **Bullet #8:** Page 6, Section "Continuing Your Benefits And Services" Pages 6-7, Section "To Continue Receiving Your Benefits and Services During The Appeal, Quick Appeal, Or Formal Hearing Process, You Must:" Page 7, Section "Understanding The Results Of Your Appeal, Quick Appeal, Or Formal Hearing"	
17. Notice of adverse benefit determination for denial of behavioral, mental health, or SUD benefits includes, in plain language: • A statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which provides that limitations placed on access to mental health and SUD benefits may be no greater than any limitations placed on access to medical and surgical benefits.		*For Information Only (RAE)*

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• A statement providing information about contacting the office of the ombudsman for BH care if the member believes his or her rights under the MHPAEA have been violated. • A statement specifying that members are entitled, upon request to the Contractor and free of charge, to a copy of the medical necessity criteria for any behavioral, mental, and SUD benefit. *HB19-1269: Section 6—10-16-113 (I), (II), and (III)* RAE Contract: None MCO Contract: None		
18. The Contractor mails the notice of adverse benefit determination within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, as defined in 42 CFR 431.211, 431.213 and 431.214 (see below). • For denial of payment, at the time of any denial affecting the claim. • For standard service authorization decisions that deny or limit services, within 10 calendar days following the receipt of the request for service. • For expedited service authorization decisions, within 72 hours after receipt of the request for service. • For extended service authorization decisions, no later than the date the extension expires. • For service authorization decisions not reached within the required time frames, on the date the time frames expire. *42 CFR 438.404(c)*	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 11, Paragraph 31(c)(i-vi): This incorporates the circumstances and timeframes by reference to Section 8.209 of State Medicaid Rules found in 10 CCR 2505-10. **Bullet #1:** Page 3, Paragraph 5: This indicates RMHP must notify the Member at least 10 days before the date of action for termination, suspension, or reduction of previously authorized Medicaid/CHP+-covered services. **Bullet #2:** Page 11, Paragraph 31(c)(ii): This indicates that RMHP provides notices denial of payment at the time of any denial affecting the claim.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B-2—8.6.3.1, 8.6.5–8.6.8 MCO Contract: Exhibit M-2— 8.6.3.1, 8.6.5-8.6.8 10 CCR 2505-10 8.209.4.A.3	**Bullet #3:** Page 12, Paragraph 31(d)(i): This indicates that RMHP will make a determination and notify the covered person and the covered person's provider of the determination within 10 calendar days after the receipt of the preauthorization request. **Bullet #4:** Page 14, Paragraph 31(e)(i): This indicates that RMHP will response to expedited service authorization requests within 72 hours of receipt. **Bullet #5:** Page 13, Paragraph 31(d)(iv)(2)(a): This indicates that RMHP will respond to extended service authorization decisions no later than the extension expiration date. **Bullet #6:** Page 14, Paragraph 31(d)(iv)(2)(d): This indicates that if RMHP fails to make a determination within the required time frame, RMHP will notify the Member of his/her appeal rights on the date the time frame expires. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the Contractor gives notice at least ten (10) days before the intended effective date of the proposed adverse benefit determination except: • The Contractor gives notice on or before the intended effective date of the proposed adverse benefit determination if: – The Agency has factual information confirming the death of a member. – The Agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns Agency mail directed to him/her indicating no forwarding address. – The Agency establishes that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse benefit determination made with regard to the preadmission screening requirements.	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 3, Paragraph 5: This describes that for reduction, suspension, or termination of previously authorized Health First Colorado (Medicaid)/CHP+-covered services, RMHP notifies the Member at least ten (10) days before the intended effective date of the proposed adverse benefit determination (action). **Bullet #1:** *I_UM_Preauthorization Policy & Procedure* Pages 11-12, Paragraph 31(c)(vi)(1): This describes the exceptions for when RMHP provides notice for reduction, suspension, or termination of a previously authorized Medicaid-covered service on or before the intended effective day of the proposed adverse benefit determination. **Bullet #2:** *I_UM_Preauthorization Policy & Procedure* Page 12, Paragraph 31(c)(vi)(2): This describes that if probable Member fraud has been verified, RMHP gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• If probable member fraud has been verified, the Contractor gives notice five (5) calendar days before the intended effective date of the proposed adverse benefit determination. *42 CFR 438.404(c)* *42 CFR 431.211* *42 CFR 431.213* *42 CFR 431.214* RAE Contract: Exhibit B-2—8.6.3.1–8.6.3.2, 8.6.4.1–8.6.4.1.8 MCO Contract: Exhibit M-2— 8.6.3.1-8.6.3.2, 8.6.4.1-8.6.4.1.8 10 CCR 2505-10 8.209.4.A.3 (a)		
20. If the Contractor extends the time frame for standard authorization decisions, it must give the member written notice of the reason for the extension and inform the member of the right to file a grievance if he or she disagrees with that decision. *42 CFR 438.404(c)(4)* RAE Contract: Exhibit B-2—8.6.6.2 MCO Contract: Exhibit M-2— 8.6.6.2 10 CCR 2505-10 8.209.4.A.3 (c)(1)	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Pages 12–13, Paragraph 31(d)(iii): This describes that RMHP may choose to request an extension. If an extension is taken, RMHP sends a written notice of the reason for the extension, which specifically describes the required information necessary to complete the request, gives the Member 14 days from the receipt of the notice to provide the specified information, and gives the Member the right to file a grievance if the Member disagrees with the decision to take the extension. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
21. The Contractor provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* RAE Contract: Exhibit B-2—14.8.6 MCO Contract: Exhibit M-2— 14.6.6	**Both RAE and Prime:** *I_UM_Appropriate Professionals for CM and Pharmacy* Page 5, Section VI: This describes RMHP's Affirmative Statement about Incentives. *I_UM_Program Description_2019-2020* Page 3, Section II: This states that RMHP does not specifically reward practitioners or other individuals for issuing denials of coverage or care and offers no incentives for Pharmacy or UM decision makers to encourage decisions that result in underutilization. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. The Contractor defines emergency medical condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.	**Both RAE and Prime:** *2019 Provider Manual* Page 80, Section – Definition of Emergent Care: Includes the regulatory definition of "emergency medical condition." *I_UM_Emergency Department Services Claim Review Policy* This policy describes that RMHP makes payment for all emergency department services without medical necessity review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(a) Contract: Exhibit B-2—2.1.33 MCO Contract: Exhibit M-2— 2.1.38	*I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: This defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(a)(i-iii): This describes that RMHP will not deny treatment to a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. **RAE-specific:** N/A	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime-specific: *RMHP Prime Member Handbook* Pages 12-13: This informs Members about when to use the emergency room, describing the circumstances contained in the regulatory definition of "emergency medical condition" – in plain language.	
23. The Contractor defines emergency services as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.34 MCO Contract: Exhibit M-2— 2.1.39	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: This defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *2019 Provider Manual* Page 80, Definition of Emergent Care: This illustrates that emergency services means covered inpatient and outpatient services furnished by a provider qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Pages 15-16, Emergency Services: This defines emergency services for Members and informs that services for evaluation and stabilization are covered.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor defines post-stabilization care services as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* Contract: Exhibit B-2—2.1.74 MCO Contract: Exhibit M-2— 2.1.83	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* Page 2, Section 4 This contains the regulatory definition of post-stabilization care. *I_UM_Preauthorization Policy & Procedure* Page 2, Definitions: This contains the regulatory definition of post-stabilization care services. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 15, Section – Emergency Services This explains that post-stabilization care to Members, including that these are covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* Contract: Exhibit B-2—14.5.6.2.2 MCO Contract: Exhibit M-2— 14.2.1.2.1	**Both RAE and Prime:** *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) Page 1, Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services. The claims manual states that RMHP always allows (pays for) services rendered in an urgent care facility or in the emergency room and all associated services. These	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph 3(b): This describes that RMHP covers emergency department services by participating and non-participating practitioners and providers. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(a)(i-iii): This describes that preauthorization is not required in medically urgent/emergent situations. *I_UM_Program Description_2019-2020* Page 21, Prospective Review Process Objectives: This states that urgent and emergent services do not require prospective review and all emergency room claims are paid without review through the normal claims payment processes. *2019 Provider Manual* Page 32, Section Access to Care, Paragraph 2: This describes that RMHP will not deny payment for emergency services if the services were provided by an out-of-network provider.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 7, Section – Doctors that do not work with RMHP: This informs Members that the requirement for obtaining care from doctors that work with RMHP does not apply to emergency care.	
26. The Contractor may not deny payment for treatment obtained under either of the following circumstances: • A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; – Serious impairment to bodily functions; or – Serious dysfunction of any bodily organ or part. *(Note: The Contractor bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR 438.114—Preamble)* • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(1)(ii)* RAE Contract: Exhibit B-2—14.5.6.2.6 MCO Contract: Exhibit M-2— 14.2.1.2.1.2	**Both RAE and Prime:** *I_UM_Emergency Department Services Claim Review Policy* Page 1, Policy (a): This describes that appropriateness of services is assumed based on Prudent Layperson definition. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(a-b): This describes that RMHP will not deny treatment to a Member with an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part. RMHP will not deny treatment if a representative of RMHP instructed the Member to seek emergency services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	2019 Provider Manual Page 80, Section – Definition of Emergent Care, Paragraph 2: This defines emergent care and describes that RMHP will not deny payment for treatment obtained under the circumstances described in the regulation and contract. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Pages 12, Section – When to use the emergency room: This informs Members about when to use the emergency room, explains the prudent layperson standard, and provides examples of when a person should go to the emergency room. Page 15, Section – Emergency Services: This informs Members that emergency services are covered.	
27. The Contractor does not: • Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent failing to notify the member's primary care provider or the Contractor of the member's screening and treatment within 10 calendar days of presentation for emergency services.	**Both RAE and Prime:** *I_UM_Emergency Department Services Claim Review Policy* Page 1, Paragraph (3)(a).: This states that RMHP makes payment for all emergency department services at a claim processer level without medical necessity review. Appropriateness of services is assumed based on Prudent Layperson definition.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.114(d)(1) RAE Contract: Exhibit B-2—14.5.7.2.8 MCO Contract: Exhibit M-2— 14.2.1.2.1.3, 14.2.1.4.1	*I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(c-d): This describes that RMHP will not limit what constitutes an emergency based on a list of diagnoses or symptoms. RMHP will not refuse to cover emergency services based upon failure of the emergency room provider, hospital, or fiscal agent to notify the Member's primary care provider or RMHP of the Member's screening and treatment within 10 calendar days of presentation for emergency services. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) Page 1, Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services. The claims manual states that emergency services are allowed (paid for) when rendered in an urgent care facility or in the emergency room. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* RAE Contract: Exhibit B-2—14.5.6.2.9 MCO Contract: Exhibit M-2— 14.2.1.2.1.4	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(e): This describes that RMHP will not hold a Member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Member. *I_CL_Emergency_Urgent Care_Claims Manual_Screenshot* (available electronically onsite upon request) Page 1, Section 1: Emergency Services Claims Policy, Medical Specialties- Emergency Room, Urgent Care, Professional Services. The claims manual states that emergency services are allowed (paid for) when rendered in an urgent care facility or in the emergency room. These services are deemed urgent or emergent. RMHP allows (pays for) services for follow up care received for said services. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 15, Section – Emergency Services: This defines “emergency services” to include services necessary to evaluate, (i.e., screen) and stabilize the Member. It is further explained that RMHP will provide the medically necessary covered care and services needed	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	to the Member to continue to get better, referred to as "post-stabilization". Page 37, Copayment Table: This informs Members that they have no copayment for emergency services provided in an emergency room.	
29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* RAE Contract: Exhibit B-2—14.5.6.2.10 MCO Contract: Exhibit M-2— 14.2.1.2.1.5	**Both RAE and Prime:** *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 8(f): This describes that RMHP allows the attending emergency physician, or the provider actually treating the Member, to be responsible for determining when the Member is sufficiently stabilized for transfer or discharge, and that determination is binding on RMHP who is responsible for coverage and payment. *2019 Provider Manual* Page 32, Section – Access to Care: This describes that the attending emergency physician or provider actually treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 15, Section – Emergency Services:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This informs Members that the Member's doctor will decide when the Member receiving emergency services is ready for transfer or discharge.	
30. The Contractor is financially responsible for post-stabilization services that are prior authorized by an in-network provider or Contractor representative, regardless of whether they are provided within or outside the Contractor's network of providers. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* RAE Contract: Exhibit B-2—14.5.6.2.11 MCO Contract: Exhibit M-2— 14.2.1.2.1.6	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 1: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have been pre-approved (prior authorized) by RMHP or its representative. *I_UM_Preauthorization Policy & Procedure* Page 4, Paragraph 10: This describes that RMHP is financially responsible for post-stabilization services that are prior authorized by an in-network provider or RMHP representative, regardless of whether they are provided within or outside of RMHP's network of providers. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
31. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within one (1) hour of a request to the organization for pre-approval of further post-stabilization care services. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii)* RAE Contract: Exhibit B-2—14.5.6.2.12 MCO Contract: Exhibit M-2— 14.2.1.2.1.7	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 2: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have not been pre-approved (prior authorized) by RMHP or its representative. *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 13(a): This describes that RMHP is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if: RMHP does not respond to a request for pre-approval within 1 hour. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: • The organization does not respond to a request for pre-approval within 1 hour. • The organization cannot be contacted. • The organization's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in 422.113(c)(3) is met. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iii)* RAE Contract: Exhibit B-2—14.5.6.2.12 MCO Contract: Exhibit M-2— 14.2.1.2.1.7	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 3: This describes that RMHP is financially responsible for post-stabilization services obtained within or outside of the network that have not been pre-approved by RMHP or its representative under all of the circumstances set forth in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 13(a-c): This describes that RMHP is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the Member's stabilized condition if: RMHP does not respond to a request for pre-approval within 1 hour, RMHP cannot be contacted, or RMHP's representative and the treating physician cannot reach an agreement concerning the Member's care and a plan physician is not available for consultation. In this situation, RMHP gives the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the Member until a plan provider is reached.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
33. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care, • A plan physician assumes responsibility for the member's care through transfer, • A plan representative and the treating physician reach an agreement concerning the member's care, or • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(3)* RAE Contract: Exhibit B-2—14.5.6.2.14 MCO Contract: Exhibit M-2— 14.2.1.2.1.8	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* This document defines the circumstances under which RMHP is financially responsible for Post-Stabilization Care Services. Page 1, Section 3.0, Paragraph 3(c): This describes that RMHP's financial responsibility for post-stabilization services it has not pre-approved ends when any of the four situations occur as stated in 42 CFR 438.114(e) and 42 CFR 422.113(c). *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 13(d)(i-iv): This describes that RMHP's financial responsibility for post-stabilization care services it has not pre-approved ends when: a plan physician with privileges at the treating hospital assumes responsibility for the Member's care, a plan physician assumes responsibility for the Member's care through transfer, a plan representative and the treating physician reach an agreement concerning the Member's care, or the Member is discharged. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. If the member receives post-stabilization services from a provider outside the Contractor's network, the Contractor does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider. *42 CFR 438.114(e)* *42 CFR 422.113(c)(iv)* RAE Contract: Exhibit B-2—14.5.6.2.13 MCO Contract: Exhibit M-2— 14.2.1.2.1.7.4	**Both RAE and Prime:** *I_CS_Post-stabilization Services_Medicaid_CHP+ Responsibility* Page 2, Section 6.0, Paragraph D: This describes that Member liability is limited to an amount no greater than what RMHP would charge the Member if he or she had obtained the services through RMHP. *I_UM_Preauthorization Policy & Procedure* Page 5, Paragraph 11: This describes that if a Member receives post-stabilization services from a provider outside RMHP's network, RMHP does not charge the Member more than he or she would be charged if he or she had obtained services through an in-network provider. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 16, Section - Emergency Services: This describes that Member costs for post-stabilization care rendered by a non-RMHP provider will be no more than what the Member would have paid if treated by a RMHP provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Prime Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	27	X	.00	=	27
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	4	X	NA	=	NA
Total Applicable		=	30	**Total Score**		=	27
Total Score ÷ Total Applicable						=	90%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE maintains and monitors a PCMP and BH network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Adult mental health providers • Pediatric mental health providers • SUD providers • Psychiatrists • Child psychiatrists • Psychiatric prescribers • Family planning providers The MCO maintains a and monitors a network of providers sufficient to provide access to all covered services to all members, including those with limited English proficiency or physical or mental disabilities. The provider network includes the following provider types and areas of expertise: • Adult primary care providers • Pediatric primary care providers • OB/GYNs • Family planning providers • Gerontologists • Internal medicine providers • Physician specialists	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* Pages 18-23, Provider Type Counts: The Network Adequacy Plan is an annual contract deliverable to the Department that describes how the provider network is maintained, monitored, and incentivized to provide adequate access to quality services for RAE and Prime Members. *II_ R1NetworkRptQ1FY1920.xls* The Network Report is a quarterly contract deliverable to the Department for network adequacy reporting. This is the spreadsheet component of the report. See BehavioralHealthProviders_Tab1 and BehavioralHealthProviders_Tab2 for child psychiatrist and psychiatric prescriber data. *2019 Provider Manual* Page 94, Provider Rights and Responsibilities: This describes that RMHP recommends that providers have a policy and/or procedure that documents how they ensure effective communication with Members with limited English proficiency. It also urges provider's offices and/or facilities to accommodate people with disabilities and/or special health care needs. **RAE-specific:** *II_2020 RAE Provider Directory*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.206(b)(1) RAE Contract: Exhibit B-2—9.5.1.1, 9.5.1.3 MCO Contract: Exhibit M-2— 9.4.1.1, 9.4.1.3.	This illustrates providers who are able to serve Members with limited English proficiency as well as if they are handicap accessible. **Prime-specific:** *II_ R1NetworkRptQ1FY1920.xls* We report on Prime specialists on the *PhysHealthProvs_PrimeSPC* tabs. This includes gerontologists or internal medicine providers. *II_2019 Prime Provider Directory* This illustrates providers who are able to serve Members with limited English proficiency as well as if they are handicap accessible.	
2. In establishing and maintaining the network adequacy standards, the Contractor considers: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of network providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering distance, travel time, and means of transportation used by members. • The ability of providers to communicate with limited-English-proficient members in their preferred language.	**Both RAE and Prime:** *II_PNM_2017&2018 Availability of Practitioner Analysis* Pages 5-12, RAE/Prime data and analysis. This document uses data from GeoAccess reports to monitor network adequacy to ensure that providers are sufficient in number and accessibility based on current regulatory standards for distance and Member/Provider ratios for all provider networks. In addition this document describes the ability and option to utilize telemedicine. **Bullet #1:** *II_R1NetworkAdequacyPlnFY19-20* Page 15, Process for Monitoring and Assuring Network Sufficiency:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for members with physical or mental disabilities. • The availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *42 CFR 438.206(a); 438.68(c)(i)–(ix)* RAE Contract: Exhibit B-2—9.1.4, 9.1.5, 9.1.7.1, 9.5.1.2, 9.5.1.4-6 MCO Contract: Exhibit M-2— 9.4.1.1-6, 9.4.1.9	This describes that RMHP considers anticipated Medicaid enrollment. **Bullet #2:** *II_R1NetworkAdequacyPlnFY19-20* Page 16: This describes the expected utilization of services, by taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the RMHP's service area. **Bullet #3:** *II_ R1NetworkRptQ1FY1920.xls* [Throughout report] This demonstrates the numbers, types, and specialties of network providers required to furnish the contracted Medicaid services. **Bullet #4:** *II_ R1NetworkRptQ1FY1920.xls* See the "Summary" tab for the number of network providers accepting/not accepting new Medicaid Members. *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to Providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and provide relevant information to Members. **The tools ask providers to report whether they are accepting new Medicaid Members.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_PNM_Provider Directory Screenshot Examples RAE* *II_PNM_Provider Directory Screenshot Examples Prime* Pages 1- 3: These screenshots from the RMHP online provider directory indicate whether a provider is accepting new Members. *II_CDPE_2020 RAE Resource Guide* Pages 44-48, Tier Demonstration Criteria: This details expectations of practices by Tier as it relates to Medicaid access within the PCMP office. Higher Tier practices must be completely open to Medicaid patients. This document is geared toward RAE PCMPs which includes CHP and Prime providers. **Bullet #5:** *II_CI_Oct2019_RAE_PRIME_BH_GeoAccess* [Throughout report] This demonstrates the geographic location of behavioral health providers in relationship to where Medicaid Members live, considering	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	distance, travel time, and means of transportation used by Members. *II_CI_Oct2019_RAE_PRIME_PH_GeoAccess* [Throughout report] This demonstrates the geographic location of physical health providers in relationship to where Medicaid Members live, considering distance, travel time, and means of transportation used by Members. **Bullet #6:** *II_R1NetworkAdequacyPlnFY19-20* Page 27, Members with Limited English Proficiency and Illiteracy: This describes that RMHP has identified providers with the capability to communicate with Members who have limited-English-proficiency or in their preferred language. *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The tools ask providers to report their Language Capabilities for Member communication needs.**	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_PNM_Provider Directory Screenshot Examples RAE* *II_PNM_Provider Directory Screenshot Examples Prime* Pages 7 – 9: These screenshots from the RMHP online provider directory demonstrate that RMHP informs Members of the types of languages spoken by the provider and/or staff. *II_PNM_2018 RMHP Provider Language Analysis* See pages 2-3 and 6 for Medicaid (RAE & Prime combined) data and analysis. This document uses data from GeoAccess reports to monitor providers' ability to accommodate the linguistic needs and preferences of Members. **Bullet #7:** *II_R1NetworkAdequacyPlnFY19-20* Page 28, Members Living with Physical Disabilities or Needing Reasonable Accommodation: This describes the ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Members with physical or mental disabilities.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool: The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tool include provider's ability to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Members with physical disabilities.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_PNM_Provider Directory Screenshot Examples RAE* *II_PNM_Provider Directory Screenshot Examples Prime* Pages 4 – 6: These screenshots from the RMHP online provider directory demonstrate that RMHP informs Members of the accessibility of a provider's office for people with physical disabilities. *2019 Provider Manual* Page 94, Provider Rights and Responsibilities: This demonstrates that RMHP urges providers to ensure that their offices and/or facilities are able to	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	accommodate people with disabilities and/or special health care needs. **Bullet #8:** *II_R1NetworkAdequacyPlnFY19-20* Page 16, Access to Care: This describes the Network Advisory Committee recommendations for providers to utilize telemedicine when travel is difficult or prohibited for the Member. *II_R1NetworkRptQ1FY1920.doc* Pages 4-5: This describes the availability of triage lines or screening systems, as well as use of telemedicine, e-visits, and/or other technology solutions. *II_CDPE_RAE Resource Guide* Page 29, CareNow: Virtual Care Platform: This describes RMHP's virtual care program that allows Members to connect to a doctor or therapist through their computer or mobile device. CareNow is available at no cost to RMHP RAE, Prime and CHP+ Members *II_CI_CareNow Webpage* This document contains a link to and screenshot of the CareNow webpage on RMHP.org. This webpage informs Members about how CareNow can be used as an alternative to health care visits.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: See above **Prime-specific:** See above	
3. The Contractor ensures that its RAE and MCO PCMP provider network complies with time and distance standards as follows: • Adult primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pediatric primary care providers: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Obstetrics or gynecology: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes The MCO provider network also complies with the following additional time and distances standards: • Specialists—adult and pediatric: – Urban counties—30 miles or 30 minutes – Rural counties—45 miles or 45 minutes – Frontier counties—60 miles or 60 minutes • Pharmacy: – Urban counties—10 miles or 10 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Acute care hospitals:	**Both RAE and Prime:** *II_CI_Oct2019_RAE_PRIME_PH_GeoAccess* The physical health (PH) Geo Access report evaluates the availability of physical health providers in the network by examining time and distance standards. Includes: Adult Primary Care Providers, Pediatric Primary Care Providers, and OBGYN Providers. *2019 Provider Manual* Pages 27 -28: Informs providers of the RAE and Prime network time and distance standards. *2020 Provider Manual* Pages 27 -28: Informs providers of the RAE & Prime network time and distance standards. *II_PNM_P&P Practitioner Availability and Accessibility* This P&P describes how RMHP maintains an effective organizational process for monitoring network adequacy, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
– Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes *42 CFR 438.206(a); 438.68(b)* RAE Contract: Exhibit B-2—9.4.7 MCO Contract: Exhibit M-2—9.3.8	*II_PNM_2017&2018 Availability of Practitioner Analysis* Pages 6-9, This report shows the provider to Member ratio and distance/drive time RAE and Prime requirements for: adult primary care, pediatrics, OB/GYN and other various specialties. **RAE-specific:** N/A **Prime-specific:** *II_CI_Oct2019_RAE_PRIME_PH_GeoAccess* The physical health (PH) Geo Access report evaluates the availability of physical health providers in the network by examining time and distance standards. Includes: Prime Adult Specialists and Prime Pediatric Specialists.	
4. The Contractor ensures that its BH provider network complies with time and distance standards as follows: • Acute care hospitals: – Urban counties—20 miles or 20 minutes – Rural counties—30 miles or 30 minutes – Frontier counties—60 miles or 60 minutes • Psychiatrists and psychiatric prescribers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes	**Both RAE and Prime:** See below. **RAE-specific:** *II_CI_Oct2019_RAE_PRIME_BH_GeoAccess* The behavioral health (BH) Geo Access report evaluates the availability of behavioral health providers in the network by examining time and distance standards. Includes: Adult Mental Health Providers, Pediatric Mental Health Providers, Adult	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Mental health providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes • SUD providers for both adults and children: – Urban counties—30 miles or 30 minutes – Rural counties—60 miles or 60 minutes – Frontier counties—90 miles or 90 minutes *Note: If there are no BH providers that meet the BH provider standards within the defined area for a specific member, then the Contractor shall not be bound by the time and distance requirements. (Exhibit B2—9.4.10.1)* *42 CFR 438.206(a); 438.68(b)* RAE Contract: Exhibit B-2—9.4.9 MCO Contract: Exhibit M-2— 9.3.8	Psych Prescriber Providers, Pediatric Psych Prescriber Providers, and Substance Use Disorder Providers *2019 Provider Manual* Pages 27-28: This informs providers of the RAE and Prime Member/Provider ratios as well as time and distance standards. *II_PNM_P&P Practitioner Availability and Accessibility* This P&P describes how RMHP maintains an effective organizational process for monitoring network adequacy, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues. *II_PNM_2017&2018 Availability of Practitioner Analysis* Page 10-11: This shows the provider to Member ratio and distance/drive time RAE and Prime requirements for psychiatry and marriage and family therapy.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The Contractor provides female members with direct access to a women's health care specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health care specialist. *42 CFR 438.206(b)(2)* RAE Contract: Exhibit B-2—9.2.7 MCO Contract: Exhibit M-2— 9.2.8.3.2	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* Page 17, Women's Health: This describes direct access for women's health within the network. *2019 Provider Manual* Page 66, Paragraph 4: This describes how RMHP provides female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services and is in addition to the Member's designated source of primary care if that source is not a women's health care specialist. *II_CM_P&P_Direct Access for OBGYN Care* This policy describes that RMHP provides for a female Member to have direct access to a contracting obstetrician or gynecologist (OB/GYN) for her reproductive and gynecological care, and that the OB/GYN may serve as the woman's primary care provider. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 8, Care for pregnancy and other health care for women: This describes direct access within the network for women's health care.	
6. The Contractor provides for a second opinion from a network provider or arranges for the member to obtain one outside the network (if there is no qualified provider within the network), at no cost to the member. *42 CFR 438.206(b)(3)* RAE Contract: Exhibit B-2—9.7.6 MCO Contract: Exhibit M-2— 9.3.13	**Both RAE and Prime:** *II_CM_Second Opinions_Out-of-Network Services* Page 1, Policy: This explains that RMHP provides for a second opinion from an in-network provider or arranges for the Member to obtain a second opinion outside the network at no cost to the Member. *2019 Provider Manual* Page 109, RMHP Prime and CHP+ Members: This shows that RMHP covers one second opinion per medical condition without a referral. *2020 Provider Manual* Pages 108-109, Section – It is your right, Bullet 11: This informs providers that Members can get a second opinion with no referral and at no cost to the Member. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 21 Second Opinion:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This informs Members that second opinions are covered without copayment and explains how to obtain one. Page 37 Copayment Chart: This informs Members that second opinions are covered without copayment.	
7. If the provider network is unable to provide necessary covered services to a particular member in network, the Contractor must adequately and in a timely manner cover the services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* RAE Contract: Exhibit B-2—14.6.1.1 MCO Contract: Exhibit M-2— 9.3.10	**Both RAE and Prime:** *2019 Provider Manual* Page 67, Out-of-Network/Out-of-Plan Services: This informs providers of out-of-network/out-of-plan services available to Members in a timely manner at the in-network benefit level. *II_CM_Second Opinions_Out-of-Network Services* Page 2, Services Not Available in Network This explains that if the RMHP network is unable to provide necessary covered services, RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. **RAE-specific:** N/A **Prime-specific:** *II_R1NetworkAdequacyPlnFY19-20* Pages 14-15, Out-of-Network/Out-of-Plan Services: This explains that if the RMHP network is unable to provide necessary covered services, RMHP will adequately and timely cover these services out of	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	network for the Member, for as long as RMHP is unable to provide the services.	
8. The Contractor requires out-of-network providers to coordinate with the Contractor for payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* RAE Contract: Exhibit B-2—14.7.11.1 MCO Contract: Exhibit M-2— None	**Both RAE and Prime:** *2019 Provider Manual* Page 67, Out-of-Network/Out-of-Plan Services: This informs providers that out-of-network/out-of-plan services are available to members at the in-network benefit level. *II_CM_Second Opinions_Out-of-Network Services* Page 2, Services Not Available in Network: This explains that RMHP will coordinate payment with out-of-network providers to ensure that the cost to the Member is no greater than it would be if the services were furnished in-network. **RAE-specific:** N/A **Prime-specific:** *II_R1NetworkAdequacyPlnFY19-20* Page 14, Out-of-Network/Out-of-Plan Services: This describes how Members may receive out-of-network services upon approval, at the in-network benefit level.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The Contractor demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services. *42 CFR 438.206(b)(7)* RAE Contract: Exhibit B-2— 9.5.1.1, 9.5.1.3.10 MCO Contract: Exhibit M-2— 9.4.1.3.4	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* Pages 18 and 23, Provider Type tables: This demonstrates that the RMHP RAE and Prime networks include family planning participating providers that ensure timely access to covered services. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor must meet, and require its providers to meet, the State standards for timely access to care and services, taking into account the urgency of the need for services. The Contractor ensures that services are available as follows: • Emergency BH care (RAE only): – By phone within 15 minutes of the initial contact. – In-person within 1 hour of contact in urban and suburban areas. – In-person within 2 hours of contact in rural and frontier areas. • Urgent care within 24 hours from the initial identification of need. • Non-urgent symptomatic care visit within 7 days after member request. • Well-care visit within 1 month after member request.	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* Pages 25-27: This describes Emergency BH care, urgent care and non-urgent care standards information. Page 18, Paragraph 2: This describes that Members may not be placed on waiting lists for initial routine services. *2019 Provider Manual* Pages 30-31, RAE Appointment Wait Time Standards: This lists the RAE and Prime Appointment Wait Time Standards that demonstrate RMHP's guidelines and standards around emergency behavioral care, urgent care, non-urgent symptomatic care, well care visits within 30 days after the request, outpatient follow up	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Outpatient follow-up appointments within 7 days after discharge from hospitalization. • Members may not be placed on waiting lists for initial routine BH services. (RAE only) *42 CFR 438.206(c)(1)(i)* RAE Contract: Exhibit B1—9.4.13 MCO Contract: Exhibit M-2— 9.3.9.1	appointments, and explains that Members will not be placed on waiting lists for initial routine services. *2020 Provider Manual* Pages 30-31, RAE Appointment Wait Time Standards: This lists the RAE and Prime appointment wait time requirements that include specifics for behavioral health services and explains that Members may not be placed on waiting lists for initial routine behavioral health Services. *II_PNM_Revised Appointment Availability Analysis 2019* This report describes RMHP access to service and wait time standards. It reviews how Member surveys are sent annually to ensure that appointment availability is sufficient. RMHP is considering conducting these surveys quarterly in 2020. Pages 23-24, Qualitative Analysis: This describes the results from the Member survey relating to the standards for timely access to care and services. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
11. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service. The Contractors network provides: • Minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. • Extended hours on evenings and weekends. • Alternatives for emergency department visits for after-hours urgent care. *42 CFR 438.206(c)(1)(ii)* RAE Contract: Exhibit B-2—9.4.2–9.4.4 MCO Contract: Exhibit M-2— 9.3.2-9.3.4	**Both RAE and Prime:** **Bullet #1:** *2019 Provider Manual* Page 66, Paragraph 1, RMHP Prime/CHP+ Members: This informs providers that they may not limit their hours of operation in a manner which is less than is offered to Members of non-publicly-financed programs. *2020 Provider Manual* Page 66: This section describes that RMHP highly recommends providers to have minimum hours of provider operation from 8 a.m. to 5 p.m. Monday through Friday. *II_PNM_Physicians Medical Services Agreement* Pages 5-6, Section A, Medical Services to Covered Persons: This states that providers arranges such time provisions required by any Health Care Plan which is offered by RME to covered persons in the service area. (Due to the numerous lines of business we offer we must write the agreements in general terms to meet all contractual obligations.) Page 15, Section DD, Non-discrimination – Publicly Finance Programs: This provider contract template describes that providers may not discriminate against any covered	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	person enrolled in a publicly financed program, including limiting the hours of operation. **Bullet #2:** *II_R1NetworkAdequacyPlnFY19-20* Page 23: This shows the count of providers offering after-hours and weekend appointment availability *II_R1NetworkRptQ1FY1920.xls* All tabs have identification of providers offering after-hours appointment availability information. *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tools include Appointment Availability questions for extended hours on evenings and weekends.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. **Bullet #3:** *II_R1NetworkRptQ1FY1920.doc* Pages 3-4, CareNow information:	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	CareNow is a no-cost, chat-based program that allows RMHP RAE, Prime and CHP+ Members to message, send photos, or video chat with a doctor or therapist anywhere the Internet can be accessed. *II_CI_CareNow Webpage* This document contains a link to and screenshot of the CareNow webpage on RMHP.org. CareNow can be used by Members as an alternative to emergency department visits for after-hours urgent care. *II_CDPE_RAE Resource Guide* Page 29, CareNow: Virtual Care Platform: This describes RMHP's virtual care program that allows Members to connect to a doctor or therapist through their computer or mobile device. CareNow is available at no cost to RMHP RAE, Prime and CHP+ Members. *II_PNM_Spring_Summer Provider Newsletter 2019* Page 8: This includes news about CareNow, a tool that can be used by RAE, Prime and CHP+ Members as an alternative to emergency department visits for after-hours urgent care. **RAE-specific:** N/A **Prime-specific:** *See Above*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary. *42 CFR 438.206(c)(1)(iii)* RAE Contract: Exhibit B-2—9.4.6 MCO Contract: Exhibit M-2— 9.3.7	**Both RAE and Prime:** *II_PNM_Physicians Medical Services Agreement* Page 15, Section AA - 24-Hour Coverage: This describes the requirement for providers to provide or arrange for 24-hour coverage for emergency medical services. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor ensures timely access by: • Establishing mechanisms to ensure compliance with access (e.g., appointment) standards by network providers. • Monitoring network providers regularly to determine compliance. • Taking corrective action if there is failure to comply. *42 CFR 438.206(c)(1)(iv)–(vi)* RAE Contract: Exhibit B-2—9.5.1.8 MCO Contract: Exhibit M-2— 9.4.1.8	**Both RAE and Prime:** *II_PNM_P&P Appointment Availability Surveys* This P&P describes how RMHP maintains an effective organizational process for monitoring appointment scheduling and wait times, through the use of member surveys, by analyzing data, identifying areas of possible non-compliance, and formulating an action plan to address issues if applicable. *II_PNM_Patient Appointment Wait Time Survey* The Appointment Wait Time Surveys are sent annually to Members as a mechanism to ensure compliance with access by network providers, which includes behavioral health providers (prescribing and non-prescribing); primary care providers; and specialists (high-volume & high-impact). *2019 Provider Manual* Page 23, Access to Care:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This describes how RMHP maintains quality standards to identify, evaluate, and remedy problems relating to access of care. It also identifies RMHPs targets (goals) for Member/provider ratios, time and distance drive time standards as well as appointment wait time standards. *II_CDPE_2020 RAE Resource Guide* Pages 44-48, Tier Demonstration Criteria, Supporting Documentation/Assessment: This details expectations of practices by Tier as it relates to Medicaid access within the PCMP practice. Higher Tier practices must be completely open to Medicaid patients. Practices must show empanelment and continuity of care for Members within their care teams. Practices must regularly deliver care in alternative formats to meet the needs of the patient population. This also describes assessment criteria related to follow up appointment standards for hospital and emergency room discharges. This document also describes the Value Based Contracting Review Committee (VBCRC) process for evaluating providers participating in RMHPs Tiering Program. This document refers to RAE PCMPs which includes CHP and Prime providers. *II_CPDE_VBCRC Charter* Page 1: The Value Based Contracting Review Committee (VBCRC) Charter details the aim, scope and general	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	structure of the committee that evaluates practices in value based contracts with RMHP for compliance with contractual expectations and requirements. This committee evaluates practices in Tiers 1, 2, & 3. *II_CPDE_VBCRC Process* Page 2 – 4: This details how the Value Based Contracting Review Committee (VBCRC) evaluates practices in value based contracts with RMHP as it relates to contractual expectations and requirements. Specifically, this document details the frequency of review as well as how practices are notified if there is failure to comply with any requirements and a corrective action plan is implemented. *II_CDPE_RAE PCMP Tiering & Attribution Analysis* This analysis demonstrates that 116/198 (59%) of RAE PCMPs and 40/56 (71%) of Prime PCMPs are evaluated within the VBCRC process for the Value Based Payment Tiering Program. This accounts for 76% of the attributed RAE Member population and 90% of the attributed Prime Member population. *II_CI_Region 1 BH Focus Group Report* This is the final report from the behavioral health focus groups that RMHP conducted throughout the region in Spring 2019, in partnership with the Colorado Cross-Disability Coalition. Focus group participants, made up of both providers and clients,	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	reported their experiences with access to care/network gaps. Follow-up community meetings were held to discuss the report findings and next steps in Fall 2019. **RAE-specific:** N/A **Prime-specific:** N/A	
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. This includes: • Making written materials that are critical to obtaining services available in prevalent non-English languages. • Providing cultural and disability competency training programs, as needed, to network providers and health plan staff regarding: – Health care attitudes, values, customs and beliefs that affect access to and benefit from health care services. – Medical risks associated with the member population's racial, ethnic, and socioeconomic conditions. • Identifying members whose cultural norms and practices may affect their access to health care. These efforts shall include, but are not limited to, inquiries conducted by the Contractor of the language proficiency of individual members. • Providing language assistance services for all Contractor interactions with members. *42 CFR 438.206(c)(2)* RAE Contract: Exhibit B-2—7.2.1–7.2.6 MCO Contract: Exhibit M-2— 7.2.1-7.2.6	**Both RAE and Prime:** The following documents illustrate that RMHP delivers services to Members in a culturally competent manner to all Members. *COMBINED_1557Notice_ MLIS (Medicaid CHP+)* RMHP's notice of nondiscrimination provides for meaningful access and effective communication and includes protections for those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. *II_CM_CM & UM Communication Policy and Procedure* Page 1 – 2: This describes RMHP's commitment to meaningful and effective communication. *II_CM_Culturally Sensitive Services* This P&P describes RMHP's care management approach to addressing culturally sensitive and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	diverse Member populations, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. **Bullet #1:** *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tools include Staff Training elements.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_CM_CM & UM Communication Policy and Procedure* Page 2: This describes that RMHP ensures written materials that are critical to obtaining services are available in prevalent non-English languages. ***Bullet #2:*** *2019 Provider Manual* Page 107:	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This describes cultural competency and provides direction to providers about where and how to complete cultural competency training. *II_CI_Culturally Responsive Care Online Resources for Providers* This screenshot lists the links to Culturally Responsive Care resources on the RMHP.org website that providers can access for further training. *II_CI_R1PracSupportFY19-20* Page 9: This describes Disability Competent Care trainings that RMHP offers to providers. *II_QI_RMHP 2018 Annual Cultural and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of Members and the actions RMHP takes to meet those needs. Page 8: This includes information about staff training that addresses special needs, cultural competency and health disparities as well as diversity and inclusion training. *II_CI_Disability Competent Care Training Slides for MFHC 04-30-19*	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This is the slide deck for the Disability Competent Care training that Julie Reiskin with the Colorado Cross-Disability Coalition provided on RMHP's behalf to Mountain Family Health Centers (MFHC) providers on 4/30/19. These trainings are available to RMHP providers upon request and asking the question about training on the Provider Attributes Survey prompted MFHC's request. *II_CI_Disability Competent Care Training for MFHC 04-30-19_Evaluations* These are the evaluation forms from MFHC providers for the Disability Competent Care training that Julie Reiskin with the Colorado Cross-Disability Coalition provided on RMHP's behalf to Mountain Family Health Centers providers on 4/30/19. ***Bullet #2:*** *II_CPDE_Cultural and Generational Communication Presentation* The Practice Transformation team at RMHP hosted an Advanced Practice Learning Collaborative in November 2019 which included a presentation on Cultural and Generational Communication. Over 100 participants from PCMP's across Region 1 attended. ***Bullet #3:*** *II_CM_Culturally Sensitive Services* Page 3, Section 5.0, Paragraph 4:	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This demonstrates that RMHP Care Management staff participate in efforts to identify Members whose cultural norms and practices may affect their access to health care. These efforts include health education or newsletter articles. *II_CM_Cultural and Linguistic Assessment* This document reflects RMHP's approach to identify Members who have cultural norms and practices that may affect their access to healthcare. *II_QI_RMHP 2018 Annual Cultural and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of Members and the actions RMHP takes to meet those needs. Page 11, Analysis: This describes RMHP's response related to cultural norms and practices that were found to impact Member's access to care. ***Bullet #4:*** *II_CM_CM & UM Communication Policy and Procedure* Pages 4 – 5: This describes translation, interpreter, and auxiliary services that RMHP has available to communicate with members.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	II_CM_Culturally Sensitive Services Page 3, Section 5.0, Paragraph 1: This explains how RMHP facilitates culturally and linguistically appropriate care and outreach to members with diverse cultural and ethnic backgrounds for prevention, health education and treatment for diseases prevalent to those groups. *II_QI_RMHP 2018 Annual Cultural and Linguistic Needs Report* This report represents RMHP's most recent annual assessment of the cultural and linguistic needs of Members and the actions RMHP takes to meet those needs. Page 1: This describes that RMHP offers language assistance services in over 200 languages through interpretation and translation vendors. *II_CDPE_2020 RAE Resource Guide* Page 29, Supplemental Resources for Patient Care, Rural Interpreting Service Project (RISP): This describes the availability for providers to use RISP services when providing care to Members who are deaf, hard of hearing, or deafblind in rural areas at no cost. *II_PNM_Spring Provider Newsletter* Page 4:	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	The newsletter provides information about the Rural Interpreting Services Project (RISP), a free resource for providers who may need language assistance services for deaf, hard of hearing or deafblind patients. **RAE-specific:** N/A **Prime-specific:** See Above	
15. The Contractor must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR 438.206(c)(3)* RAE Contract: Exhibit B-2—9.1.4.5, 9.1.7.1, 9.5.1.2 MCO Contract: Exhibit M-2—9.1.5.5, 9.4.1.2	**Both RAE and Prime:** *II_PNM_RMHP_PCMP,BH,Prime Spec_ProviderDemographicTool:* The Demographic Tools are the forms that RMHP sends on a quarterly basis to providers as part of our Provider Attributes Survey process. Providers are asked to provide important demographic information that RMHP uses to update our provider directories and provide relevant information to Members. **The questions asked on the tools include a provider's ability to ensure physical access, reasonable accommodations, and accessible equipment for Members with physical disabilities.** Note: There are 3 versions of this tool: PCMP, BH Provider, and Prime Specialist. *II_PNM_ Standards for Practitioner Office Sites* This P&P describes how RMHP maintains an effective organizational process for monitoring the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	quality and safety of clinical care and services provided to Members. **RAE-specific:** N/A **Prime-specific:** See above	
16. The Contractor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor offers an appropriate range of preventive, primary care, and specialty services that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. • A Network Adequacy Plan is submitted to the State annually. • A Network Adequacy Report is submitted to the State quarterly. *42 CFR 438.207(b)* RAE Contract: Exhibit B-2—9.5.1–9.5.4 MCO Contract: Exhibit M-2— 9.4.1-9.4.4	**Both RAE and Prime:** *II_R1NetworkAdequacyPlnFY19-20* This annual report provides an overview of RMHP's RAE and Prime Provider Network and Access Plan. It is submitted annually to the Department of Health Care Policy and Finance. *II_R1NetworkRtpQ1FY1920.xls* *II_ R1NetworkRptQ1FY1920.doc* This quarterly report is 2 parts; a quantitative report in an Excel spreadsheet and a narrative report in a Word document. This comprehensive report provides Member/Provider ratios and time and distance reporting according to contract standards and is submitted to the Department quarterly. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Prime Results for Standard II—Access and Availability							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	15
Total Score ÷ Total Applicable						=	100%

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The Contractor has an internal grievance and appeal system in place for members. A grievance and appeals system means the processes the Contractor implements to handle grievances and appeals of an adverse benefit determination, as well as processes to collect and track information about grievances and appeals. *42 CFR 438.400(b)* *42 CFR 438.402(a)* RAE Contract: Exhibit B2—8.1 MCO Contract: Exhibit M-2— 8.1 10 CCR 2505-10—8.209.1	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *VI_CS_Notice of Appeal Resolution* *VI_CS_Process for Accepting Appeal or Grievance* The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor defines adverse benefit determination as: • The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole, or in part, of payment for a service.	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 16, Section VII, Paragraph A-G: This defines "Adverse Benefit Determination." **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The failure to provide services in a timely manner, as defined by the State. • The failure to act within the time frames defined by the State for standard resolution of grievances and appeals. • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other member financial liabilities). *42 CFR 438.400(b)* RAE Contract: Exhibit B2—2.1.3 MCO Contract: Exhibit M-2— 2.1.3 10 CCR 2505-10—8.209.2.A		
3. The Contractor defines an appeal as a review by the Contractor of an adverse benefit determination. *42 CFR 438.400(b)* RAE Contract: Exhibit B2—2.1.5 MCO Contract: Exhibit M-2— 2.1.5 10 CCR 2505-10—8.209.2.B	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 16, Section VI: This defines "appeal" as a review by RMHP of an adverse benefit determination. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 15-16, Section V: *VI_CS_Grievance Policy and Procedure*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. A grievance includes a member's right to dispute an extension of time proposed by the Contractor to make an authorization decision. *42 CFR 438.400(b)* Contract: Exhibit B2—2.1.42, 8.6.6.2 MCO Contract: Exhibit M-2— 2.1.47, 8.6.6.2 10 CCR 2505-10—8.209.2.D, 8.209.4.A.3.c.(i)	Page 6, Section 5.0 - Definitions: In both documents, grievance is defined as a verbal or written expression of dissatisfaction about any matter other than an adverse benefit determination, including but not limited to quality of care or services provided, aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the Member's rights regardless of whether remedial action is requested. Grievance includes a Member's right to dispute an extension of time proposed by RMHP to make an authorization decision. **RAE-specific:** N/A **Prime-specific:** N/A	
5. The Contractor has provisions for who may file: • A member may file a grievance or a Contractor-level appeal and may request a State fair hearing. • With the member's written consent, a provider or authorized representative may file a grievance or a Contractor-level appeal and may request a State fair hearing on behalf of a member. *Note: Throughout this standard, when the term "member" is used it includes providers and authorized representatives (with the exception that providers cannot exercise the member's right to request continuation of benefits under 42 CFR 438.420).*	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 3.0, Paragraph III: This indicates that a Member or their designated representative may file grievances. Page 2, Section 4.0, Paragraph IV: This states that RMHP must obtain authorization in writing from the Member or his/her designated client representative (DCR), including a treating health care professional, to represent his or her interests related to grievances.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.402(c) RAE Contract: Exhibit B2—8.5.1, 8.5.3, 8.7.1, 8.7.15.1, 8.7.5 MCO Contract: Exhibit M-2— 8.5.1, 8.7.5, 8.7.15.1,	*VI_CS_Appeals Policy and Procedure* Page 2, Section I, Paragraph C: This indicates that procedures for authorized representatives to appeal on a Member's behalf are outlined in the "Designation of Representatives" Process. Page 11-12, Section XI: This states that the Member or their DCR may request a State Fair Hearing. *VI_CS_Process Designation of Representatives* Page 1, Section 3.0, Paragraph 2: This states that a Member, or a designated client representative acting on behalf of a Member with the Member's written consent, or the legal representative of a deceased Member's estate, may file a grievance, a health plan-level appeal, and may request a State Fair hearing. **RAE-specific:** N/A **Prime-specific:** N/A	
6. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, as well as providing interpreter services and toll-	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 1-2, Section 4.0, Subsection I, Paragraph B: This explains how RMHP assists Members in completing any forms required, putting verbal requests, including requests for a State fair hearing, into writing and taking other procedural steps.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
free numbers that have adequate TTY/TDD and interpreter capability. *42 CFR 438.406(a)* RAE Contract: Exhibit B2—8.3 MCO Contract: Exhibit M-2— 8.3 10 CCR 2505-10 8.209.4.C	*VI_CS_Grievance Policy and Procedure* Page 2, Section 4.0, General Information paragraph: This explains how RMHP assists Members with completing any forms or completing other procedural steps. *COMBINED_1557Notice_MLIS (Medicaid CHP+) Tagline and Notice of Nondiscrimination* This document is sent with all significant Member communications, including with all appeals and grievances Member mailings. Page 1: The Notice of Nondiscrimination states that RMHP takes reasonable steps to ensure meaningful access and effective communication is provided timely and free of charge, including auxiliary aids and services, free language assistance services, qualified interpreters and more. **RAE-specific:** N/A **Prime-specific:** N/A	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: – An appeal of a denial that is based on lack of medical necessity. – A grievance regarding the denial of expedited resolution of an appeal. – A grievance or appeal that involves clinical issues. *42 CFR 438.406(b)(2)* RAE Contract: Exhibit B2—8.5.4, 8.7.4 MCO Contract: Exhibit M-2— 8.5.3, 8.7.4 10 CCR 2505-10 8.209.5.C, 8.209.4.E	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 4, Section IV, Paragraph C: This describes the requirements for the grievances and appeals reviewers/decision-makers. The Medical Director and the clinical consultant must not have been involved in the initial decision or be the subordinate of the medical director involved in the initial review. The reviewer or consultant must have the appropriate clinical expertise in treating the Member's condition or disease. *VI_CS_Grievance Policy and Procedure* Pages 4-5, Section I, Bullet 3: This indicates that RMHP ensures that individuals who make decisions on grievances are individuals who were not involved in any aspect of the circumstances or decision-making that led to the grievance nor a subordinate of any individual who was involved, and have the appropriate clinical expertise in treating the Member's condition or disease. **RAE-specific:** N/A **Prime-specific:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: RMHP's *Appeals Policy and Procedure* and *Grievance Policy and Procedure* stated these requirements almost verbatim. While all appeal record reviews confirmed the appeal decision was made by a person with appropriate clinical expertise, one record that involved a grievance		

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
about the member's clinical treatment was not reviewed by an RMHP clinician, but rather referred the member back to the treating provider group—subject of the grievance—to resolve the issue.		
Required Actions: RMHP must develop a mechanism to ensure that any grievance regarding treatment by a provider is reviewed and resolved by an RMHP clinician with appropriate clinical expertise in treating the member's condition.		
8. The Contractor ensures that the individuals who make decisions on grievances and appeals: • Take into account all comments, documents, records, and other information submitted by the member or the member's representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR 438.406(b)(2)* RAE Contract: Exhibit B2—None MCO Contract: Exhibit M-2—None	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 4, Section IV, Paragraph C(4): This states that the individuals who make decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the Member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor accepts grievances orally or in writing. *42 CFR 438.402(c)(3)(i)* RAE Contract: Exhibit B2—8.5.3 MCO Contract: Exhibit M-2— 8.5.3 10 CCR 2505-10—8.209.5.D	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 4.0-General Information: This lists the ways that RMHP accepts grievances, both orally and in writing. *VI_CS_Process for Accepting Appeal or Grievance* This document describes the process that Customer Service Representatives follow to accept Member grievances orally by phone.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VI_CS_Complaints and Appeals Routing Page 2, Section 6.0: This explains how Customer Service Representatives receive grievances by phone or email. **RAE-specific:** N/A **Prime-specific:** N/A	
10. Members may file a grievance at any time. *42 CFR 438.402(c)(2)(i)* RAE Contract: Exhibit B2—8.5.3 MCO Contract: Exhibit M-2— 8.5.3 10 CCR 2505-10—8.209.5.A	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 2, Section 4.0-General Information: States that Members or their designated representative can file grievances at any time. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor sends the member written acknowledgement of each grievance within two (2) working days of receipt. *42 CFR 438.406(b)(1)* RAE Contract: Exhibit B2—8.1 MCO Contract: Exhibit M-2— 8.1 10 CCR 2505-10 8.209.5.B	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 3, Section V: This states that acknowledgment letters are sent to Members within two working days. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The Contractor must resolve each grievance and provide notice as expeditiously as the member's health condition requires, and within 15 working days of when the member files the grievance. • Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR 438.408(a) and (b)(1) and (d)(1)* RAE Contract: Exhibit B2—8.5.5, 7.2.7.3, 7.2.7.5 MCO Contract: Exhibit M-2— 8.5.4, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.5.D	**Both RAE and Prime:** *VI_CS_Grievance Policy and Procedure* Page 5, Section I, Paragraph 3: This states that RMHP must respond to a grievance within 15 working days from the date of receipt, or as expeditiously as the Member's health condition requires. Page 3, Section VI: This describes that the reviewer's resolution must be in language that is easily understandable. It must provide a rationale in sufficient detail that may be easily understood by the Member. *VI_CS_ Grievance Resolution Template RAE-PRIME* This template is used to provide notice to the Member of the disposition/resolution of their grievance. They are in a format and include standard language that can be easily understood by Members. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The written notice of grievance resolution includes: • Results of the disposition/resolution process and the date it was completed.	**Both RAE and Prime:** *VI_CS_ Grievance Resolution Template RAE-PRIME* This template includes the disposition /resolution process and the date it was completed.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
RAE Contract: Exhibit B2—8.1 MCO Contract: Exhibit M-2— 8.1 10 CCR 2505-10 8.209.5.G	**RAE-specific:** N/A **Prime-specific:** N/A	
Findings: The *Grievance Policy and Procedure* and on-site record reviews confirmed the required content of the grievance resolution letter. However, HSAG noted one grievance record in which RMHP's resolution did not address the member's complaint regarding provider treatment and inappropriately referred the member back to the provider to resolve the issue.		
Required Actions: RMHP must develop a mechanism to ensure that each member grievance is thoroughly addressed by RMHP staff members.		
14. The Contractor may have only one level of appeal for members. *42 CFR 438.402(b)* RAE Contract: Exhibit B2—None MCO Contract: Exhibit M-2—None	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* *VI_CS_Grievance Policy and Procedure* *VI_CS_MD.CHP Timelines* *VI_CS_Process Designation of Representatives* *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* *VI_CS_Notice of Appeal Resolution* *VI_CS_Process for Accepting Appeal or Grievance* The above documents describe the RMHP established internal grievance and appeal procedures, including the processes to collect and track information. The documents indicate that there is only one level of appeal with the health plan for RAE and Prime Members. Members are provided clear instructions about how to request a State Fair Hearing after	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	exhausting RMHP's appeal process, or if RMHP fails to adhere to the required timeframes for processing appeals. **RAE-specific:** N/A **Prime-specific:** N/A	
15. A member may file an appeal with the Contractor within 60 calendar days from the date on the adverse benefit determination notice. *42 CFR 438.402 (c)(2)(ii)* RAE Contract: Exhibit B2—8.7.5.1 MCO Contract: Exhibit M-2— 8.7.5.1 10 CCR 2505 10 8.209.4.B	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* Page 1, Member Appeal Submission: This indicates the 60 calendar day time frame Members have to submit an appeal. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42 CFR 438.402(c)(3)(ii)* RAE Contract: Exhibit B2—8.7.5.2 MCO Contract: Exhibit M-2— 8.7.5.2 10 CCR 2505-10 8.209.4.F	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 1, Section I, Paragraph A(4): This indicates that appeals will be accepted verbally. Page 3, Section II, Paragraph A(1): This explains how verbal appeals are acknowledged and describes the process for obtaining a written, signed appeal of an oral request. *VI_ CS_Verbal Appeal Acknowledgment Template*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This template explains to Members what RMHP believes to be the reason for the appeal, and indicates that the Member can sign and return the letter if they agree that RMHP understands what they are appealing. This notice also explains that the Member must sign and return the letter. **RAE-specific:** N/A **Prime-specific:** N/A	
17. The Contractor sends written acknowledgement of each appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution. *42 CFR 438.406(b)(1)* RAE Contract: Exhibit B2—8.1, 8.7.2 MCO Contract: Exhibit M-2— 8.1 10 CCR 2505-10 8.209. 4.D	**Both RAE and Prime:** *VI_CS_MD,CHP Timelines* This document indicates the time frame to acknowledge receipt of a standard appeal. *VI_CS_Verbal Appeal Acknowledgment Template* *VI_CS_Written Appeal Acknowledgment Template* These letter templates are used to provide written acknowledgement of verbal and written appeals and are sent within two working days of receipt of standard appeals. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
18. The Contractor's appeal process must provide: • That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date). • That if the member orally requests an expedited appeal, the Contractor shall not require a written, signed appeal following the oral request. • That included, as parties to the appeal, are: – The member and his or her representative, or – The legal representative of a deceased member's estate. *42 CFR 438.406(b)(3) and (6)* RAE Contract: Exhibit B2—8.7.6, 8.7.7, 8.7.11 MCO Contract: Exhibit M-2— 8.7.6, 8.7.7, 8.7.11 10 CCR 2505-10 8.209. 4.F, 8.209.4.I	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 3, Section II, Paragraph A: This explains that verbal inquiries are treated as appeals. Page 3, Section II, Paragraph A(1): This describes the procedure for confirming a standard appeal in writing and that written confirmation is not required for an expedited appeal. *VI_CS_Process Designation of Representatives* Page 1, Section 3.0(2): This explains that the Member, the Member's designated representative or the legal representative of a deceased Member's estate are the parties to the appeal. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. The Contractor's appeal process must provide: • The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. (The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution time frame in the case of expedited resolution.)	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 3, Section II.A.2: This explains how RMHP gives Members an opportunity to submit further evidence, including in cases of expedited resolution where time is limited.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional documents considered, relied upon, or generated by the Contractor in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. *42 CFR 438.406(b)(4-5)* RAE Contract: Exhibit B2—8.7.8–8.7.10 MCO Contract: Exhibit M-2— 8.7.8-8.7.10 10 CCR 2505-10 8.209. 4.G, 8.209.4.H	**RAE-specific:** *VI_Health First Colorado Member Handbook* This handbook, which can be accessed via a link on the RMHP and Health First Colorado websites, provides information regarding the appeals process. **Prime-specific:** *RMHP Prime Member Handbook* Page 39-40, Section – Appeals and Grievances: This describes that Members are informed how they will receive information about how to access their appeal file and that they may provide more information about their appeal to RMHP either in person, by telephone, or in writing.	
20. The Contractor maintains an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life; physical or mental health; or ability to attain, maintain, or regain maximum function. The Contractor's expedited review process includes that: • The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. *42 CFR 438.410(a–b)* RAE Contract: Exhibit B2—8.7.14.2.1, 8.7.12 MCO Contract: Exhibit M-2— 8.7.14.2.1, 8.7.12 10 CCR 2505-10 8.209.4.Q-R	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 5-6, Section V: This describes the expedited review process. Page 6, Section V, Paragraph B(3): This states that punitive action will not be taken against a provider for requesting an expedited appeal or supporting a Member's appeal. *VI_PNM_Physicians Medical Services Agreement* Page 22, Section 7, Paragraph G. Limitations on Adverse Actions: This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	VI_PNM_Professional Services Agreement Pages 23-24, Section 7, Paragraph G. Limitations on Adverse Actions: This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. *VI_PNM_Hospital Services Agreement* Page 25, Section 8, Paragraph G. Limitations on Adverse Actions: This describes that RMHP will not take an adverse action against a provider for assisting a Member in seeking reconsideration of a coverage decision. **RAE-specific:** N/A **Prime-specific:** N/A	
21. If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and within two (2) calendar days provide the member written notice of the reason for the decision and inform the member of the right to file a grievance if he or she disagrees with that decision.	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 6, Section V, Paragraph B (1): This describes that if RMHP denies a request for expedited resolution, it will transfer the appeal decision to the standard time frame and will make reasonable efforts to give the Member verbal notice followed by written notice of the denial within two calendar days. *VI_CS_Appeals Policy and Procedure* Page 6, Section V, Paragraph B (4):	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.410(c) RAE Contract: Exhibit B2—8.7.14.2.2 MCO Contract: Exhibit M-2— 8.7.14.2.2 10 CCR 2505-10 8.209.4.S	This describes that the Member has the right to file a grievance if he or she disagrees with the decision not to expedite the appeal. **RAE-specific:** N/A **Prime-specific:** N/A	
22. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR 438.408(b)(2)* *42 CFR 438.408(d)(2)* *42 CFR 438.10* RAE Contract: Exhibit B2—8.7.14.1. 7.2.7.3, 7.2.7.5 MCO Contract: Exhibit M-2— 8.7.14.1, 7.2.7.3, 7.2.7.5 10 CCR 2505-10 8.209.4.J.1	**Both RAE and Prime:** **Bullet 1 –** *VI_CS_MD,CHP Timelines* This document provides timeframes for appeals process and decisions. **Bullet 2 –** *VI_CS_Appeals Policy and Procedure* Page 5, Section IV, Paragraph D: This describes the content of appeal resolution letters, including that they must be in a format and language that is easily understood by the Member. *VI_CS_Notice of Appeal Resolution* This template provides the standard text contained in a notice of appeal resolution and demonstrates that the content is in a format and language that may be easily understood by the Member.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	RAE-specific: N/A **Prime-specific:** N/A	
Findings: RMHP's *Appeals Policy and Procedures* and associated time frames for notifying the member of appeal resolution accurately addressed these requirements. On-site record reviews demonstrated compliance with the required 10-working day time frame. However, 50 percent of the record reviews included language not easy for the member to understand, largely due to including extensive clinical information excerpted from clinical reviewer criteria in the description of the reason for the appeal decision.		
Required Actions: RMHP must develop a mechanism to ensure that the reason for the appeal decision in appeal resolution letters sent to Medicaid members simplifies the reason for the decision and is written in language at or near the sixth-grade reading level.		
23. For expedited appeal, the Contractor must resolve the appeal and provide written notice of disposition to affected parties within 72 hours after the Contractor receives the appeal. • For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42 CFR 438.408(b)(3) and (d)(2)(ii)* RAE Contract: Exhibit B2—8.7.14.2.3, 8.7.14.2.6 MCO Contract: Exhibit M-2— 8.7.14.2.3, 8.7.14.2.6 10 CCR 2505-10 8.209.4.J.2, 8.209.4.L	**Both RAE and Prime:** *VI_CS_MD.CHP Timelines* This document describes that the timeframe for resolving an expedited appeal is within 72 hours of receipt. *VI_CS_Appeals Policy and Procedure* Page 6, Section V, Paragraph B (2): This describes that RMHP will make reasonable efforts to provide oral notice to the Member of the expedited resolution. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
24. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The Contractor shows (to the satisfaction of the Department, upon request) that there is need for additional information and how the delay is in the member's interest. *42 CFR 438.408(c)(1)* RAE Contract: Exhibit B2—8.7.14.2, 8.7.14.2.4, 8.5.6 MCO Contract: Exhibit M-2— 8.5.6, 8.7.14.2, 8.7.14.2.4 10 CCR 2505-10 8.209.4.K, 8.209.5.E	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 7-8, Section VI, Paragraph H (1): This explains the circumstances under which RMHP will extend the time frames for resolution of both expedited and standard appeals. *VI_CS_Grievance Policy and Procedure* Page 5, Section I: This explains the circumstances under which RMHP will extend the time frame for resolution of a grievance. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
25. If the Contractor extends the time frames, it must—for any extension not requested by the member: • Make reasonable efforts to give the member prompt oral notice of the delay. • Within two (2) calendar days, give the member written notice of the reason for the delay and inform the member of the right to file a grievance if he or she disagrees with that decision. • Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 7-8, Section VI, Paragraph H (1): This explains that if RMHP extends the time frame, reasonable efforts will be made to give the Member prompt oral notice of the delay and the Member will be given written notice of the reason for the delay within two calendar days, informing the Member that they may file a grievance if they disagree with the decision. Further, this P&P explains that the appeal will be resolved as expeditiously as the Member's health condition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.408(c)(2) RAE Contract: Exhibit B2—8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6 MCO Contract: Exhibit M-2— 8.5.7, 8.7.14.1, 8.7.14.2.1, 8.7.14.2.5-6	requires and no later than the date the extension expires. **RAE-specific:** N/A **Prime-specific:** N/A	
26. The written notice of appeal resolution must include: • The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing, and how to do so. – The right to request that benefits/services continue* while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's adverse benefit determination. **Continuation of benefits applies only to previously authorized services for which the Contractor provides 10-day advance notice to terminate, suspend, or reduce.* *42 CFR 438.408(e)* RAE Contract: Exhibit B2—8.7.14.3, 8.7.14.4 MCO Contract: Exhibit M-2—8.7.14.3, 8.7.14.4 10 CCR 2505-10 8.209.4.M	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 5, Section IV, Paragraph M: This describes the information that must be included in the notice of appeal resolution. *VI_CS_Notice of Appeal Resolution* This template illustrates that the notices of appeal resolution contains the required language. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
27. The member may request a State fair hearing after receiving notice that the Contractor is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • If the Contractor does not adhere to the notice and timing requirements regarding a member's appeal, the member is deemed to have exhausted the appeal process and may request a State fair hearing. *42 CFR 438.408(f)(1–2)* RAE Contract: Exhibit B2—8.7.15.1–8.7.15.2 MCO Contract: Exhibit M-2—8.7.15.1-8.7.15.2 10 CCR 2505-10 8.209.4.N and O	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Pages 11-12, Section XI, Paragraph A.: This explains that the Member or their DCR may request a State fair hearing within 120 days from the date of the notice of resolution. The P&P also explains that a Member is deemed to have exhausted the appeal process and may request a State fair hearing if RMHP does not adhere to the notice and timing requirements. **RAE-specific:** N/A **Prime-specific:** *RMHP Prime Member Handbook* Page 41, Paragraph 2: Members are informed they may request a State fair hearing within 120 calendar days from the date of the notice of resolution and that if RMHP does not adhere to the notice and timing requirements, the Member may request a State fair hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The parties to the State fair hearing include the Contractor as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR 438.408(f)(3)* RAE Contract: Exhibit B2—8.7.15.3 MCO Contract: Exhibit M-2— 8.7.15.3	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section XI, Paragraph D: This explains that RMHP, as well as the Member and his or her representative, participate in the State Fair Hearing. *VI_CS_Process Designation of Representatives* Page 1, Section 3, Paragraph 2:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	This explains that a representative of a deceased Member's estate is considered a party to a State Fair Hearing. **RAE-specific:** N/A **Prime-specific:** N/A	
29. The Contractor provides for continuation of benefits/services (when requested by the member) while the Contractor-level appeal and the State fair hearing are pending if: • The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the Contractor mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required time frames. ** This definition of timely filing only applies for this scenario—i.e., when the member requests continuation of benefits for previously*	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section XII: This describes the policy for continuation of benefits during the appeal process. *VI_CS_Notice of Appeal Resolution* Page 2, How to Ask for your Services to Continue During a State Fair Hearing: This Member notice describes the continuation of benefits policy while RMHP appeal and State fair hearing are pending. **RAE-specific:** N/A **Prime-specific:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
authorized services proposed to be terminated, suspended, or reduced. (Note: The provider may not request continuation of benefits on behalf of the member.) *42 CFR 438.420(a) and (b)* RAE Contract: Exhibit B2—8.7.13.1 MCO Contract: Exhibit M-2—8.7.13.1 10 CCR 2505-10 8.209.4.T		
Findings: RMHP's *Appeal Policy and Procedure* addressed the circumstances applicable to providing continuation of benefits during an appeal or SFH, although inaccurately stated that the member must file the *appeal* within 10 days of the NABD (the member must request *continuation of benefits* within 10 days but may still file appeal up to 60 days following the NABD). In addition, the policy defined that a criterion for requesting continued benefits during an SFH included "the original period covered by the original authorization has not expired." This criterion applies only to requesting continuation of benefits during an appeal, not a SFH (in the case of an SFH, the member must have previously requested that benefits be continued during the appeal and must again request they be continued during the SFH). These inaccuracies were repeated in the RMHP Prime Member Handbook and the RMHP Provider Manual.		
Required Actions: RMHP must correct the *Appeal Policy and Procedure* and related documents to accurately reflect that the member must request continuation of benefits—not file the appeal—within 10 days after the NABD or within 10 days of the notice of appeal resolution, as applicable. In addition, RMHP must revise its documents to clarify that "the original period covered by the original authorization has not expired" does not apply to requesting continued benefits during an SFH.		
30. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal or State fair hearing is pending, the benefits must be continued until one of the following occurs: • The member withdraws the appeal or request for a State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section XII, Paragraph F (1-3): This describes how long benefits are continued while an appeal or State Fair Hearing is pending and the events that must occur before benefits can be discontinued. **RAE-specific:** N/A	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Contractor sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR 438.420(c)* RAE Contract: Exhibit B2—8.7.13.2 MCO Contract: Exhibit M-2— 8.7.13.2 10 CCR 2505-10 8.209.4.U	**Prime-specific:** N/A	
Findings: RMHP's *Appeal Policy and Procedure* addressed each of these circumstances but also included "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue. Whereas this stipulation applies to the ability to initially request continued benefits during an appeal, it is not an applicable criterion once continuation of benefits have been requested by the member.		
Required Actions: RMHP must revise its *Appeal Policy and Procedure* and related documents to remove "the time period or service limits of a previously authorized service has been met" as a criterion for how long benefits will continue during an appeal or SFH.		
31. Member responsibility for continued services: • If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's adverse benefit determination, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR 438.420(d)* RAE Contract: Exhibit B2—8.7.13.3 MCO Contract: Exhibit M-2— 8.7.13.3 10 CCR 2505-10 8.209.4.V	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, Section XII, Paragraph G (1): This describes the Member's responsibility for the cost of continued services if the appeal decision is adverse to the Member. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
32. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services as promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. *42 CFR 438.424(a)* RAE Contract: Exhibit B2—8.7.13.4 MCO Contract: Exhibit M-2— 8.7.13.4 10 CCR 2505-10 8.209.4.W	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 13, Section XII, Paragraph G (3): This describes RMHP's responsibility for effectuating the State hearing decision if it reverses RMHP's decision to deny, limit or delay services that were not furnished while the appeal was pending. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
33. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. *42 CFR 438.424(b)* RAE Contract: Exhibit B2—8.7.13.5 MCO Contract: Exhibit M-2— 8.7.13.5 10 CCR 2505-10 8.209.4.X	**Both RAE and Prime:** *VI_CS_Appeals Policy and Procedure* Page 12, XII, Paragraph G (2): This describes that RMHP must pay for services when the State fair hearing officer reverses a decision to deny authorization of services and the Member received the disputed services while the appeal was pending. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
34. The Contractor maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. • The record of each grievance and appeal must contain, at a minimum, all of the following information: – A general description of the reason for the grievance or appeal. – The date received. – The date of each review or, if applicable, review meeting. – Resolution at each level of the appeal or grievance. – Date of resolution at each level, if applicable. – Name of the person for whom the appeal or grievance was filed. • The Contractor quarterly submits to the Department a Grievance and Appeals report including this information. *42 CFR 438.416* RAE Contract: Exhibit B2—8.9.1–8.9.1.6 MCO Contract: Exhibit M-2— 8.9.1-8.9.1.6 10 CCR 2505-10 8.209.3.C	**Both RAE and Prime:** **Bullet #1:** *VI_CS_Appeals Policy and Procedure* Page 2, Section I, Paragraph G.: This describes the records of appeals that RMHP maintains. *VI_CS_Grievance Policy and Procedure* Page 4, Section XII: This describes the records of grievances that RMHP maintains. **Bullet #2:** *VI_CI_Quarterly Grievance and Appeals Report Submission* This document shows evidence of quarterly submissions of the Grievance and Appeals report to the Department. **RAE-specific:** N/A **Prime-specific:** N/A	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
35. The Contractor provides the information about the grievance, appeal, and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals.	**Both RAE and Prime:** *VI_PNM._Physician(s) Medical Services Agreement* Page 12, Section 2, Paragraph T. Expressing Disagreement: Informs providers that RMHP has a process for submitting grievances and appeals for Members	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing after the Contractor has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The fact that, when requested by the member: – Services that the Contractor seeks to reduce or terminate will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. *42 CFR 438.414* *42 CFR 438.10(g)(xi)* RAE Contract: Exhibit B2—8.4 MCO Contract: Exhibit M-2— 8.4 10 CCR 2505-10 8.209.3.B	that is described in the RMHP Provider Manual which can be accessed online or requested in written form. Page 12, Section 2, Paragraph S. Compliance, Cooperation and Participation in RME's Policies and Procedures: Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *VI_PNM_Professional Services Agreement* Pages 12-13,Section 2, Paragraph Q. Expressing Disagreement: Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 12, Section 2, Paragraph P. Compliance, Cooperation and Participation in RME's Policies and Procedures: Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. *VI_PNM_Hospital Services Agreement* Page 15, Section 2, Paragraph W. Expressing Disagreement:	

Standard VI—Grievances and Appeals		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Informs providers that RMHP has a process for submitting grievances and appeals for Members that is described in the RMHP Provider Manual which can be accessed online or can be requested in written form. Page 15, Section 2, Paragraph V. Compliance, Cooperation and Participation in RME's Policies and Procedures: Informs providers that RMHP will provide a copy of the RMHP Provider Manual within 14 days of a request. **RAE-specific:** N/A **Prime-specific:** *2019 Provider Manual* Pages 53-55, Appeals and Grievances: This describes the Appeals and Grievances process for Prime.	

Prime Results for Standard VI—Grievances and Appeals							
Total	Met	=	30	X	1.00	=	30
	Partially Met	=	5	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	35	**Total Score**		=	30
Total Score ÷ Total Applicable						=	86%