

Colorado Medicaid  
Managed Care Program

**FY 2010–2011 SITE REVIEW REPORT**  
*for*  
**Rocky Mountain Health Plans**

June 2011

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



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3133 East Camelback Road, Suite 300 • Phoenix, AZ 85016  
Phone 602.264.6382 • Fax 602.241.0757

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### Overview of FY 2010–2011 Compliance Monitoring Activities

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

This is the third year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Managed Care Program. For the fiscal year (FY) 2010–2011 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools for reviewing the three performance areas chosen. The standard areas chosen were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard VIII—Credentialing and Recredentialing.

Various health plan administrative records were reviewed to evaluate implementation of (1) Medicaid managed care regulations related to member denials and notices of action and (2) the National Committee for Quality Assurance (NCQA) requirements related to credentialing and recredentialing of contracted and employed practitioners and organizational providers. Reviewers used standardized monitoring tools to review records and to document findings.

HSAG used a sample of 20 records with an oversample of five records for the denials record review, and a sample of 10 records with an oversample of five records for the credentialing review and for the recredentialing review. Using a random sampling technique, HSAG selected the samples from all applicable health plan Medicaid denials that occurred between January 1, 2010, and September 15, 2010. HSAG used the same random sampling technique to select samples from all providers who had been credentialed and recredentialed during the same time period.

For the record reviews, the health plan received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal regulations and contract requirements was evaluated through review of the three standards and review of the administrative denial, credentialing, and recredentialing files. The health plan received an overall percentage of compliance score for the standards and a separate overall percentage of compliance score for the record reviews.

This report documents results of the FY 2010–2011 site review activities for the review period—January 1, 2010, through the date of the on-site review January 27 and 28, 2011. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the health plan was successful in completing corrective actions required as a result of the 2009–2010 site review activities. Appendices A, B, C, and D contain data collection and record review tools. Appendix E is a list of HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix F

describes the corrective action process the health plan will be required to complete and the template for this process.

## Methodology

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

In developing the data collection tools and in reviewing the three standards, HSAG used **Rocky Mountain Health Plans' (RMHP's)** contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key **RMHP** personnel to determine compliance. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

The three standards chosen for the FY 2010–2011 site reviews represent a portion of the requirements based on the Medicaid managed care contract and BBA requirements. Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement will be reviewed in subsequent years.

## Objective of the Site Review

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

- ◆ The MCO's/PIHP's compliance with federal regulations and contract requirements in the three areas of review.
- ◆ Strengths, opportunities for improvement, and actions required to bring the **RMHP** into compliance with federal health care regulations in the standard areas reviewed.
- ◆ The quality and timeliness of, and access to, health care furnished by the MCO/PIHP, as assessed by the specific areas reviewed.
- ◆ Possible interventions to improve the quality of **RMHP's** services related to the areas reviewed.
- ◆ Activities to sustain and enhance performance processes.

## Summary of Results

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

Table 1-1 presents the score for **RMHP** for each of the standards. Details of the findings for each standard follow in Appendix A. Table 1-2 presents the scores for each of the record reviews. Details of the findings for record reviews can be found in Appendices B, C, and D.

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I	Coverage and Authorization of Services	27	27	22	5	0	0	81%
II	Access and Availability	13	13	13	0	0	0	100%
VIII	Credentialing and Recredentialing	47	45	39	4	2	2	87%
<b>Totals</b>		<b>87</b>	<b>85</b>	<b>74</b>	<b>9</b>	<b>2</b>	<b>2</b>	<b>87%</b>

Record Review	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	120	82	46	0	36	38	56%
Credentialing	80	78	78	0	0	2	100%
Recredentialing	80	69	69	0	0	11	100%
<b>Totals</b>	<b>280</b>	<b>229</b>	<b>193</b>	<b>0</b>	<b>36</b>	<b>51</b>	<b>84%</b>

## 2. Summary of Performance Strengths and Required Actions for Rocky Mountain Health Plans

### Overall Summary of Performance

For the Credentialing and Recredentialing standard, **RMHP** earned an overall percentage-of-compliance score of 87 percent and a score of 81 percent for Coverage and Authorization of Services, representing an opportunity for continued improvement. **RMHP** had a score of 100 percent for the Access and Availability standard, representing a clear strength for the health plan.

### Standard I—Coverage and Authorization of Services

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

**RMHP** had documented evidence through its policies, procedures, processes, and member communications that it provided covered services in a sufficient amount, duration, and scope. Policies specified that utilization decisions were made in a fair, impartial, and consistent manner using standardized, measureable criteria, and were based on medical necessity. **RMHP** policy specified that all actions regarding utilization review decisions would be reviewed by an individual with applicable expertise. The denial records review score was 56 percent, which demonstrated that the processes did not consistently mirror policy requirements.

#### *Summary of Strengths*

**RMHP**'s definition of medical necessity was consistent across policies and with the BBA definition. **RMHP**'s definitions of emergency medical condition, emergency medical services, and poststabilization services were also congruent with federal requirements. Simplified definitions for these terms were also included in the member handbook.

**RMHP**'s care management processes were integrated with utilization management (UM) processes.

#### *Summary of Required Actions*

Of the 20 **RMHP** denial records reviewed on-site, three determination decisions were not made by a health care professional with clinical expertise in treating the condition. Two of these cases were denials for emergency service coverage made by nonclinical administrative staff. These determinations should have gone through medical review with consideration given to the prudent layperson standard. One record contained no evidence that a notice of action letter was sent. None of the 20 records reviewed was compliant with the content requirements for the notification letter. For the 17 records reviewed for required time frames, eight records had evidence that the notification letter had been sent within the allowable time frame. **RMHP** must ensure that it adheres to its policy that denial decisions must be made by a health care professional who has appropriate

clinical expertise in treating the member's condition or disease. The health plan must ensure that it makes authorization decisions within the allowable time frames. **RMHP** must also ensure that notices of action are provided to members and to providers, and that notices to members include information that the provider can file an appeal on the member's behalf. Letters to members should not state that the member may have to pay for the services.

The **RMHP** Preauthorization of Services for Medicaid Members policy stated that expedited preauthorization decisions must be made within three working days, but there were also references in the policy to decisions within 72 hours. These time periods were inconsistent because three working days could represent more than 72 hours if the time period included a weekend. **RMHP** must ensure its policies are consistent as to time frames. In the same policy, preservice elective and retrospective requests were addressed in the same section, and the policy stated that if a member or a member's provider failed to submit enough information necessary to make a determination, **RMHP** would give the member at least 30 days from the receipt of the notice to provide the specified information. While allowing this time frame may be acceptable for retrospective requests/claims decisions, it is not compliant with federal requirements when applied to extensions on preservice requests. **RMHP** must ensure that its written policies, procedures, and processes adhere to federal managed care requirements—specifically, that extensions of time frames for authorization decisions are only up to 14 calendar days for both standard and expedited authorization decisions.

The **RMHP** Claims Medical Processing Manual contained a list of emergent diagnoses. Although notes adjacent to the list stated the list was only a reference and was not inclusive of all diagnoses that could be involved in an emergent situation, there was evidence that coverage decisions were made based on diagnoses. **RMHP** must ensure that it does not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms for Medicaid members.

The Claims Medical Processing Manual stated that **RMHP** must be notified within 48 hours of out-of-area emergency services. **RMHP** must ensure that it does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider (PCP), the contractor, or the State agency of the member's screening and treatment within 10 days of presentation for emergency services.

## Standard II—Access and Availability

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

**RMHP**'s 2010 Medicaid Access Plan documented the organization's efforts to make covered services available and accessible to its members. **RMHP** stated that to ensure care was located within a reasonable travel time and distance to members, the plan contracted with most available acute care hospitals, PCPs, specialists, and subspecialists who met the credentialing and quality standards. To attract providers to certain areas, the plan had invested in tuition reimbursement as an incentive for PCPs to stay in certain rural areas.

**RMHP** policies stated that when covered services were not available or accessible in a timely fashion, services were authorized and provided out of network. **RMHP**'s 2010 Medicaid Access Plan demonstrated that **RMHP** considered the anticipated enrollment, expected utilization, numbers and types of providers, numbers of providers not accepting new patients, and geographic location when measuring the adequacy of its network.

**RMHP** had numerous policies and processes in place and under development to promote the delivery of services in a culturally competent manner to all members, including those with limited English skills. **RMHP**'s vital documents were available in English and Spanish, including the member handbook and provider directory. **RMHP** had a documented process for assisting members who required member materials in an alternate format such as large print or Braille.

### *Summary of Strengths*

Through its various quality improvement initiatives, **RMHP** monitored timely access to services and had mechanisms to improve performance. This included analyzing information from member grievances, member satisfaction surveys, and Healthcare Effectiveness Data and Information Set (HEDIS) performance measures. **RMHP** ranked in the top 10 percent of HEDIS 2009 national performance on several access and availability measures, including childhood immunizations, children's and adolescents' access to PCPs, timeliness of prenatal and postpartum care, and access to preventive/ambulatory health services for members 65 years of age and older.

### *Summary of Required Actions*

There were no required actions for this standard.

## Standard VIII—Credentialing and Recredentialing

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

**RMHP** had a well-defined process for credentialing and recredentialing its practitioners. The policies and procedures were clearly based on NCQA standards and guidelines as required in the Medicaid managed care contract with the Department.

### *Summary of Strengths*

An on-site review of 10 credentialing and 10 recredentialing records demonstrated that primary source verification was completed within the prescribed time frames and that credentialing and recredentialing was completed within the required time frame. The on-site record reviews also demonstrated that primary source verification was completed using NCQA-approved sources. The credentialing and recredentialing records contained all of the required documentation and were well organized.

### *Summary of Required Actions*

NCQA clarified that its requirement regarding reporting actions that alter the condition of a practitioner's relationship with **RMHP** applied to all practitioners licensed or certified by the State to practice independently that have an independent relationship with the organization. **RMHP** must develop a process to report any actions taken against nonphysician practitioners for quality reasons to the appropriate authorities, including the Colorado Department of Regulatory Agencies (DORA) for nonphysician practitioners.

**RMHP** must maintain documentation to demonstrate that its Medical Practice Review Committees (MPRCs) function as the credentialing committees, use a peer review process, and include representation from a range of participating providers.

**RMHP** must develop a process for conducting on-site quality assessments of organizational providers, when applicable. The process may include accepting a State survey in lieu of performing an on-site assessment if NCQA guidelines are followed. **RMHP** must develop its own criteria for organizational provider assessment for each type of organizational provider and determine if State or CMS site visits evaluate each of **RMHP**'s assessment and site visit standards. In addition, **RMHP** must have a process for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners, as applicable.

### 3. Follow-up on FY 2009–2010 Corrective Action Plan for Rocky Mountain Health Plans

#### Methodology

As a follow-up to the FY 2009–2010 site review, each MCO/PIHP was required to submit a corrective action plan (CAP) to the Department addressing all requirements for which it received a score of *Partially Met* or *Not Met*. The plan was required to describe interventions designed to achieve compliance with the specified requirements, the timelines associated with those activities, anticipated training and follow-up activities, and documents anticipated to be sent following the completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the MCO/PIHP and determined whether the MCO/PIHP successfully completed each of the required actions. HSAG and the Department continued to work with the MCO/PIHP until HSAG and the Department determined that the MCO/PIHP completed each of the required actions from the FY 2008–2009 compliance monitoring site review, or until the time of the on-site portion of the MCO's/PIHP's FY 2009–2010 site review.

#### Summary of 2009–2010 Required Actions

As a result of the FY 2009–2010 site review, **RMHP** was required to create a CAP to address deficiencies in the Coordination and Continuity of Care, Member Information, and Grievance System standards.

For Coordination and Continuity of Care, **RMHP** was required to ensure that it informs all new members of the circumstances under which a member who has special health care needs (as defined in the Colorado Code of Regulations [CCR], 10-CCR 2505-10.8.205.9) may continue to receive covered services from his or her provider and the time frames within which those services may continue.

For Member Information, **RMHP** was required to notify all members at least once a year of their right to request and obtain required information as specified in the Code of Federal Regulations (CFR) at 42 CFR 438.10.

**RMHP** was required to take steps to ensure that its providers offer Early and Preventive Screening, Diagnosis, and Treatment (EPSDT) appointments within two weeks of a request, in accordance with contract requirements. **RMHP** was required to modify its access plan and provider manual to reflect these changes and notify the provider network of any changes needed to its service accessibility. Subsequent monitoring of the provider network for its adherence to appointment availability standards was required to focus on attaining compliance with the EPSDT appointment standards.

**RMHP** was also required to enhance its member handbook to include a statement that members can request a State fair hearing at any time, and to include rules that govern representation at State fair hearings. The health plan was required to include definitions and descriptions of poststabilization services in its member handbook and how members can access them. Furthermore, **RMHP** was required to revise member materials to include the correct time frame for filing an appeal if

members request a continuation of benefits/services and to notify members of the appeal rights available to providers to challenge the failure of **RMHP** to cover a service.

**RMHP** was required to address 13 separate elements of the Grievance System standard. Several of these required actions were to correct discrepancies between **RMHP**'s policies and processes and its template letters used for notices of action. **RMHP**'s policies and procedures were missing pertinent information and included information that was not accurate or consistent with BBA requirements.

## Summary of Corrective Action/Document Review

**RMHP** submitted its CAP to HSAG in June 2010. HSAG and the Department agreed that the plan was not sufficient as written and asked **RMHP** to resubmit its CAP. **RMHP** revised the plan and resubmitted it to HSAG and the Department in September 2010. HSAG and the Department determined that if **RMHP** implemented the CAP as written, it would achieve compliance. **RMHP** was advised to move forward with implementation, and it was asked to submit documentation providing evidence of having completed the required actions. **RMHP** continued to work with HSAG and the Department to revise documents and made its final submission of documents February 7, 2010.

## Summary of Continued Required Actions

**RMHP** successfully revised all documents, clarifying inconsistencies and inaccuracies. The final submission of documents, however, occurred following the FY 2010–2011 site review process. Therefore, **RMHP** continued to implement the designated changes to its processes during FY 2010–2011.

*Appendix A.* **Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

The completed compliance monitoring tool follows this cover page.

<b>Standard I—Coverage and Authorization of Services</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.</p> <p align="right"><i>42CFR438.210(a)(3)(i)</i></p> <p>Contract:            DHMC: II.C.1.a            RMHP: II.D.1.a</p>	<p>CM Process Medicaid Preauthorization see I.1.            QI Disease Management and High Risk OB Description entire document.            RMHP Medicaid Member Handbook see I.1 p.13-20</p> <p>The attached documents demonstrate the list of Covered Services consistent with the RMHP contract and address Care Coordination, Utilization Management and Disease Management.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            RMHP had established a broad network of providers for the Medicaid service areas. There was evidence that RMHP contracted with most available providers, hospitals, and specialists. The 2010 Medicaid Access Plan documented that RMHP’s participating providers included 215 PCPs, 128 specialists, and nine hospitals. Other types of participating providers included skilled nursing facilities, home health agencies, laboratories, therapists, and other miscellaneous ancillary providers. RMHP had written policies and processes to ensure that it provided timely and coordinated covered services to its Medicaid members. Policies and procedures addressed service accessibility, attention to individual needs, acuity/complexity level, continuity of care, maintenance of health, and independent living. RMHP allowed members to access specialists without a referral. RMHP posted evidence-based guidelines and tools on its Web site to help providers develop a treatment plan for patients who had diagnoses of asthma, cardiovascular disease, depression, or diabetes.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>2. The Contractor provides the same standard of care for all members regardless of eligibility category and makes all covered services as accessible in terms of timeliness, amount, duration, and scope to members as those services are to non-Medicaid recipients within the same area.</p> <p>Contract:            DHMC: II.C.1.b            RMHP: II.D.1.b</p>	<p>PR Physician Medical Services Agreement see I.2. p 12 Z and AA</p> <p>Attached is the model contract for use with physicians. It specifically addresses requirement 2.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



*Appendix A. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p><b>Findings:</b>            The Physician Medical Services Agreement, the Professional Medical Services Agreement, and the Hospital Services Agreement included a “non-discrimination in providing services” clause that specifically prohibited providers from discriminating against members regarding medically necessary services based on the source of payment, sex, age, race, color, religion, origin, health status, or handicap. The criteria for Medicaid and RMHP’s other lines of business for wait times, provider-to-member ratios, and geographic access were comparable.</p> <p><b>Required Actions:</b>            None</p>		
<p>3. 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.</p> <p align="right"><i>42CFR438.210(a)(3)(ii)</i></p> <p>Contract:            DHMC: II.C.1.c            RMHP: II.D.1.c</p>	<p>CM Process Medicaid Preauthorization see I.3.</p>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> N/A</p>
<p><b>Findings:</b>            The Preauthorization of Services for Medicaid Members process included specifications for the processing of authorization requests. RMHP used the Milliman Care Guidelines as the set of criteria for clinical review for Medicaid members. Rocky Mountain supplemented the Milliman Care Guidelines with an established process, including the use of medical policy guidelines. According to RMHP’s Medicaid Clinical Policy Development policy, guidelines were reviewed to ensure that they were not discriminatory or arbitrary, were applied consistently, were financially responsible, and aligned with the organization’s mission and values.</p> <p><b>Required Actions:</b>            None</p>		

<b>Standard I—Coverage and Authorization of Services</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>4. If the Contractor places limits on services, it is:</p> <ul style="list-style-type: none"> <li>◆ On the basis of criteria applied under the State plan (medical necessity).</li> <li>◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.</li> </ul> <p align="right"><i>42CFR438.210(a)(3)(iii)</i></p> <p>Contract:            DHMC: II.H.1.a            RMHP: II.I.1.a</p>	<p>Medicaid Member Handbook_ see I. 4. a. Limits</p> <p>RMHP Provider Manual see I.4. a. p 16, I.4. a and b p 71, I .4.b p 72            Criteria and Utilization Control</p> <p>Preauthorization Medicaid Policy see I.4</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            RMHP covered services were congruent with the health plan’s contract with the Department. RMHP used nationally recognized criteria—Milliman Care Guidelines—to make decisions regarding medical necessity and appropriateness of authorizations. Some services with limits or restrictions—e.g., home health, physical therapy, and speech therapy—were addressed in the preauthorization policy, and specific requirements, such as treatment plan or care coordination were identified.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>5. The Contractor specifies what constitutes “medically necessary services” in a manner that:</p> <ul style="list-style-type: none"> <li>◆ Is no more restrictive than that used in the State Medicaid program.</li> <li>◆ Addresses the extent to which the Contractor is responsible for covering services related to the following:               <ul style="list-style-type: none"> <li>▪ The prevention, diagnosis, and treatment of health impairments,</li> <li>▪ The ability to achieve age-appropriate growth and development,</li> <li>▪ The ability to attain, maintain, or regain functional capacity.</li> </ul> </li> </ul> <p align="right"><i>42CFR438.210(a)(4)</i></p>	<p>Medicaid Member Handbook see I.5. definition of “Medically Necessary”</p> <p>Preauthorization Medicaid Policy see I.5</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



*Appendix A. Colorado Department of Health Care Policy & Financing*  
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<b>Standard I—Coverage and Authorization of Services</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
Contract: DHMC: Exhibit A2 RMHP: Exhibit A		
<b>Findings:</b> The Preauthorization policy’s definition of medically necessary services was no more restrictive than the Department’s. It addressed RMHP’s responsibility to cover services related to prevention, diagnosis, and treatment. The definition also included services “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, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs.”		
<b>Required Actions:</b> None		
6. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services.  <div style="text-align: right;"><i>42CFR438.210(b)</i></div> Contract: DHMC: II.H.1.a RMHP: II.I.1.a	Preauthorization Medicaid Policy see I.6	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<b>Findings:</b> RMHP’s Preauthorization of Services for Medicaid Members process included the methods for processing requests for authorization of services. The process detailed specific instructions for preauthorization specific to Medicaid, limitations for home health and therapies, out-of-network services, expedited requests, peer-to-peer review, and continuity of care for new members. RMHP also had a discharge planning policy and procedure. The 2010–2011 Care Management Program Description stated that there was a concurrent review process that included on-site or telephonic review and discharge.		
<b>Required Actions:</b> None		



*Appendix A. Colorado Department of Health Care Policy & Financing*  
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<b>Standard I—Coverage and Authorization of Services</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>7. The Contractor’s written policies and procedures include mechanisms to ensure consistent application of review criteria for authorization decisions.</p> <p align="right"><i>42CFR438.210(b)(2)(i)</i></p> <p>Contract:            DHMC: II.H.1.b            RMHP: II.I.1.b</p>	<p>Preauthorization Medicaid Policy see I.7</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            The Preauthorization of Services for Medicaid Members policy included instructions for processing requests for authorization of services. The document stated that decisions were based on eligibility, covered benefits, medical necessity, and appropriateness of care. The 2010–2011 Care Management Program Description stated that RMHP conducted interrater reliability (IRR) audits to evaluate consistency in documentation.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>8. The Contractor’s written policies and procedures include a mechanism to consult with the requesting provider when appropriate.</p> <p align="right"><i>42CFR438.210(b)(2)(ii)</i></p> <p>Contract:            DHMC: II.H.1.b            RMHP: II.I.1.b</p>	<p>Preauthorization Medicaid Policy see I.8</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            RMHP’s Preauthorization of Services for Medicaid Members policy stated that the medical director, who was responsible for making the final determination on medical appropriateness, could consult with the requesting physician when necessary. The policy also allowed for peer-to-peer review, which provided the requesting provider the opportunity to request, on behalf of the covered person, a peer-to-peer conversation regarding an adverse determination with the person responsible for the decision. Records included in the on-site record review demonstrated that a request for additional documentation from a provider was initiated when needed to make an authorization decision.</p>		
<p><b>Required Actions:</b>            None</p>		



*Appendix A. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Compliance Monitoring Tool**  
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<b>Standard I—Coverage and Authorization of Services</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>9. The Contractor’s written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member’s condition or disease.</p> <p align="right"><i>42CFR438.210(b)(3)</i></p> <p>Contract:            DHMC: II.H.1.e            RMHP: II.I.1.e</p>	<p>Preauthorization Medicaid Policy see I.9</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            The Pharmacy policy and flow chart indicated that any denials would be made by a pharmacist and approved by the medical director. The Preauthorization of Services for Medicaid Members policy provided that all utilization management decisions would be made by individuals with “knowledge and skills to evaluate working diagnoses and proposed treatment plans.” The policy specified that nurses with unrestricted licenses in Colorado conducted clinical reviews and could approve requests and make administrative denial determinations. When documentation did not meet medical necessity criteria or coverage guidelines, a medical director would review the case to make the determination. The policy further stated that care management business support and administrative staff would conduct nonclinical reviews and could approve requests or make administrative denial determinations. Of the 20 records reviewed on-site, one record (No. 8) was not made by a health care professional with clinical expertise in treating the condition. There was no determination letter for one record (No. 21), so all record review elements for this case were scored <i>Not Met</i>. Two records (No. 11 and No. 18) were denials for emergency service coverage made by nonclinical administrative staff. While denial of payment for emergency services for a dental caries diagnosis was consistent with RMHP’s contract with the Department and, therefore, was deemed a valid reason for denial of payment, HSAG recommends that RMHP escalate denied emergency claims to medical review (per its policies) to ensure the application of the prudent layperson standard.</p>		
<p><b>Required Actions:</b>            Based on the record review (case No. 8), RMHP must ensure that it adheres to its policy (and federal health care regulations) that denial decisions must be made by a health care professional who has appropriate clinical expertise in treating the member’s condition or disease.</p>		



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<p>10. The Contractor’s written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).</p> <p align="right"><i>42CFR438.210(c)</i></p> <p>Contract:            DHMC: II.H.1.b            RMHP: II.I.1.b</p>	<p>Preauthorization Medicaid Policy see I.10 p 5</p> <p>Provider Manual notification of denied or reduced services I.10. p 72</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            RMHP’s Preauthorization of Services for Medicaid Members policy included the processes for notifying both the member and the requesting provider of preauthorization decisions. RMHP provided online services for providers that included the ability to check authorizations. The on-site record review showed that in 19 of the 20 records reviewed, the member and the provider were notified of denial decisions. One record (No. 21) had no indication that notification had been given to the provider or that written notice of the decision had been sent to the member. None of the 20 records reviewed on-site were compliant with the content requirements for the notification letter. The first paragraph of each letter reviewed stated: “You may have to pay the doctor yourself.” None of the 20 letters reviewed stated specifically that a member’s physician could file an appeal on his or her behalf.</p>		
<p><b>Required Actions:</b>            RMHP must ensure that notices of an authorization decision (notices of action) are provided to members and providers, and that notices to members include information that the provider can file an appeal on the member’s behalf. Letters to members should not state that the member may have to pay for the services.</p>		



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<p>11. The Contractor’s written policies and procedures include the following timeframes for making standard and expedited authorization decisions:</p> <ul style="list-style-type: none"> <li>◆ For standard authorization decisions—10 calendar days.</li> <li>◆ For expedited authorization decisions—3 days.</li> </ul> <p align="right"><i>42CFR438.210(d)</i></p> <p>Contract:            DHMC: Exhibit I— 8.209.4.A.3.c and 8.209.6            RMHP: Exhibit B— 8.209.4.A.3.c and 8.209.6</p>	<p>Preauthorization Medicaid Policy see I.11 p 5</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            The Preauthorization of Services for Medicaid Members policy stated that standard authorization decisions must be made within 10 days after receipt of the request. The policy required that expedited preauthorization decisions be made within three <i>working</i> days, but there were also references in the policy to decisions within 72 hours. The on-site record review demonstrated that RMHP did not adhere to the time frames for making standard authorization decisions, with 47 percent, or eight of the 17 applicable records, having met the requirement.</p>		
<p><b>Required Actions:</b>            RMHP must ensure that its policies are internally congruent as to time frames (e.g., three working days would not represent 72 hours if the time frame included a weekend). RMHP must also ensure that it follows its policies and federal health care regulations regarding decision time frames for authorization decisions.</p>		
<p>12. The Contractor’s written policies and procedures include the following timeframes for possible extension of timeframes for authorization decisions:</p> <ul style="list-style-type: none"> <li>◆ Standard authorization decisions—up to 14 calendar days.</li> <li>◆ Expedited authorization decisions—up to 14 calendar days.</li> </ul> <p align="right"><i>42CFR438.210(d)</i></p> <p>Contract:            DHMC: None            RMHP: None</p>	<p>Preauthorization Medicaid Policy see I.12.a and I.12.b</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A

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Requirement	Evidence as Submitted by the Health Plan	Score
<p><b>Findings:</b>            The Preauthorization of Services for Medicaid Members policy stated at 14.1.3 that the time period within which a determination would be made begins on the date the request is received by RMHP. In cases involving an extension, notification would be provided within 24 days (10 days plus the 14-day extension). However, at 14.1.2, the policy stated that if the member or the member’s provider failed to submit enough information necessary to make the determination, RMHP would give the member at least 30 days from the receipt of the notice to provide the specified information. The policy stated, “Rocky Mountain sets this timeframe. It is not a regulatory requirement.” While allowing this time frame may be acceptable for retrospective requests or claims decisions, it is not compliant with federal requirements when applied to preservice requests. (Both preservice elective and retrospective requests were addressed under Section 14.1) CMS explanatory comments on the maximum time allowed to make determinations for preservice requests were published in the Federal Register, Volume 67, No. 115, Friday, June 14, 2002, page 41048. <a href="http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2002_register&amp;docid=fr14jn02-22.pdf">http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=2002_register&amp;docid=fr14jn02-22.pdf</a></p>		
<p><b>Required Actions:</b>            RMHP must ensure that its written policies, procedures, and processes adhere to federal managed care regulations—specifically, that time frames for authorization decisions can only be extended by up to 14 calendar days for both standard and expedited authorization decisions.</p>		
<p>13. The Contractor’s written policies and procedures 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.</p> <p align="right"><i>42CFR438.210(e)</i></p> <p>Contract:            DHMC: II.I.3.a            RMHP: None</p>	<p>Care Management Program Description see I.13.            Preauthorization Medicaid Policy see I.13            Provider Manual I.13. p 73, I.13. p82 Compensation without withholding care            PR –Physician Services Agreement see p 10 section S            PR – Hospital Agreement see I.13. p 14            Note: Ancillary Agreements use the same contract form as Physician Services Agreement.</p>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> N/A</p>
<p><b>Findings:</b>            The Care Management Program Description and the Preauthorization of Services for Medicaid Members policy stated that RMHP “does not offer incentives to providers or staff to issue denials or encourage inappropriate under-utilization.” The provider manual, the physician services agreement, and the hospital agreement all included the statement, “RMHP does not compensate for denials nor does it offer incentives that encourage denials.”</p>		
<p><b>Required Actions:</b>            None</p>		



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<p>14. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:</p> <ul style="list-style-type: none"> <li>◆ 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,</li> <li>◆ Serious impairment to bodily functions,</li> <li>◆ Serious dysfunction of any bodily organ or part.</li> </ul> <p align="right"><i>42CFR438.114(a)</i></p> <p>Contract: DHMC: I.12 RMHP: I.14</p>	<p>Medicaid Member Handbook see I.14. ER/UC pp 8-9 and I.14.ER Benefit p 15</p> <p>CM Process Emergency Services see I.14. Definitions “Emergency”</p> <p>CM Process Emergency Services see I.14” “Prudent Layperson”</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b> RMHP’s policies defined “emergency medical condition” using terminology consistent with 42 CFR 438.114(a). The Medical Claims Review policy stated that a medical emergency included severe pain, a bad injury, a serious illness, or a medical condition that was quickly worsening.</p>		
<p><b>Required Actions:</b> None</p>		
<p>15. The Contractor defines Emergency Services as 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.</p> <p align="right"><i>42CFR438.114(a)</i></p> <p>Contract: DHMC: I.13 RMHP: I.15</p>	<p>CM Process Emergency Services see I.15 Emergency Services</p> <p>Medicaid Member Handbook see I.15. ER/UC pp 8-9 and I.15.ER Benefit p 15</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b> RMHP’s Emergency Services process defined “emergency services” consistent with 42 CFR 438.114(a).</p>		



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<b>Required Actions:</b> None		
16. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member’s condition.  <i>42CFR438.114(a)</i>  Contract: DHMC: II.C.4.d RMHP: II.D.4.d	CM Process Emergency Services see I.16 Post Stabilization	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<b>Findings:</b> The Emergency Services policy stated that RMHP shall cover poststabilization care related to an emergency medical condition provided after a member was stabilized to maintain the stabilized condition or to improve or resolve the member’s condition.		
<b>Required Actions:</b> None		
17. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.  <i>42CFR438.114(c)(1)(i)</i>  Contract: DHMC: II.C.4.a.4 RMHP: II.D.4.a.4	CM Process Emergency Services see I.17. Does not require preauthorization CM Process Emergency Services see I.17. 2.1 Provider Manual see I.17 p 16 Non contracting providers Medicaid Member Handbook see I.17. ER/UC pp 8-9 and I.17.ER Benefit p 15	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<b>Findings:</b> The Emergency Services process stated that RMHP did not require preauthorization for urgent or emergent services. It stated that urgent/emergent care is covered to screen and stabilize a Medicaid member regardless of whether the provider of services was a contracted provider. The Emergency Services policy stated that RMHP would reimburse nonparticipating providers in accordance with the member’s benefits.		
<b>Required Actions:</b> None		



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18. The Contractor does not require prior authorization for emergency or urgently needed services.  <p align="center"><i>42CFR438.10(f)(6)(viii)(B)</i></p> DHMC: II.C.4.a.3 RMHP: II.D.4.a.3	Preauthorization Medicaid Policy see I.18 Medicaid Member Handbook see I.18 ER/UC pp 8-9	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<b>Findings:</b> The Emergency Services process stated that RMHP did not require preauthorization for urgent or emergent services. Similar information was provided in the member handbook, the provider manual, the Emergency Services policy, the Preauthorization of Services for Medicaid Members policy, the physician services agreement, and the hospital services agreement.		
<b>Required Actions:</b> None		
19. The Contractor may not deny payment for treatment obtained under either of the following circumstances: <ul style="list-style-type: none"> <li>◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the following outcomes:               <ul style="list-style-type: none"> <li>▪ 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,</li> <li>▪ Serious impairment to bodily functions,</li> <li>▪ Serious dysfunction of any bodily organ or part.</li> </ul> </li> <li>◆ A representative of the Contractor’s organization instructed the member to seek emergency services.</li> </ul> <p align="center"><i>42CFR438.114(c)(1)(ii)</i></p> Contract: DHMC: II.C.4.a.4 RMHP: II.D.4.a.4	Preauthorization Medicaid Policy see I.19 Medicaid Member Handbook see I.19 ER/UC pp 8-9	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p><b>Findings:</b>            The Emergency Services policy included the required language. These provisions were repeated in the physician services agreement and the hospital services agreement. RMHP’s Emergency Services policy defined “emergency medical condition” using terminology consistent with 42 CFR 438.114(a). The policy stated that if it was later determined that the condition was not an emergency, RMHP would pay for the services if it would appear to a prudent layperson that the signs and symptoms of the condition were an emergency.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>20. The Contractor does not:</p> <ul style="list-style-type: none"> <li>◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms.</li> <li>◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider, the Contractor or State agency of the member’s screening and treatment within 10 days of presentation for emergency services.</li> </ul> <p align="right"><i>42CFR438.114(d)(1)</i></p> <p>Contract:            DHMC: II.C.4.c            RMHP: II.D.4.c</p>	<p>Preauthorization Medicaid Policy see I.20 2.8            Preauthorization Medicaid Policy see I.20 2.9</p> <p>Medicaid Member Handbook see I.20 ER/UC pp 8-9</p>	<p><input type="checkbox"/> Met  <input checked="" type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> N/A</p>
<p><b>Findings:</b>            RMHP’s Emergency Services policy stated that services would be covered regardless of whether an emergency room provider, hospital, or fiscal agent notified the member’s PCP or RMHP of the member’s screening and treatment. However, the policy did not state that the services would be covered regardless of whether notification was provided within 10 days of presentation for emergency services. The ER Physician/Urgent Care chapter of the Claims Medical Processing Manual stated in the Types of Services: Initial Emergent/Urgent Care section that “RMHP must be notified within 48 hours of out of area emergency services.”</p> <p>The Emergency Services policy stated that RMHP would not limit the definition of an emergency medical condition to a list of diagnoses or symptoms. The Medical Claims Review/Care Management policy also stated that RMHP would not limit what constitutes and emergency medical condition based on lists of diagnoses or symptoms and that reimbursement would be in accordance with the member’s covered benefits. However, the ER</p>		

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Requirement	Evidence as Submitted by the Health Plan	Score
	<p>Physician/Urgent Care chapter of the Claims Medical Processing Manual contained a list of emergent diagnoses. Although notes adjacent to the list stated, “the list is only a reference and may not include all diagnoses that could be involved in an emergent situation,” a subsequent section in the chapter, Types of Services: Initial Emergent/Urgent Care: Diagnoses, stated, “Refer to the Emergent Diagnoses list. Consider the age of the patient as well as the diagnosis when trying to determine emergency status. If the claim appears to be emergent, but the diagnosis is not on the approved list, pend the claim UM60 to Medical Review.” The Out-of-Area chapter of the Claims Medical Processing Manual in the Emergency Claims sections also stated that “if after checking Claims Inquiry, Prospective UM, the Emergent Diagnoses list, it is not clear if the claim is payable, pend the claim...to Medical Review for determination.” The Emergency Services policy stated that emergency and urgent care claims are paid at the claims processor level except for services that are benefit exclusions. The Medical Claims Review/Care Management policy stated that RMHP would authorize payment for emergency services necessary to screen and stabilize a covered person in accordance with the “Managed Care Rule 438.114(d)(2).” Two records included in the on-site record review (No. 11 and No. 18) were denials based on diagnoses, dental caries. These cases did not appear to have been through medical review. The determination letters were signed “Customer Services.”</p> <p>While it was clear that dental <i>treatment</i> was not a covered benefit, application of the prudent layperson standard requires that a person presenting to an emergency room with severe pain be screened to diagnose and ascertain whether infection or other underlying reasons are causing the pain. The Medical Claims Review policy stated that RMHP would not deny benefits for medical conditions that a prudent layperson would perceive as emergent. HSAG recommends that emergency claims not initially paid by the system be escalated to medical review for application of the prudent layperson standard.</p>	
<b>Required Actions:</b>	<p>RMHP must ensure that it does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s PCP, the contractor, or a State agency of the member’s screening and treatment within 10 days of presentation for emergency services. RMHP must also ensure that it does not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms for Medicaid members.</p>	



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<p>21. 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.</p> <p align="right"><i>42CFR438.114(d)(2)</i></p> <p>Contract:            DHMC: None            RMHP: None</p>	<p>Preauthorization Medicaid Policy see I.21 2.10            Preauthorization Medicaid Policy see I.21 2.2</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            The Emergency Services policy included this provision. The hospital services agreement stated that a Medicaid recipient who had a medical emergency could not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Medicaid recipient.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>22. 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.</p> <p align="right"><i>42CFR438.114(d)(3)</i></p> <p>Contract:            DHMC: II.C.4.a.5            RMHP: II.D.4.a.5</p>	<p>Preauthorization Medicaid Policy see I.22 2.5</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            The Emergency Services process stated that RMHP would cover emergency services “if the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on RMHP as responsible for coverage and payment.”</p>		
<p><b>Required Actions:</b>            None</p>		



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<p>23. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are pre-approved by a plan provider or other organization representative.</p> <p align="right"><i>42CFR438.114(e)</i></p> <p>Contract: DHMC: II.C.4.d RMHP: II.D.4.d</p>	<p>Preauthorization Medicaid Policy see I.23 2.5</p> <p>See claims denial universe</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b> The Emergency Services policy stated that claims for emergency services necessary to screen and stabilize the patient and claims for poststabilization care services that were medically necessary to maintain the covered person’s stabilized condition would not be denied for failure by the covered person or the emergency service provider to obtain prior authorization.</p>		
<p><b>Required Actions:</b> None</p>		
<p>24. 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 1 hour of a request to the organization for pre-approval of further post-stabilization care services.</p> <p align="right"><i>42CFR438.114(e)</i></p> <p>Contract: DHMC: II.C.4.d RMHP: II.D.4.d</p>	<p>Preauthorization Medicaid Policy see I.24</p> <p>Preauthorization Medicaid Policy see I.24 2.3</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b> The Emergency Services process stated that RMHP would not deny services for screening and stabilization of emergency conditions when notification to RMHP was required if there was documentation that it was not reasonably possible to communicate with RMHP within the time limits.</p>		
<p><b>Required Actions:</b> None</p>		



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<p>25. 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:</p> <ul style="list-style-type: none"> <li>◆ The organization does not respond to a request for pre-approval within 1 hour,</li> <li>◆ The organization cannot be contacted,</li> <li>◆ The organization 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.</li> </ul> <p align="right"><i>42CFR438.114(e)</i></p> <p>Contract:            DHMC: II.C.4.d            RMHP: II.D.4.d</p>	<p>Preauthorization Medicaid Policy see I.25 2.3</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            The Emergency Services process stated that RMHP would not deny services for screening and stabilization of emergency conditions where notification to RMHP was required if there was documentation that it was not reasonably possible to communicate with RMHP within such time limits. The process also stated that urgent/emergent care was covered to screen and stabilize a Medicaid member regardless of whether the provider furnishing the services was a contracted provider.</p>		
<p><b>Required Actions:</b>            None</p>		

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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>26. The Contractor must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor.</p> <p align="right"><i>42CFR438.114(e)</i></p> <p>Contract:            DHMC: II.C.4.d            RMHP: II.D.4.d</p>	<p>A RMHP Medicaid member will never incur more charges for post-stabilization care. Regardless of the circumstance, RMHP Medicaid members will not be subject to charges greater than copayments set by the Colorado Department of Health Care Policy and Financing.</p> <p>In addition Post-stabilization services are covered by RMHP in accordance with 42.CFR422.112(c) which eliminates the possibility of providers attempting to bill RMHP Medicaid members for post-stabilization services.</p> <p>RMHP will gladly review this requirement during the on-site visit.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            The Emergency Services process stated that RMHP would not hold a member who had an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The ER Physician/Urgent Care chapter of the Claims Medical Processing Manual stated that emergency room visits should “not pull a co-pay for Medicaid members, including all related charges such as lab and radiology.” The Preauthorization Medicaid policy stated that if a member was referred for services outside of RMHP’s network, RMHP would ensure that the cost of the benefit to the member would be no greater than if the service had been provided in network. During the on-site interview, RMHP provided a template for the Medicaid Out of Network Authorization and Negotiation letter, which specified that the provider would accept Colorado Medicaid rates and co-pays. The Professional Services Agreement stated that the contractor could not hold a Medicaid recipient liable for services furnished under a contract, referral, or other arrangement, to the extent that those payments were in excess of the amount that the enrollee would owe if RMHP had provided the services directly.</p>		
<p><b>Required Actions:</b>            None</p>		



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Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
27. The Contractor’s financial responsibility for post-stabilization care services it has not pre-approved ends when: <ul style="list-style-type: none"> <li>◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care,</li> <li>◆ A plan physician assumes responsibility for the member's care through transfer,</li> <li>◆ A plan representative and the treating physician reach an agreement concerning the member's care,</li> <li>◆ The member is discharged.</li> </ul> <p align="right"><i>42CFR438.114(e)</i></p> <p>Contract:            DHMC: II.C.4.d            RMHP: II.D.4.d</p>	Preauthorization Medicaid Policy see I.27 2.5	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<b>Findings:</b> The Emergency Services process stated that RMHP would cover emergency services “if the attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on RMHP as responsible for coverage and payment.”		
<b>Required Actions:</b> None		

Results for Standard I—Coverage and Authorization of Services					
<b>Total</b>	Met	=	<u>22</u>	X	1.00 = <u>22</u>
	Partially Met	=	<u>5</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>0</u>
<b>Total Applicable</b>		=	<u>27</u>	<b>Total Score</b>	= <u>22</u>
<b>Total Score ÷ Total Applicable</b>					= <u>81%</u>



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<b>Standard II— Access and Availability</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
1. The Contractor ensures that all covered services are available and accessible to members.  <p align="right"><i>42CFR438.206(a)</i></p> Contract: DHMC: II.D.1.a.2 RMHP: II.E.1.a.2	RMHP Access Report Excel RMHP Access Report pdf  Medicaid Access Plan  PR Physician Medical Services Agreement see p 5. 2.A.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<b>Findings:</b> RMHP’s 2010 Medicaid Access Plan described the processes used by RMHP to monitor and measure network adequacy. The plan described RMHP’s geographic time and distance standards, provider-to-member ratios, and appointment wait times. RMHP monitored availability and accessibility through a variety of mechanisms, including quarterly Managed Care Accessibility Analysis reports, HEDIS measures, and member satisfaction surveys. RMHP ranked in the top 10 percent of HEDIS 2009 national performance on several access and availability measures, including childhood immunizations, children’s and adolescents’ access to PCPs, timeliness of prenatal and postpartum care, and access to preventive/ambulatory health services for members 65 years of age and older. Two Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures addressed access and availability, and RMHP showed strong performance on those measures. For the child Medicaid population, RMHP had the highest rates among Colorado health plans in FY 2009–2010 for the Getting Needed Care measure (64.1 percent) and the Getting Care Quickly measure (75.3 percent). For the adult population, the rate for Getting Needed Care was 58.4 percent, and the rate for Getting Care Quickly was 61.4 percent.		
<b>Required Actions:</b> None		



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<p>2. The Contractor maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.</p> <p align="right"><i>42CFR438.206(b)(1)</i></p> <p>Contract:            DHMC: II.D.1.a.2            RMHP: II.E.1.a.2</p>	<p>RMHP Access Report Excel            RMHP Access Report pdf</p> <p>Medicaid Member Handbook see II.2. Access p 7            PR Physician Medical Services Agreement see p 5. 2.A.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            RMHP maintained a broad network of providers and had written agreements with PCPs, specialists, and facilities. RMHP staff members stated during the on-site interview that it was the organization’s philosophy to contract with most available physicians in the service area to promote the accessibility and availability of services to members. RMHP presentation materials indicated that the Medicaid population had access to more than 90 percent of available specialists in its service area. The Managed Care Accessibility Analysis reports documented that, overall, RMHP met the State geographic access standards for urban, suburban, and rural areas.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>3. In establishing and maintaining the network, the Contractor considers:</p> <ul style="list-style-type: none"> <li>◆ The anticipated Medicaid enrollment,</li> <li>◆ 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,</li> <li>◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services,</li> <li>◆ The numbers of network providers who are not accepting new Medicaid patients,</li> <li>◆ The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides</li> </ul>	<p>Medicaid Access Plan</p> <p>RMHP Access Report Excel            RMHP Access Report pdf</p> <p>Medicaid Member Handbook see II.3. Access p 7</p> <p>Provider Manual see II.3. e p 13, Availability II.3.e p 14 Access</p> <p>Note: With regard to physicians in the Grand Valley, RMHP has a program for physician recruitment of primary care (Family Practitioners and Internists). Substantial funds have been devoted over a period of time for tuition reimbursement to incent PCP's to stay in the area.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A

<b>Standard II— Access and Availability</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>physical access for Medicaid members with disabilities.</p> <p align="center"><i>42CFR438.206(b)(1)(i) through (v)</i></p> <p>Contract:            DHMC: II.D.1.a.3            RMHP: II.E.1.a.3</p>		
<p><b>Findings:</b>            The Medicaid Access Plan indicated that, when evaluating the adequacy of its network, RMHP considered the anticipated Medicaid enrollment, the expected utilization of services, the number and types of providers, and the geographic location of providers and Medicaid members. RMHP provided access reports demonstrating that it measured the provider-to-member ratio and the geographic location of providers and members quarterly. RMHP’s Medicaid Access Plan stated that, to ensure available care was located within a reasonable travel time and distance to members, it contracted with most available acute care hospitals, PCPs, specialists, and subspecialists who met the credentialing and quality standards. To attract providers to certain areas, the plan had invested in tuition reimbursement as an incentive for PCPs to stay in certain rural areas.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>4. The Contractor provides female members with direct access to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventative 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.</p> <p align="center"><i>42CFR438.206(b)(2)</i></p> <p>Contract:            DHMC: II.D.1.a.4            RMHP: II.E.1.a.4</p>	<p>CM Policy Direct Access to OB/GYN Care entire document</p> <p>Medicaid Member Handbook see II.4 No referral for specialty care p.7, II.4. Care for pregnancy/women p 7, II.4. Preventive care p 18, II.4. Pregnancy/delivery p.18</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            RMHP’s Direct Access to OB/GYN Care policy clearly stated that members have direct access to contracted obstetrician/gynecologist (OB/GYN) providers. The policy explained that a woman’s OB/GYN may serve as her PCP and listed the types of specialty services available to women. As evidenced in policy and the member handbook, RMHP allowed members direct access to a contracting obstetrician or gynecologist for reproductive and gynecological care, which included medical and surgical management of disorders, pregnancy, childbirth, related preventive care, and family planning services. Members were not required to have prior approval or obtain a referral from a PCP or the health plan for an appointment with a participating obstetrician or gynecologist.</p>		



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<b>Required Actions:</b> None		
5. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.  Contract: DHMC: II.D.1.a.5 RMHP: II.E.1.a.	Medicaid Member Handbook see II.5. second opinion p 19  Medicaid Access Plan  Preauthorization Medicaid Policy see II.5  Provider Manual see II. 5. e pp 14,63 and 98 Second Opinion	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<b>Findings:</b> The Medicaid Member Handbook stated that second opinions were a covered benefit. The handbook stated that referrals were not required for second opinions and that customer service could provide assistance. The provider manual informed providers that second opinions were available to members—one per medical condition—free of charge. The Preauthorization Medicaid policy stated that services by out-of-network providers could be approved for a second opinion. The Medicaid Access Plan stated that second opinions were provided with no co-pay.		
<b>Required Actions:</b> None		
6. If the Contractor is unable to provide necessary services to a member in-network, the Contractor must adequately and timely cover the services out of network for the member, for as long as the Contractor is unable to provide them.  Contract: DHMC: II.D.1.b.1 RMHP: II.E.1.b.1	Preauthorization Medicaid Policy see II.6.  Provider Manual Out of area coverage see II.6. p 16  Medicaid Member Handbook see 11.6. Access p 7	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<b>Findings:</b> The Medicaid Access Plan and the Preauthorization Medicaid policy listed circumstances under which members could be directed to out-of-network providers. The Medicaid Member Handbook stated that if members could not find a network doctor close to where they live, they should call a customer service representative for help. The provider manual informed providers that in some instances, RMHP would authorize services from nonparticipating		



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<p>providers. The Preauthorization of Services for Medicaid Members policy stated that RMHP would arrange for covered services to be provided through agreements with nonparticipating providers when the health plan did not have the direct capacity to provide medically necessary, covered services in an appropriate manner to members with disabilities.</p> <p><b>Required Actions:</b> None</p>		
<p>7. The Contractor requires out-of-network providers to coordinate with the Contractor with respect to payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network.</p> <p align="right"><i>42CFR438.206(b)(5)</i></p> <p>Contract: DHMC: II.D.1.b.2 RMHP: II.E.1.b.2</p>	<p>Medicaid Access Plan Preauthorization Medicaid Policy see II.7</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b> The Preauthorization Medicaid policy stated that if a member was referred for services outside of RMHP’s network, RMHP would ensure that the cost of the benefit to the member would be no greater than if the service had been provided in network. During the on-site interview, RMHP provided a template for the Medicaid Out of Network Authorization and Negotiation letter, which specified that the provider would accept Colorado Medicaid rates and co-pays. The Professional Services Agreement stated that the contractor could not hold a Medicaid recipient liable for services furnished under a contract, referral, or other arrangement, to the extent that those payments were in excess of the amount that the enrollee would owe if RMHP had provided the services directly.</p>		
<p><b>Required Actions:</b> None</p>		
<p>8. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services. The Contractor has written policies and procedures for how 24-hour availability of services will be achieved and communicates the information to participating providers and members:</p> <ul style="list-style-type: none"> <li>◆ Emergency services are available 24 hours per day, 7 days per week.</li> </ul>	<p>Medicaid Access Plan no auth for Emergency and 2 week appointments</p> <p>Medicaid Member Handbook see II.8. Urgent/Emergency</p> <p>Provider Manual see II.8. a. p 15, Emergency/Urgent 24/7, II.8. b. 2) and 3) p 16 Access and backup, II.8. c. p 16 Non-urgent, II.8. d. p 16 Adult well care 4 mos., II.8. e. p 15 Urgent within 48 hours</p> <p>PR Physician Medical Services Agreement see II.8.a p 12. X.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A

<b>Standard II— Access and Availability</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<ul style="list-style-type: none"> <li>◆ The Contractor has a comprehensive plan for triage of requests for services on a 24-hour-7-day per week basis including:               <ul style="list-style-type: none"> <li>▪ Immediate medical screening exam by the primary care physician or hospital emergency room,</li> <li>▪ Access to a qualified health care practitioner via live telephone coverage either on-site, call-sharing, or answering service,</li> <li>▪ Practitioner back-up covering all specialties.</li> </ul> </li> <li>◆ Non-urgent healthcare is scheduled within two weeks.</li> <li>◆ Adult, non-symptomatic well care physical examinations are scheduled within 4 months.</li> <li>◆ Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor.</li> </ul> <p align="right"><i>42CFR438.206(c)(1)(i)</i></p> <p>Contract:            DHMC: II.D.1.d &amp; e            RMHP: II.E.1.d &amp; e</p>		
<p><b>Findings:</b>            RMHP’s Medicaid Access Plan specified that emergency care was immediately available 24 hours a day, 365 days a year. The plan affirmed that appointments for urgent medical care would be available within 48 hours of the request. The plan required that nonurgent appointments be available within two weeks and that preventive well-care appointments be available within 120 days. The member handbook instructed members to call 9-1-1 or go to an emergency room if they had an emergency, and to call their doctor for urgent needs. The handbook stated that if a member left a message, a doctor would call back and advise the member what to do. The handbook said that a member would get an urgent care appointment within two days. The Physician Medical Services Agreement and the Professional Services Agreement required that emergency service coverage be provided or arranged 24 hours a day, 365 days a year. The provider manual specified the standards for emergency, urgent, nonurgent, and well-care services.</p>		
<p><b>Required Actions:</b>            None</p>		



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<p>9. 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, if the provider serves only Medicaid members.</p> <p align="right"><i>42CFR438.206(c)(1)(ii)</i></p> <p>Contract: DHMC: None RMHP: None</p>	<p>Medicaid Member Handbook see II.8. Timely access non-urgent p 6, II.8. Timely Access p 4, II.8.ER/UC p 9, II.8. ER benefit p 9.</p> <p>CS Template Letter</p> <p>Note: Customer Service hours of operation are the same for Medicaid, Medicare, commercial plans and CHP+</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b> The Physician Services Agreement and the Professional Services Agreement each contained a clause regarding nondiscrimination in providing services. The RMHP member handbook and the customer service template letter indicated that the hours of operation were the same for Medicaid, Medicare, commercial plans, and CHP+.</p>		
<p><b>Required Actions:</b> None</p>		
<p>10. The Contractor makes Services available 24 hours a day, 7 days a week, when medically necessary.</p> <p align="right"><i>42CFR438.206(c)(1)(iii)</i></p> <p>Contract: DHMC: II.D.1.d RMHP: II.E.1.d</p>	<p>Medicaid Access Plan – no auth for Emergency and 2 week appointments</p> <p>Medicaid Member Handbook see II.10. ER/UC</p> <p>Provider Manual Access 24/7, see II. 10. p 15 and II.10 p 16.</p> <p>PR Physician Medical Services Agreement see p 10. 12.X.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b> RMHP’s Medicaid Access Plan, provider manual, Medicaid Member Handbook, Physician Medical Services Agreement, and Professional Services Agreement all specified that emergency services must be available 24 hours a day, 365 days a year, at any emergency department or by calling 9-1-1. The Physician Medical Services Agreement and the Professional Services Agreement required contractors to provide or arrange coverage for emergency services 24 hours a day, seven days a week. The member handbook included instructions for obtaining services 24 hours a day, seven days a week.</p>		
<p><b>Required Actions:</b> None</p>		



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<p>11. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, and has mechanisms to monitor providers regularly to determine compliance and to take corrective action if there is failure to comply.</p> <p align="right"><i>42CFR438.206(c)(1)(iv) through (vi)</i></p> <p>Contract:            DHMC: None            RMHP: None</p>	<p>RMHP submits quarterly Enrollment / Disenrollment Reports to the Department that include codes and reasons for disenrollment, including access barriers and voluntary vs. involuntary disenrollment numbers.</p> <p>RMHP utilizes the CAHPP Survey to monitor satisfaction relative to appointment waiting times and other measures of satisfaction as they relate to access.</p> <p>RMHP submits reports quarterly on Appeals and Grievances. RMHP monitors these reports for information on grievances relating to time access.</p> <p>RMHP is prepared to discuss any or all of these measures and how they help RMHP comply with this requirement.</p> <p>Medicaid Access Plan</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p><b>Findings:</b>            RMHP monitored availability and accessibility through the quarterly Managed Care Accessibility Analysis reports, HEDIS measures, CAHPS surveys, and RMHP internal member satisfaction surveys. The provider manual described that care management activities were linked with the RMHP quality improvement (QI) process. Care management reports regarding adherence to standards of care were evaluated in conjunction with member complaints, any applicable quality reviews, and member satisfaction surveys. The reports were used as part of the recertification process. RMHP ranked in the top 10 percent of HEDIS 2009 national performance in several key access and availability measures: childhood immunizations, children’s and adolescents’ access to PCPs, timeliness of prenatal and postpartum care, and access to preventive/ambulatory health services for members 65 years of age and older. RMHP demonstrated strong performance on the adult and child CAHPS measures for Getting Needed Care and for Getting Care Quickly. RMHP staff members reported that RMHP monitored providers through its Quality Assessment and Performance Improvement (QAPI) program and monitored grievance and appeal data for trends regarding access and availability. In the previous year, RMHP had developed a corrective action plan in response to an analysis of complaints regarding the dissatisfaction of members with their current PCP and members having trouble finding new PCPs. Analysis resulted in an internal corrective action plan to track the auto-assign process for the PCPs.</p>		
<p><b>Required Actions:</b>            None</p>		



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<p>12. 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 or reading skills including those with diverse cultural and ethnic backgrounds by:</p> <ul style="list-style-type: none"> <li>◆ Maintaining policies to reach out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those group,</li> <li>◆ Maintaining policies to provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation,</li> <li>◆ Make a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include inquiries conducted by the Contractor of the language proficiency of members during the Contractor’s orientation calls or being served by participating providers or improving access to health care through community outreach and Contractor publications,</li> <li>◆ Develop and/or provide cultural competency training programs, as needed, to the network providers and Contractor staff regarding:               <ul style="list-style-type: none"> <li>▪ health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services,</li> <li>▪ the medical risks associated with the Client population’s racial, ethical and socioeconomic conditions.</li> </ul> </li> <li>◆ Make available written translation of Contractor materials, including member Medicaid Member</li> </ul>	<p>CS Customer Welcome Call Policy and Procedure entire document II.8.a)-c)            CS Expedited and Non-Expedited Welcome Call Script II.8.a)-c)</p> <p>CS Alternate Language or Large Print Request entire document II.8.i.3)&amp;4)            CS Template Medicaid Letter With TDD and Braille II.8.i.3)&amp;4)</p> <p>CS Interpretation Services for Documents and Calls P&amp;P II 8.e., 8.f. 1 &amp; 2, 8.g., 8. i. 1)-4)</p> <p>Medicaid Access Plan II.12 8. a)-f)</p> <p>Provider Manual see II.12.i. Accommodations and II.12. j Equal Opportunity</p> <p>HR Core Competencies see paragraph 4 Diversity Awareness Employees are evaluated annually, and a significant part of the performance rating/feedback is based on the corporate competencies. 12.8.d</p> <p>CM Culturally Sensitive Services Policy entire document II. 12 8 a)-c)</p> <p>CM Culturally Sensitive Services Process entire document II. 12 8 a)-c)</p> <p>Bridges out of Poverty Training by DHHS Course taken by 20 Care Management, Quality Improvement and other RMHP personnel. II.8.d)</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A

<b>Standard II— Access and Availability</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>Handbook , correspondence and newsletters.            Written member information and correspondence shall be made available in languages spoken by prevalent non-English speaking member populations within the Contractor’s service area. Prevalent populations shall consist of 500 or more members speaking each language,</p> <ul style="list-style-type: none"> <li>◆ Develop policies and procedures, as needed, on how the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in service areas where language may pose a barrier so that Participating Providers can:               <ul style="list-style-type: none"> <li>▪ Conduct the appropriate assessment and treatment of non-English speaking members (including Members with a communication disability),</li> <li>▪ promote accessibility and availability of covered services, at no cost to Members.</li> </ul> </li> <li>◆ Develop policies and procedures on how the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats</li> <li>◆ Make a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse and culturally, competent clinical providers that represent the racial and ethnic communities being served,</li> <li>◆ Provide access to interpretative services by a qualified interpreter for members with a hearing impairment in such a way that it shall promote accessibility and availability of covered services,</li> </ul>	<p>Bridges out of Poverty Attendance Sheet Signature of attendees of March 4, 2010 training session referenced above. II.8.d)</p> <p>QI Cultural Competency II.8.d)</p> <p>A copy of the HR training module used by RMHP will be made available with the materials provided on site. This tool required all employees to log in and complete the module. II.8.d)</p> <p>Seven Nurses with Quality Improvement and Care Management have completed the Office of Minority Affairs Cultural Competency Training certification tool. Certificates of completion will be provided on-site at the request of the site reviewers. II.8.d)</p> <p>Medicaid Member Handbook in Spanish 8.e.</p> <p>RMHP Cultural Competency Newsletter Fall Winter 2009 II.8.a)&amp;d).</p> <p>RMHP Cultural Competency Newsletter Fall Winter 2010 II.8.a)&amp;d)</p> <p>RMHP Cultural Competency Newsletter Winter 2010 8.a. II.8.a)&amp;d)</p> <p>PR Physician Medical Services Agreement 12.I.1 Exhibit C pp 6-7 II.8.i)</p> <p>RMHP Compliance Plan June 2010 See page 24 no. 8 Re: Americans with Dishabilles Act 1990. 12.I.1 Exhibit C pp 6-7 II.8.i)</p>	

<b>Standard II— Access and Availability</b>		
Requirement	Evidence as Submitted by the Health Plan	Score
<ul style="list-style-type: none"> <li>◆ Develop and maintain written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973,</li> <li>◆ Arrange for Covered Services to be provided through agreements with non-participating providers when the Contractor does not have the direct capacity to provide covered services in an appropriate manner, consistent with independent living, to members with disabilities,</li> <li>◆ Provide access to TDD or other equivalent methods for members with a hearing impairment in such a way that it will promote accessibility and availability of covered services,</li> <li>◆ Make member information available upon request for members with visual impairments, including, but not limited to, Braille, large print, or audiotapes. For members who cannot read, member information shall be available on audiotape.</li> </ul> <p style="text-align: right;"><i>42CFR438.206(c)(2)</i></p> <p>Contract:            DHMC: II.D.6.c            RMHP: II.E.6.c (Cultural and Linguistic Competency)</p>		
<p><b>Findings:</b>            RMHP provided evidence that it promoted the delivery of services in a culturally competent manner to members, including those with limited English proficiency or reading skills and those with diverse cultural and ethnic backgrounds through its internal training processes, contracts with providers, policies and procedures, and member materials. The member handbook and other member documents such as the open enrollment letter and denial letter were available in Spanish and could be translated into any other language. The member portal on RMHP’s Web site contained links for members to obtain information about disease management, pregnancy resources, and preventive care topics in English and Spanish, and several member forms on the Web site could be downloaded in English or Spanish. The member handbook informed members of the availability of member information in alternate formats, and RMHP’s member handbook and provider directory contained information about the availability of oral interpretation services for members.</p>		



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<b>Standard II— Access and Availability</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>Spanish translation was available through customer service’s Spanish-speaking representatives or through AT&amp;T’s Language Line services. Translation for other non-English languages was available through the Language Line. The Alternate Language or Large Print Request policy and the Interpretation Service for Documents and Calls policy described the processes for RMHP staff members to follow for requests for written materials, materials in other formats (e.g. Braille), or interpretation services. The Culturally Sensitive Services policy specified that all Rocky Mountain care management clinical staff would complete the U.S. Department of Health &amp; Human Services Office of Minority Health’s “A Physician’s Practical Guide to Culturally Competent Care” training within six months of hire and that care management staff must participate in the RMHP cultural competency corporate education classes. The RMHP policy, Accommodations for Members With Disabilities, stated that members who were hearing impaired could access RMHP via a teletype (TTY) line and that customer service staff members were trained to handle AT&amp;T relay calls. The RMHP 2010 Compliance Plan outlined the corporate structure that ensured training and compliance with federal requirements. The Physicians Medical Services Agreement required that contractors provide interpreter services for those with communication disabilities and non-English-speaking members. Additionally, the agreement required contractors to comply with all of the applicable federal requirements (e.g., the Age Discrimination Act, the Age Discrimination in Employment Act, the Americans with Disabilities Act, Titles VI and VII of the Civil Rights Act, as well as the Colorado Revised Statutes).</p>		
<p><b>Required Actions:</b> None</p>		
<p>13. The Contactor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor:</p> <ul style="list-style-type: none"> <li>◆ Offers an appropriate range of preventative, primary care, and specialty services that is adequate for the anticipated number of members for the services area,</li> <li>◆ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.</li> </ul> <p align="right"><i>42CFR438.207(b)</i></p> <p>Contract: DHMC: II.D.2.c RMHP: II.E.2.c</p>	<p>RMHP Access Report Excel RMHP Access Report pdf</p>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> N/A</p>



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<b>Standard II— Access and Availability</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<b>Findings:</b> RMHP provided copies of its Managed Care Accessibility Analysis report. The Department verified that the reports are routinely submitted as required.		
<b>Required Actions:</b> None		

<b>Results for Standard II—Access and Availability</b>					
<b>Total</b>	Met	=	<u>13</u>	X	1.00 = <u>13</u>
	Partially Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>0</u>
<b>Total Applicable</b>		=	<u>13</u>	<b>Total Score</b>	= <u>13</u>

<b>Total Score ÷ Total Applicable</b>				=	<u>100%</u>
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<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.</p> <p>NCQA CR1</p>	<p>Credentialing Process entire document            Recredentialing Process entire document</p> <p>Note: All of RMHP’s credentialing and re-credentialing processes are designed to comply with NCQA standards.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP’s Credentialing Process policy and procedure and its Recredentialing Process policy and procedure demonstrated that RMHP had a well-defined process for evaluating and selecting licensed independent practitioners. The documents were consistent with NCQA 2010 Standards and Guidelines for Health Plans.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify:</p> <p>2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include MDs, Dentists, Chiropractors, Osteopaths, Podiatrists).</p> <p align="right"><i>42CFR438.214(a)</i></p> <p>NCQA CR1—Element A1            Contract:            DHMC: II.F.1.b &amp; c            RMHP: II.G.1.b &amp; c</p>	<p>Credentialing Process see pp 2-8            Recredentialing Process see pp 2-8</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            The Credentialing Process policy and the Recredentialing Process policy listed the types of practitioners subject to credentialing and recredentialing and the specific criteria required for each type of practitioner.</p>		
<p><b>Required Actions:</b>            None</p>		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
2.B. The verification sources used.  NCQA CR1—Element A2	Credentialing Process see pp 9-12	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> Both the Credentialing Process policy and the Recredentialing Process policy described NCQA-approved primary sources for verification of each element.		
<b>Required Actions:</b> None		
2.C. The criteria for credentialing and recredentialing.  NCQA CR1—Element A3	Credentialing Process see pp 2-8 Recredentialing Process see pp 2-8	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> The Credentialing Process policy and the Recredentialing Process policy listed criteria required for participation. These documents stated that applicants who do not meet all required criteria may be considered for participation at the discretion of the chief medical officer (CMO) or MPRC.		
<b>Required Actions:</b> None		
2.D. The process for making credentialing and recredentialing decisions.  NCQA CR1—Element A4	Credentialing Process see pp 12-14 Recredentialing Process see pp 14-15	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> The Credentialing Process policy and Recredentialing Process policy clearly delineated the process for making credentialing and recredentialing decisions.		
<b>Required Actions:</b> None		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
2.E. The process for managing credentialing/recredentialing files that meet the Contractor’s established criteria. NCQA CR1—Element A5	Credentialing Process see p 13 Recredentialing Process see p 14	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> The Credentialing Process policy and the Recredentialing Process policy outlined the expectations for managing credentialing and recredentialing files throughout the application process. The policies defined what were considered complete or incomplete files. The policies also indicated that clean files received approval and incomplete files or files not meeting criteria were deferred to the MPRC for discussion or further processing, as applicable. In addition, the documents delineated the process for maintaining credentialing and recredentialing files for the duration of the contract and for seven years after the contract ends. On-site review of files and documentation of CMO communication via e-mail revealed that the CMO reviewed and approved a list of names designated as applicants with clean files.		
<b>Required Actions:</b> None		
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	Delegated Credentialing-Rec credentialing Process entire document	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> The Delegated Credentialing/Rec credentialing policy and procedure outlined the process for delegating credentialing and/or recredentialing. The policy and procedure specified exactly what portion of the process could be delegated (application collection, primary source verification, and site visits) and the portion that could not be delegated (final decision). The policy included the procedure for evaluating the ability of an entity to perform the delegated activities. The policy also delineated the credentialing and recredentialing process that delegates are expected to follow, and the process for ensuring that the delegate’s processes met RMHP’s standards. The on-site record review included one record that had been credentialed by RMHP’s delegate. The record review indicated that RMHP had followed its procedures for processing this file.		
<b>Required Actions:</b> None		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes).</p> <p>NCQA CR1—Element A7</p>	<p>Non Discriminatory Credentialing entire document</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP’s Credentialing Process policy and Recredentialing Process policy and procedures clearly stated that decisions would not be based on race, ethnicity, gender, age, sexual orientation, or types of procedures in which the practitioner specializes. To ensure that its policies and procedures were adhered to, RMHP implemented the Non Discriminatory Credentialing policy and procedure. This procedure stated that the credentialing manager will track all providers who are denied or terminated as a result of the credentialing or recredentialing process. Furthermore, an internal audit director will review all denied providers on an annual basis to ensure that the decision was nondiscriminatory. The policy allowed for the internal audit director to consult with a medical director who was not involved in the original file review. On-site review of a completed audit demonstrated that RMHP followed its process to ensure that the credentialing process was not inadvertently discriminatory.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>2.H. The process for notifying practitioners if information obtained during the Contractor’s credentialing/recredentialing process varies substantially from the information they provided to the Contractor.</p> <p>NCQA CR1—Element A8</p>	<p>Credentialing Process see p 9</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP’s Credentialing Process policy and the Recredentialing Process policy stated that applicants would be notified telephonically if any information collected by the credentialing staff varied substantially from the information provided by the applicant.</p>		
<p><b>Required Actions:</b>            None</p>		

Standard VIII—Credentialing and Recredentialing		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>2.I. The process for ensuring that practitioners are notified of the credentialing/recredentialing decision within 60 calendar days of the committee’s decision.</p> <p>NCQA CR1—Element A9</p>	<p>Credentialing Process see p 13                      Recredentialing Process see p 15</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>                      RMHP’s Credentialing Process policy stated that the RMHP professional relations representative will notify a practitioner within 60 days of a decision to approve his or her application. The policy stated that if the application was denied, the CMO will notify the practitioner within five days. The Recredentialing Process policy included the process to notify applicants of a decision to deny participation within five days.</p>		
<p><b>Required Actions:</b>                      None</p>		
<p>2.J. The medical director or other designated physician’s direct responsibility and participation in the credentialing/ recredentialing program.</p> <p>NCQA CR1—Element A10</p>	<p>Credentialing Process see p 12                      Recredentialing Process see p 14</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>                      The Credentialing Process policy and Recredentialing Process policy indicated that the CMO had the authority and responsibility to review and approve files designated as clean files. The policies also stated that files not determined to be clean files were deferred to the MPRC for the appropriate region. During the on-site interview, RMHP credentialing staff clarified that each MPRC included a qualified medical director designated the responsibility for that particular MPRC.</p>		
<p><b>Required Actions:</b>                      None</p>		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law.</p> <p>NCQA CR1—Element A11</p>	<p>Credentialing Process see p 14            Recredentialing Process see p 15</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP’s processes for ensuring the confidentiality of all credentialing and recredentialing information (as stated in the Credentialing Process policy and Recredentialing Process policy) included the provision for keeping physical files in locked file cabinets in the credentialing area and limiting access to the files to the credentialing staff, the CMO, and legal counsel.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty.</p> <p>NCQA CR1—Element A12</p>	<p>Practitioner Specialties entire document</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            The Credentialing Process policy stated that practitioner directories were created from Facets tables and that the specialty and board certification information for the directory was obtained using the information entered by credentialing staff and was based on the provider’s qualifications. During the on-site interview, RMHP staff members stated that, while the hard copy of the provider directory was printed annually for enrollment packets, the online provider directory was refreshed daily.</p>		
<p><b>Required Actions:</b>            None</p>		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>2.M. The right of practitioners to review information submitted to support their credentialing/ recredentialing application.</p> <p>NCQA CR1—Element B1</p>	<p>Credentialing Process see p 9                      Recredentialing Process see pp 10-11</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>                      The Credentialing Process policy and Recredentialing Process policy stated that practitioners may review their credentials files upon request.</p>		
<p><b>Required Actions:</b>                      None</p>		
<p>2.N. The right of practitioners to correct erroneous information.</p> <p>NCQA CR1—Element B2</p>	<p>Credentialing Process see p 9                      Recredentialing Process see pp 10-11</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>                      The Credentialing Process policy and Recredentialing Process policy stated that practitioners will be given the opportunity to supply supporting documentation or to correct or clarify any discrepancies if information obtained from primary sources varies from information provided on the application.</p>		
<p><b>Required Actions:</b>                      None</p>		
<p>2.O. The right of practitioners, upon request, to receive the status of their credentialing or recredentialing application.</p> <p>NCQA CR1—Element B3</p>	<p>Credentialing Process see p 9                      Recredentialing Process see pp 10-11</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>                      The Credentialing Process policy and Recredentialing Process policy stated that practitioners may, upon request, be informed of the status of their application.</p>		
<p><b>Required Actions:</b>                      None</p>		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>2.P. The right of the applicant to receive notification of their rights under the credentialing program.</p> <p>NCQA CR1—Element B4</p>	<p>Credentialing Process see p 8                      Recredentialing Process see p 10</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>                      The credentialing section of the RMHP Web site provider page included each of the practitioner rights under the credentialing process.</p>		
<p><b>Required Actions:</b>                      None</p>		
<p>2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles including:</p> <ul style="list-style-type: none"> <li>◆ Collecting and reviewing Medicare and Medicaid sanctions,</li> <li>◆ Collecting and reviewing sanctions or limitations on licensure,</li> <li>◆ Collecting and reviewing complaints,</li> <li>◆ Collecting and reviewing information from identified adverse events,</li> <li>◆ Implementing appropriate interventions when it identified instances of poor quality related to the above.</li> </ul> <p>NCQA CR9—Element A</p>	<p>On-going Monitoring entire document</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>                      RMHP’s Mid-Cycle Credentialing policy and procedure described the process followed by RMHP to monitor provider Medicare and Medicaid sanctions, sanctions and/or limitations on licensure, complaints, and adverse events. On-site review of Office of Inspector General (OIG) monthly printouts demonstrated that RMHP followed its policy for ongoing monitoring of providers. An excerpt from RMHP’s MPRC meeting minutes demonstrated that the committee discussed and determined appropriate action in a case involving poor quality of care.</p>		
<p><b>Required Actions:</b>                      None</p>		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>2.R. The range of actions available to the Contractor if the provider does not meet the Contractor’s standards of quality.</p> <p>NCQA CR10—Element A1</p>	Reduction Suspension, Termination see p 4	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b></p> <p>The Reduction, Suspension, or Termination policy stated that if a provider does not meet RMHP’s standards for quality, RMHP may suspend the provider and appoint an MPRC to investigate and make recommendations. As a result of the MPRC investigation, RMHP may impose limits or restrictions on the provider’s practice (involving RMHP members) or may terminate the practitioner.</p>		
<p><b>Required Actions:</b></p> <p>None</p>		
<p>2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities.</p> <p>NCQA CR10—Element A2</p>	Reduction Suspension, Termination see p 4	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b></p> <p>The Reduction, Suspension, or Termination policy and procedure stated that the CMO would be responsible for reporting any sanction, suspension, or termination of a practitioner due to quality-of-care issues to the Colorado Board of Medical Examiners (CBME), the National Practitioner Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB). The policy did not address reporting to the Colorado Department of Regulatory Agencies (DORA) for nonphysician practitioners. During the on-site interview, RMHP credentialing staff reported that sanction or termination information was reported only for physicians, not for nonphysician practitioners such as nurse practitioners or physician assistants.</p>		
<p><b>Required Actions:</b></p> <p>NCQA clarified that its requirement applies to all practitioners licensed or certified by the State to practice independently that have an independent relationship with the organization. RMHP must develop a process to report any actions taken against nonphysician practitioners for quality reasons to the appropriate authorities, and must include reporting to DORA, when applicable.</p>		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>2.T. A well defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner’s participation based on issues of quality of care or service.</p> <p>NCQA CR10—Element A3</p>	Reduction Suspension, Termination see pp 2-3	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP’s Reduction, Suspension, or Termination policy and procedure stated that providers would be notified within five days of a decision to alter the conditions of their participation. The policy also stated that providers have 30 days to appeal the decision and described the hearing procedures (allowing witnesses, exhibits and evidence). In addition, the policy described written notice of the decision by the MPRC. An example of a letter that informed a practitioner of termination from the RMHP network informed the practitioner of the appeal process.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>2.U. Making the appeal process known to practitioners.</p> <p>NCQA CR10—Element A4</p>	Reduction Suspension, Termination see p 5	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            The Reduction, Suspension, or Termination policy and procedure stated that information about the appeal process would be included with the decision letter. Review of RMHP’s template letter confirmed that the letter included the required content.</p>		
<p><b>Required Actions:</b>            None</p>		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners.</p> <p>NCQA CR2—Element A</p>	Credentialing Committee entire document	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP’s Credentialing Process policy stated that the MPRCs function as the credentialing committees. The Credentialing Committee policy and procedure explained that there were 15 MPRCs throughout the RMHP service area based on the region in which physicians provide services. The policy stated that while RMHP did not specify a set of specialties that must be represented on each MPRC, it did require that each MPRC have a range of specialties and number of practitioners determined by the size of the area represented. RMHP did not provide adequate documentation and evidence of committee meetings or the content of discussion for cases that were deferred to the MPRC for discussion and final decision. RMHP provided only an excerpt of one meeting stating that a physician was discussed. The excerpt did not indicate what was discussed or who was present (to determine that a range of practitioners was represented on the committee). Other sets of minutes were not provided to demonstrate regular meetings or the membership of the committees.</p>		
<p><b>Required Actions:</b>            RMHP must maintain documentation to demonstrate that its MPRCs function as the credentialing committees, use a per review process, and represent a range of participating providers.</p>		
<p>4. The Contractor provides evidence of the following:</p> <ul style="list-style-type: none"> <li>◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds,</li> <li>◆ Medical director or equally qualified individual review and approval of clean files.</li> </ul> <p>NCQA CR2—Element B</p>	Credentialing Process see pp 12-13 Recredentialing Process see p 14	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP provided evidence that the CMO approved a list of names determined to be clean files. RMHP, however, provided inadequate evidence and documentation of the credentialing committee’s review of credentials for practitioners who did not meet established thresholds.</p>		
<p><b>Required Actions:</b>            RMHP must maintain documentation to demonstrate that it complies with NCQA requirements regarding credentialing committee review of practitioners who do not meet established thresholds.</p>		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes:</p> <ul style="list-style-type: none"> <li>◆ A current, valid license to practice (time limit 180 days),</li> <li>◆ A valid DEA or CDS certificate, if applicable (must be in effect at the time of the credentialing decision),</li> <li>◆ Education and training (time limit none) , including board certification (time limit 180 days), if applicable,</li> <li>◆ Work history (time limit 365 days),</li> <li>◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (time limit 180 days).</li> </ul>	<p>Credentialing Process see pp 9-11                      Recredentialing Process see pp 11-12</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p>NCQA CR3—Elements A and B</p>		
<p><b>Findings:</b>                      The Credentialing Process policy and the Recredentialing Process policy and procedure required that all verifications be conducted 180 days prior to MPRC review. On-site review of 10 credentialing records demonstrated timely primary source verification.</p>		
<p><b>Required Actions:</b>                      None</p>		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following:</p> <ul style="list-style-type: none"> <li>◆ Reasons for inability to perform the essential functions of the position, with or without accommodation,</li> <li>◆ Lack of present illegal drug use,</li> <li>◆ History of loss of license and felony convictions,</li> <li>◆ History of loss or limitation of privileges or disciplinary actions,</li> <li>◆ Current malpractice insurance coverage (minimums= physician—.5mil per incident/1.5mil in aggregate per year; facility—.5milper incident/3mil in aggregate per year),</li> <li>◆ The correctness and completeness of the application.</li> </ul> <p>NCQA CR4—Element A            NCQA CR7—Element C            Contract:            DHMC: II.F.2.a &amp; b            RMHP: II.G.2 a &amp; b</p>	<p>Credentialing Process see pp 10-12            Recredentialing Process see pp 11-13</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP required either the Department of Public Health &amp; Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentialing Application or the Council for Affordable Quality Healthcare’s (CAQH’s) Universal Provider Datasource for credentialing or recredentialing applications. Both application sources contained the required information and attestations, and one of the two applications was present in all credentialing and recredentialing records reviewed on-site.</p>		
<p><b>Required Actions:</b>            None</p>		



*Appendix A. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>7. The Contractor receives information on practitioner sanctions before making a credentialing decision (Verification time limit—180 days) , including:</p> <ul style="list-style-type: none"> <li>◆ State sanctions, restrictions on licensure or limitations on scope of practice,</li> <li>◆ Medicare and Medicaid sanctions.</li> </ul> <p>NCQA CR5—Element A</p>	<p>Credentialing Process see pp 11-12            Recredentialing Process see p 12            National Practitioner Data Bank entire document</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP’s Credentialing Process policy and its Recredentialing Process policy required that Medicare, Medicaid, and State sanctions be collected within 180 days before making a credentialing or recredentialing decision. On-site record review confirmed timely verification of any State sanctions and that providers were not excluded from federal health care participation using the NPDB.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets performance standards and thresholds for:</p> <ul style="list-style-type: none"> <li>◆ Office site criteria:               <ul style="list-style-type: none"> <li>▪ Physical accessibility,</li> <li>▪ Physical appearance,</li> <li>▪ Adequacy of waiting and examining room space,</li> <li>▪ Availability of appointments.</li> </ul> </li> <li>◆ Medical/treatment record criteria:               <ul style="list-style-type: none"> <li>▪ Secure/confidential filing system,</li> <li>▪ Legible file markers,</li> <li>▪ Records can be easily located.</li> </ul> </li> </ul> <p>NCQA CR6—Element A</p>	<p>Site Visit Standards entire document</p> <p>Note – Credentialing Dept. maintains the P&amp;P and partners with PR if a Site Visit needs to be conducted.</p> <p>The QI Department monitors Customer Service complaint reports, by complaint type, to help ascertain the access compliance of individual providers.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable

**Standard VIII—Credentialing and Recredentialing**

Requirement	Evidence as Submitted by the Health Plan	Score
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**Findings:**  
 The Standards for Practitioner Site Visit Reviews policy and procedure listed RMHP’s process for ensuring that practitioner offices meet the plan’s standards and thresholds. The policy indicated that three complaints against a provider related to office site quality within a 12-month period may trigger a site visit. The areas reviewed during a site visit, as listed in the policy, included all the office site and medical/treatment record criteria, as required. The template form included all requirements. During the on-site interview, RMHP staff reported that the threshold for triggering a site visit had not been met during the review period.

**Required Actions:**  
 None

<p>9. The Contractor implements appropriate interventions by:</p> <ul style="list-style-type: none"> <li>◆ Conducting site visits of offices about which it has received member complaints,</li> <li>◆ Instituting actions to improve offices that do not meet thresholds,</li> <li>◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds,</li> <li>◆ Continually monitoring member complaints for all practitioner sites and performing a site visit within 60 days of determining its complaint threshold was met,</li> <li>◆ Documenting follow-up visits for offices that had subsequent deficiencies.</li> </ul>	<p>Office Site Monitoring entire document</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
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NCQA CR6—Element B

**Findings:**  
 The Office Site Quality policy included the provisions for conducting site visits of offices when RMHP receives complaints about office quality, continually monitoring for complaints about office site quality, and performing site visits within 60 days of determining that a complaint threshold was met. The Standards for Practitioners Site Reviews policy included the provisions for instituting corrective actions, evaluating the effectiveness of those actions every six months, and documenting follow-up visits.

**Required Actions:**  
 None

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes:</p> <ul style="list-style-type: none"> <li>◆ A current, valid license to practice,</li> <li>◆ A valid DEA or CDS certificate,</li> <li>◆ Board certification,</li> <li>◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner,</li> <li>◆ State sanctions, restrictions on licensure, or limitations on scope of practice,</li> <li>◆ Medicare and Medicaid sanctions.</li> </ul> <p>NCQA CR7—Elements A, B, and D            NCQA CR8— Element A</p>	<p>Recredentialing Process see pages 10-14</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP’s Recredentialing Process policy stated that practitioners would be recredentialed every three years. The process included primary source verification of a current and valid license, U.S. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate, board certification, professional liability claims, and any State, Medicare, or Medicaid sanctions. On-site review of 10 recredentialing records demonstrated timely verification and recredentialing within 36 months for each record reviewed.</p>		
<p><b>Required Actions:</b>            None</p>		



*Appendix A. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>11. The Contractor has written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include:</p> <p>11.A. The Contractor confirms that the provider is in good standing with state and federal regulatory bodies.</p> <p>NCQA CR11—Element A1</p>	<p>Organizational Providers Credentialing Health Delivery Organizations - entire document</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            The Health Delivery Organizations policy described each type of organizational provider and stated that each type must have a State license to practice. On-site review of four organizational provider files demonstrated that RMHP obtained State licensure information and verified federal health care participation eligibility via the OIG database.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>11.B. The Contractor confirms whether the provider has been reviewed and approved by an accrediting body.</p> <p>NCQA CR11—Element A2</p>	<p>Organizational Providers Credentialing Health Delivery Organizations see p 1</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            On-site review of organizational provider records demonstrated that RMHP obtained documentation of accreditation for those providers who reported accreditation status.</p>		
<p><b>Required Actions:</b>            None</p>		



*Appendix A. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>11.C. The Contractor conducts an on-site quality assessment if the provider is not accredited.</p> <p>NCQA CR11—Element A3</p>	<p>Organizational Providers Credentialing Health Delivery Organizations see pp 2-4</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            The Health Delivery Organizations policy did indicate that on-site assessment was part of the criteria for contracting with RMHP; however, the on-site interview and review of organizational provider records indicated that RMHP did not have a process, assessment criteria, or an organizational provider site visit form. RMHP credentialing staff reported that RMHP accepted a successful State survey in lieu of an on-site assessment by RMHP; however, RMHP had not determined its on-site assessment criteria or obtained the content of the State survey to determine if RMHP’s standards were evaluated during the State survey.</p>		
<p><b>Required Actions:</b>            RMHP must develop a process for conducting on-site quality assessments, when applicable. The process may include accepting a State survey in lieu of performing an on-site assessment if NCQA guidelines are followed.</p>		
<p>11.D. The Contractor confirms at least every three years, that the organizational provider continues to be in good standing with state and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider is not reviewed and approved by an accrediting body.</p> <p>NCQA CR11—Element A4</p>	<p>Organizational Providers Credentialing Health Delivery Organizations see p 5</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            The Health Delivery Organizations policy stated that organizational providers were reassessed every three years; however, the policy did not include site visit language (site visit processes were scored in Requirement 11.C). The on-site review of records demonstrated that RMHP assessed its organizational providers every three years.</p>		
<p><b>Required Actions:</b>            None</p>		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.</p> <p>NCQA CR11—Element A</p>	<p>Organizational Providers Credentialing Health Delivery Organizations - entire document</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            The Health Delivery Organizations policy included contracting criteria for each type of organizational provider; however, the policy did not include site assessment criteria.</p>		
<p><b>Required Actions:</b>            RMHP must develop its own criteria for organizational provider assessment for each type of organizational provider and determine if State site visits evaluate each of RMHP’s assessment and site visit standards.</p>		
<p>13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.</p> <p>NCQA CR11—Element A</p>	<p>Organizational Providers Credentialing Health Delivery Organizations – entire document</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP did not have a process for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners.</p>		
<p><b>Required Actions:</b>            RMHP must have a process for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners.</p>		
<p>14. The Contractor’s organizational provider assessment policies and process includes at least:</p> <ul style="list-style-type: none"> <li>◆ Hospitals,</li> <li>◆ Home Health Agencies,</li> <li>◆ Skilled Nursing Facilities,</li> <li>◆ Free Standing Surgical Centers.</li> </ul> <p>NCQA CR11—Element B</p>	<p>Organizational Providers Credentialing Health Delivery Organizations – entire document</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



*Appendix A. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

Standard VIII—Credentialing and Recredentialing		
Requirement	Evidence as Submitted by the Health Plan	Score
<b>Findings:</b> The Health Delivery Organizations policy included hospitals, home health agencies, skilled nursing facilities, and freestanding surgical centers among the types of organizational providers to review and assess.		
<b>Required Actions:</b> None		
15. The Contractor has documentation that organizational providers have been assessed.  NCQA CR11—Element D	Organizational Providers Credentialing Health Delivery Organizations – see p 5	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> On-site review of organizational provider records demonstrated that RMHP kept a record of each organizational provider assessed.		
<b>Required Actions:</b> None		
16. If the Contractor delegates any NCQA-Required credentialing activities, there is evidence of oversight of the delegated activities.  NCQA CR12	Delegated Credentialing Oversight entire document	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> On-site review of the Montrose Community Health Plan, Inc. (MCHP), delegation oversight file demonstrated that RMHP reviewed the delegate’s policies and procedures and performed an audit based on NCQA requirements.		
<b>Required Actions:</b> None		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>17. The Contractor has a written delegation document with the delegate that:</p> <ul style="list-style-type: none"> <li>◆ Is mutually agreed upon,</li> <li>◆ Describes the responsibilities of the Contractor and the delegated entity,</li> <li>◆ Describes the delegated activities,</li> <li>◆ Requires at least semiannual reporting by the delegated entity to the Contractor,</li> <li>◆ Describes the process by which the Contractor evaluates the delegated entity’s performance,</li> <li>◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations.</li> </ul> <p>NCQA CR12—Element A</p>	<p>Delegated Credentialing-Recredentialing Process            Delegated Credentialing Agreement Termination            Delegated Credentialing Agreement – Hospital            Delegated Credentialing Agreement – Physician and LHCPP            Delegated Credentialing Agreement – Ancillary</p>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> Not Applicable</p>
<p><b>Findings:</b>            The executed delegation agreement between MCHP and RMHP contained signatures for both parties and included a description of responsibilities. The agreement required quarterly reporting by the delegate, described methods of oversight, and included a revocation clause if the delegate failed to comply with standards and requirements.</p>		
<p><b>Required Actions:</b>            None</p>		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>18. If the delegation arrangement includes the use of PHI by the delegate, the delegation document also includes:</p> <ul style="list-style-type: none"> <li>◆ A list of allowed use of PH,</li> <li>◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure,</li> <li>◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards,</li> <li>◆ A stipulation that the delegate will provide members with access to their PHI,</li> <li>◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur,</li> <li>◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends.</li> </ul> <p>NCQA CR12—Element B</p>	<p>PHI 18 Response Memo entire document</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable
<p><b>Findings:</b>            RMHP staff reported that delegates do not have access to protected health information (PHI). The executed delegation agreement did not include the use of PHI.</p>		
<p><b>Required Actions:</b>            None</p>		

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>19. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation document.</p> <p>NCQA CR12—Element C</p>	<p>Delegated Credentialing-Recredentialing Process</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>            The Delegated Credentialing/Recredentialing policy included the provision that RMHP retains the right to approve, suspend, and terminate practitioners and providers credentialed by the delegate. The on-site record review included one practitioner credentialed by the delegate. Review of that file demonstrated that RMHP retained final approval of the practitioner.</p>		
<p><b>Required Actions:</b>            None</p>		
<p>20. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed.</p> <p>NCQA CR12—Element D</p>	<p>Delegated Credentialing-Recredentialing Process            Delegated Credentialing Oversight see p 1</p>	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable
<p><b>Findings:</b>            As evidenced by the executed delegation agreement between MCHP and RMHP, the agreement has been in effect since 1997.</p>		
<p><b>Required Actions:</b>            None</p>		



*Appendix A. Colorado Department of Health Care Policy & Financing*  
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*for Rocky Mountain Health Plans*

<b>Standard VIII—Credentialing and Recredentialing</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>21. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect.</p> <p>NCQA CR12—Element E</p>	<p>Delegated Credentialing-Recredentialing Process  Delegated Credentialing Oversight see p 2</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>  Review of RMHP’s delegation oversight audit conducted September 7, 2010, demonstrated evaluation of MCHP’s credentialing files against NCQA standards.</p>		
<p><b>Required Actions:</b>  None</p>		
<p>22. For delegation agreements in effect for more than 12 months, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations.</p> <p>NCQA CR12—Element F</p>	<p>Delegated Credentialing Oversight see p 2</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>  Review of RMHP’s delegation oversight audit demonstrated RMHP’s assessment of its delegate against NCQA standards.</p>		
<p><b>Required Actions:</b>  None</p>		
<p>23. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually).</p> <p>NCQA CR12—Element G</p>	<p>Delegated Credentialing-Recredentialing Process see p 5</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<p><b>Findings:</b>  During the on-site review, RMHP provided evidence of having reviewed monthly reports required by and submitted to RMHP by its credentialing delegate.</p>		
<p><b>Required Actions:</b>  None</p>		



*Appendix A. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

Standard VIII—Credentialing and Recredentialing		
Requirement	Evidence as Submitted by the Health Plan	Score
24. For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years. The Contractor has identified and followed up on opportunities for improvement, if applicable.  NCQA CR12—Element H	Delegated Credentialing Oversight see p 2	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> The Delegated Credentialing Audit Activities policy included communication with the delegated entity to address issues identified during oversight audits as an action available if the delegate did not meet RMHP standards. The delegation oversight file indicated that there was communication with the delegate to correct issues identified during the September 7, 2010, audit.		
<b>Required Actions:</b> None		

Results for Standard VIII—Credentialing and Recredentialing					
<b>Total</b>	Met	=	<u>39</u>	X	1.00 = <u>39</u>
	Partially Met	=	<u>4</u>	X	.00 = <u>0</u>
	Not Met	=	<u>2</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>2</u>	X	NA = <u>NA</u>
<b>Total Applicable</b>		=	<u>45</u>	<b>Total Score</b>	= <u>39</u>

<b>Total Score ÷ Total Applicable</b>		=	<u>87%</u>
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*Appendix B.* **Denials Record Review Tool**  
*for Rocky Mountain Health Plans*

The completed grievance record review tool follows this cover page.



*Appendix B. Colorado Department of Health Care Policy & Financing  
 FY 2010–2011 Denials Record Review Tool  
 for Rocky Mountain Health Plans*

<b>Review Period:</b>	January 1, 2010–January 27, 2011
<b>Date of Review:</b>	January 27, 2011
<b>Reviewer:</b>	Diane Somerville
<b>Participating Plan Staff Member:</b>	Carol Ann Hendrikse

1	2	3	4	5	6	7	8	9	10	11	12
File #	Member ID	Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
		Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
1	*****	3/9	3/19	10	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: Each denial record contained notice of action letters using the same template. See Standard I, Requirement 10, for content information.											
2	*****	1/26/10	2/1	6	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments:											
3	*****	5/7	5/12	5	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments:											
4	*****	1/27			Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>
Comments: <b>This case was removed from the sample. This claim was paid. A case from the oversample was used.</b>											
5	*****	6/17	7/13	26	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: This case took 26 days for decision and notification, exceeding the required time frame of 10 calendar days.											
6	*****	5/5	5/7	2	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments:											
7	*****	8/11	8/12	1	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments:											
8	*****	3/30	5/7	38	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: An extension letter was sent; however, the notice of action was not sent within the time frame of 10 calendar days plus the 14-day extension. The decision to deny services was made by a nonclinical administrative staff member.											
9	*****	7/23	8/24	32	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: The case took 32 days for decision and notification, exceeding the required time frame of 10 calendar days.											
10	*****	5/26	6/7	12	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>
Comments: The case took 12 days for decision and notification, exceeding the required time frame of 10 calendar days.											



*Appendix B. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Denials Record Review Tool**  
*for Rocky Mountain Health Plans*

1	2	3				6	7		8	9	10	11		12
File #	Member ID	Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials						
		Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?			
11	*****	N/A	N/A	N/A	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>			
Comments: This was an emergency room visit for a member with tooth pain. Payment was denied because dental caries were not a covered diagnosis. The signature block contained "customer service" typed. There was no evidence of medical review for the prudent layperson standard. The prudent layperson standard and definition of emergency medical condition included severe pain. HSAG recommends that emergency claims not initially paid by the system be escalated to medical review for application of the prudent layperson standard. The time frame element was N/A as this was a claims denial.														
12	*****	4/12	8/13	123	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>			
Comments: The case took 123 days for decision and notification, exceeding the required time frame of 10 calendar days. An extension was requested July 28, 2010; however, the decision was not made within the extension time frame. The request was for a transcutaneous electrical nerve stimulation (TENS) unit. The provider requested prior authorization. The claim was eventually denied for lack of medical records. Nothing occurred within the required time frame.														
13	*****	3/5	3/16	11	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>			
Comments: The case took 11 days for decision and notification, exceeding the required time frame of 10 calendar days.														
14	*****				Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Comments: <b>This record was not provided, a record from the over sample was used.</b>														
15	*****	2/9	2/22	13	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>			
Comments: The case took 13 days for decision and notification, exceeding the required time frame of 10 calendar days.														
16	*****	4/12	4/20	8	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>			
Comments:														
17	*****	7/20	7/26	6	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>			
Comments:														
18	*****	N/A	N/A	N/A	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>			
Comments: This was an emergency room visit for a member with tooth pain. Payment was denied because dental caries were not a covered diagnosis. The signature block contained "customer service" typed. There was no evidence of medical review for the prudent layperson standard. The prudent layperson standard and definition of emergency medical condition included severe pain. HSAG recommends that emergency claims not initially paid by the system be escalated to medical review for application of the prudent layperson standard. The time frame element was N/A as this was a claims denial.														
19	*****	2/9	2/22	13	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>			
Comments: The case took 13 days for decision and notification, exceeding the required time frame of 10 calendar days.														
20	*****	N/A	N/A	N/A	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>			
Comments: The time frame for decisions was N/A as this was a claims denial.														



*Appendix B. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Denials Record Review Tool**  
*for Rocky Mountain Health Plans*

1	2	3				6	7	8	9	10	11	12
File #	Member ID	Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials				
		Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?	
21	*****	4/29	Unknown	Unknown	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	
Comments: There was no notice of action letter.												
22	*****	3/2	3/9	7	Y <input checked="" type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input type="checkbox"/> N <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input checked="" type="checkbox"/>	Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Comments:												
23	*****				Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Comments:												
24	*****				Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Comments:												
25	*****				Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>		Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> N/A <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	
Comments:												
# Applicable Elements						17		0	20	20	5	20
# Compliant Elements						8		0	0	16	3	19
Percent Compliant						47%		N/A	0%	80%	60%	95%
<b>Total # Applicable Elements</b>						<b>82</b>						
<b>Total # Compliant Elements</b>						<b>46</b>						
<b>Total Percent Compliant</b>						<b>56%</b>						

*Appendix C.* **Credentialing Record Review Tool**  
*for Rocky Mountain Health Plans*

The completed grievance record review tool follows this cover page.



*Appendix C. Colorado Department of Health Care Policy & Financing  
 FY 2010–2011 Credentialing Record Review Tool  
 for Rocky Mountain Health Plans*

<b>Review Period:</b>	January 1, 2010–September 30, 2010
<b>Date of Review:</b>	January 27, 2011
<b>Reviewer:</b>	Barbara McConnell
<b>Participating Plan Staff Member:</b>	Terri Wright

Sample	1		2		3		4		5		6		7		8		9		10	
<b>Provider ID#</b>	****		****		****		****		****		****		****		****		****		****	
<b>Provider Type (e.g., MD, PhD, NP, PA)</b>	DO		MD		MD		NP		DO		DO		MD		NP		MD		DO	
<b>Application Date</b>	5/3/10		5/20/10		8/2/10		5/5/10		4/30/10		7/26/10		6/8/10		2/26/10		5/7/10		2/18/10	
<b>Specialty</b>	Family		Infect Dis		Oncology		N/A		Family		Family		Internal		N/A		Family		Family	
<b>Credentialing Date (Committee/Medical Director Approval Date)</b>	6/28/10		6/1/10		8/23/10		6/14/10		5/24/10		4/7/10		8/31/10		3/22/10		6/28/10		3/15/10	
Item	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
<b>Initial Credentialing Verification:</b> The contractor, using primary sources, verifies that the following are present:																				
◆ A current, valid license to practice (with verification that no state sanctions exist)	X		X		X		X		X		X		X		X		X		X	
◆ A valid DEA or CDS certificate (if applicable)	X		X		X		N/A		X		X		X		N/A		X		X	
◆ Credentials (i.e., education and training, including board certification if the practitioner stated on the application that he or she was board certified)	X		X		X		X		X		X		X		X		X		X	
◆ Work history	X		X		X		X		X		X		X		X		X		X	
◆ Current malpractice insurance in the required amount (with a history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
◆ Verification that the provider has not been excluded from federal health care participation	X		X		X		X		X		X		X		X		X		X	
◆ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
◆ Provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
<b>Applicable Elements</b>	8		8		8		7		8		8		8		7		8		8	
<b>Point Score</b>	8		8		8		7		8		8		8		7		8		8	
<b>Percentage Score</b>	100%		100%		100%		100%		100%		100%		100%		100%		100%		100%	



*Appendix C. Colorado Department of Health Care Policy & Financing*  
**FY 2010–2011 Credentialing Record Review Tool**  
*for Rocky Mountain Health Plans*

Oversample	1		2		3		4		5											
Provider ID#																				
Provider Type (e.g., MD, PhD, NP, PA)																				
Application Date																				
Specialty																				
Credentialing Date (Committee/Medical Director Approval Date)																				
Item	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No										
<b>Initial Credentialing Verification:</b> The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no state sanctions exist)																				
♦ A valid DEA or CDS certificate (if applicable)																				
♦ Credentials (i.e., education and training, including board certification if the practitioner stated on the application that he or she was board certified)																				
♦ Work history																				
♦ Current malpractice insurance (with a history of professional liability claims)																				
♦ Verification that the provider has not been excluded from federal health care participation																				
♦ Signed application and attestation																				
♦ Provider credentialing was completed within verification time limits (see specific verification element—180/365 days)																				
<b>Applicable Elements</b>																				
<b>Point Score</b>																				
<b>Percentage Score</b>																				
<b>Total Record Review Score</b>																				
	<b>Total Applicable: 78</b>										<b>Total Point Score: 78</b>					<b>Total Percentage: 100%</b>				

**Notes:** No oversample cases were needed to obtain and review 10 credentialing records.

*Appendix D.* **Recredentialing Record Review Tool**  
*for Rocky Mountain Health Plans*

The completed grievance record review tool follows this cover page.



*Appendix D. Colorado Department of Health Care Policy & Financing  
 FY 2010–2011 Recredentialing Record Review Tool  
 for Rocky Mountain Health Plans*

<b>Review Period:</b>	January 1, 2010–September 30, 2010
<b>Date of Review:</b>	January 27, 2011
<b>Reviewer:</b>	Barbara McConnell
<b>Participating Plan Staff Member:</b>	Terri Wright

Sample	1		2		3		4		5		6		7		8		9		10	
<b>Provider ID#</b>	****		****		****		****		****		****		****		****		****		****	
<b>Provider Type (e.g., MD, PhD, NP, PA)</b>	Speech		DO		MD		MD		DO		MD		MD		MD		MD		MD	
<b>Application/Attestation Date</b>	1/11/10		5/11/10		5/19/10		3/19/10		5/12/10		6/2/10		3/3/10		1/4/10		3/26/10		2/26/10	
<b>Specialty</b>	N/A		Family		Dermatology		Neurology		Gastro		Oncology		Family		Pulmonology		Rehab		Orthopedics	
<b>Last Credentialing/Recredentialing Date</b>	7/23/07		11/19/07		12/07/07		9/24/07		12/17/10		2/11/08		8/27/07		9/24/07		9/4/07		9/24/07	
<b>Recredentialing Date (Committee/Medical Director Approval Date)</b>	2/22/10		6/7/10		8/23/10		4/12/10		6/21/10		8/30/10		4/5/10		5/3/10		4/5/10		4/2/10	
Item	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
<b>Recredentialing Verification:</b> The contractor, using primary sources, verifies that the following are present:																				
◆ A current, valid license to practice (with verification that no state sanctions exist)	X		X		X		X		X		X		X		X		X		X	
◆ A valid DEA or CDS certificate (if applicable)	N/A		X		X		X		X		X		X		X		X		X	
◆ Credentials (i.e., verified board certification only if the practitioner stated on the recredentialing application that there was new board certification since the last credentialing/recredentialing date)	N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A		N/A	
◆ Current malpractice insurance in the required amount	X		X		X		X		X		X		X		X		X		X	
◆ Verification that the provider has not been excluded from federal health care participation	X		X		X		X		X		X		X		X		X		X	
◆ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
◆ Provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
◆ Recredentialing was completed within 36 months of the last credentialing/recredentialing date	X		X		X		X		X		X		X		X		X		X	
<b>Applicable Elements</b>	6		7		7		7		7		7		7		7		7		7	
<b>Point Score</b>	6		7		7		7		7		7		7		7		7		7	
<b>Percentage Score</b>	100%		100%		100%		100%		100%		100%		100%		100%		100%		100%	



*Appendix D. Colorado Department of Health Care Policy & Financing  
 FY 2010–2011 Recredentialing Record Review Tool  
 for Rocky Mountain Health Plans*

Oversample	1		2		3		4		5										
Provider ID#																			
Provider Type (e.g., MD, PhD, NP, PA)																			
Application/Attestation Date																			
Specialty																			
Last Credentialing/Recredentialing Date																			
Recredentialing Date (Committee/Medical Director Approval Date)																			
Item	Yes	No																	
<b>Recredentialing Verification:</b> The contractor, using primary sources, verifies that the following are present:																			
◆ A current, valid license to practice (with verification that no state sanctions exist)																			
◆ A valid DEA or CDS certificate (if applicable)																			
◆ Credentials (i.e., verified board certification only if the practitioner stated on the recredentialing application that there was new board certification since the last credentialing/recredentialing date)																			
◆ Current malpractice insurance in the required amount																			
◆ Verification that the provider has not been excluded from federal health care participation																			
◆ Signed application and attestation																			
◆ Provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)																			
◆ Recredentialing was completed within 36 months of the last credentialing/recredentialing date																			
<b>Applicable Elements</b>																			
<b>Point Score</b>																			
<b>Percentage Score</b>																			
<b>Total Record Review Score</b>											<b>Total Applicable: 69</b>	<b>Total Point Score: 69</b>	<b>Total Percentage: 100%</b>						

**Notes:** No oversample cases were needed to obtain and review 10 credentialing records.

*Appendix E.* **Site Review Participants**  
for **Rocky Mountain Health Plans**

Table E-1 lists the participants in the FY 2010–2011 site review of **RMHP**.

<b>Table E-1—HSAG Reviewers and MCO/PIHP Participants</b>	
<b>HSAG Review Team</b>	<b>Title</b>
Barbara McConnell, MBA, OTR	Project Director
Diane Somerville, MSW	Director, State and Corporate Services
<b>RMHP Participants</b>	<b>Title</b>
Melissi Bashara	Member Benefit Administration Manager
Carriann Conner	Project Coordinator
Greg Coren	Contracting, Provider Network Management
Connie Dale	Compliance Assistant
Sandy Dowd	Care Management
Kevin Fitzgerald (telephonically)	Chief Medical Officer
Judi Everett	Claims Manager
Nora Foster	Customer Service Process Analyst
Kele Geisler	Contract/Configuration Manager, Provider Network Management
Patrick Gordon	Director, Government Projects
Carol Ann Hendrikse	Care Management
Mike Houtari (telephonically)	Vice President of Government Programs and Legal Affairs
Jackie Hudson	Quality Improvement Program Implementation and Regulatory Compliance Manager
David Klemm	Government Operations Manager
Mike Luedtke	Staff Attorney
Kris Malean	Director of Customer Service
Samantha Morgan	Executive Assistant, Information Technology
Dale Renzi	Provider Network Management Director
Lori Stephenson	Quality Improvement Director
LeAnna Stortz	Provider Relations Manager
Laurel Walters	Chief Operations Officer
Terri Wright	Credentialing Manager
<b>Department Observers</b>	<b>Title</b>
Kimberly deBruynKops	Quality/Compliance Specialist
Maggie Reyes-Leczinski	Quality/Compliance Specialist
Valerie Baker-Easley	Contract Manager

## Appendix F. Corrective Action Plan Process for FY 2010–2011 for Rocky Mountain Health Plans

**RMHP** 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 element that requires correction, the health plan should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the MCO/PIHP must submit documents based on the approved timeline.

Table F-1—Corrective Action Plan Process	
<b>Step 1</b>	<b>Corrective action plans are submitted</b>
	<p>Each MCO/PIHP will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting. The MCO/PIHP will submit the CAP using the template provided. The Department should be copied on any communication regarding CAPs.</p> <p>For each of the elements receiving a score of <i>Partially Met</i> or <i>Not Met</i>, 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.</p>
<b>Step 2</b>	<b>Prior approval for timelines exceeding 30 days</b>
	If the MCO/PIHP is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
<b>Step 3</b>	<b>Department approval</b>
	<p>Following review of the CAP, the Department will notify the MCO/PIHP via e-mail whether:</p> <ul style="list-style-type: none"> <li>◆ The plan has been approved and the MCO/PIHP should proceed with the interventions as outlined in the plan.</li> <li>◆ Some or all of the elements of the plan must be revised and resubmitted.</li> </ul>
<b>Step 4</b>	<b>Documentation substantiating implementation</b>
	Once the MCO/PIHP has received Department approval of the plan, the MCO/PIHP should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
<b>Step 5</b>	<b>Progress reports may be required</b>
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the MCO/PIHP to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

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

The template for the CAP follows.

**Table F-2—FY 2010–2011 Corrective Action Plan *for* Rocky Mountain Health Plans**

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
<p>I. Coverage and Authorization of Services</p> <p>9. The Contractor’s written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member’s condition or disease.</p>	<p>Of the 20 records reviewed on-site, one record (No. 8) was not made by a health care professional with clinical expertise in treating the condition. Based on the record review (case No. 8), RMHP must ensure that it adheres to its policy (and federal health care regulations) that denial decisions must be made by a health care professional who has appropriate clinical expertise in treating the member’s condition or disease.</p>				

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<p>10. The Contractor’s written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).</p>	<p>One record (No. 21) had no indication that notification had been given to the provider or that written notice of the decision had been sent to the member. None of the 20 records reviewed on-site were compliant with the content requirements for the notification letter. The first paragraph of each letter reviewed stated: “You may have to pay the doctor yourself.” None of the 20 letters reviewed stated specifically that a member’s physician could file an appeal on his or her behalf. RMHP must ensure that notices of an authorization decision (notices of action) are provided to members and providers, and that notices to members include information that the provider can file an appeal on the member’s behalf. Letters to members should not state that the member</p>				

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Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
	may have to pay for the services.				
<p>11. The Contractor’s written policies and procedures include the following timeframes for making standard and expedited authorization decisions:</p> <ul style="list-style-type: none"> <li>◆ For standard authorization decisions—10 calendar days.</li> <li>◆ For expedited authorization decisions—3 days.</li> </ul>	<p>The Preauthorization of Services for Medicaid Members policy required that expedited preauthorization decisions be made within three <i>working</i> days, but there were also references in the policy to decisions within 72 hours. The on-site record review demonstrated that RMHP did not adhere to the time frames for making standard authorization decisions, with 47 percent, or eight of the 17 applicable records, having met the requirement. RMHP must ensure that its policies are internally congruent as to time frames (e.g., three working days would not represent 72 hours if the time frame included a weekend). RMHP must also ensure that it follows its policies and federal health care regulations regarding</p>				

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	decision time frames for authorization decisions.				
<p>12. The Contractor’s written policies and procedures include the following timeframes for possible extension of timeframes for authorization decisions:</p> <ul style="list-style-type: none"> <li>◆ Standard authorization decisions—up to 14 calendar days.</li> <li>◆ Expedited authorization decisions—up to 14 calendar days.</li> </ul>	<p>The Preauthorization of Services for Medicaid Members policy stated at 14.1.3 that the time period within which a determination would be made begins on the date the request is received by RMHP. In cases involving an extension, notification would be provided within 24 days (10 days plus the 14-day extension). However, at 14.1.2, the policy stated that if the member or the member’s provider failed to submit enough information necessary to make the determination, RMHP would give the member at least 30 days from the receipt of the notice to provide the specified information. The policy stated, “Rocky Mountain sets this timeframe. It is not a regulatory requirement.” While allowing this time</p>				

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	<p>frame may be acceptable for retrospective requests or claims decisions, it is not compliant with federal requirements when applied to preservice requests. RMHP must ensure that its written policies, procedures, and processes adhere to federal managed care regulations—specifically, that time frames for authorization decisions can only be extended by up to 14 calendar days for both standard and expedited authorization decisions.</p>				
<p>20. The Contractor does not:</p> <ul style="list-style-type: none"> <li>◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms.</li> <li>◆ Refuse to cover</li> </ul>	<p>RMHP must ensure that it does not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s PCP, the contractor, or a State agency of the member’s screening and treatment within 10 days of presentation for emergency services. RMHP must also</p>				

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Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
<p>emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider, the Contractor or State agency of the member’s screening and treatment within 10 days of presentation for emergency services.</p>	<p>ensure that it does not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms for Medicaid members.</p>				
<p>VIII. Credentialing and Recredentialing 2.S.If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the</p>	<p>The Reduction, Suspension, or Termination policy did not address reporting to the Colorado Department of Regulatory Agencies (DORA) for nonphysician practitioners. During the on-site interview, RMHP credentialing staff reported that sanction or termination</p>				

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Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
appropriate authorities.	information was reported only for physicians, not for nonphysician practitioners such as nurse practitioners or physician assistants. NCQA clarified that its requirement applies to all practitioners licensed or certified by the State to practice independently that have an independent relationship with the organization. RMHP must develop a process to report any actions taken against nonphysician practitioners for quality reasons to the appropriate authorities, and must include reporting to DORA, when applicable.				
3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The	RMHP did not provide adequate documentation and evidence of committee meetings or the content of discussion for cases that were deferred to the MPRC for discussion and final decision. RMHP provided only an excerpt of one meeting stating that a physician was discussed.				

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Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
committee includes representation from a range of participating practitioners.	The excerpt did not indicate what was discussed or who was present (to determine that a range of practitioners was represented on the committee). Other sets of minutes were not provided to demonstrate regular meetings or the membership of the committees. RMHP must maintain documentation to demonstrate that its MPRCs function as the credentialing committees, use a peer review process, and represent a range of participating providers.				
<p>4. The Contractor provides evidence of the following:</p> <ul style="list-style-type: none"> <li>◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds,</li> </ul>	RMHP provided evidence that the CMO approved a list of names determined to be clean files. RMHP, however, provided inadequate evidence and documentation of the credentialing committee’s review of credentials for practitioners who did not meet established thresholds. RMHP must maintain documentation to				

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<ul style="list-style-type: none"> <li>◆ Medical director or equally qualified individual review and approval of clean files.</li> </ul>	<p>demonstrate that it complies with NCQA requirements regarding credentialing committee review of practitioners who do not meet established thresholds.</p>				
<p>11.C. The Contractor conducts an on-site quality assessment if the provider is not accredited.</p>	<p>The Health Delivery Organizations policy did indicate that on-site assessment was part of the criteria for contracting with RMHP; however, the on-site interview and review of organizational provider records indicated that RMHP did not have a process, assessment criteria, or an organizational provider site visit form. RMHP credentialing staff reported that RMHP accepted a successful State survey in lieu of an on-site assessment by RMHP; however, RMHP had not determined its on-site assessment criteria or obtained the content of the</p>				

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	<p>State survey to determine if RMHP’s standards were evaluated during the State survey. RMHP must develop a process for conducting on-site quality assessments, when applicable. The process may include accepting a State survey in lieu of performing an on-site assessment if NCQA guidelines are followed.</p>				
<p>12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.</p>	<p>The Health Delivery Organizations policy included contracting criteria for each type of organizational provider; however, the policy did not include site assessment criteria. RMHP must develop its own criteria for organizational provider assessment for each type of organizational provider and determine if State site visits evaluate each of RMHP’s assessment and site visit standards.</p>				

**Table F-2—FY 2010–2011 Corrective Action Plan *for* Rocky Mountain Health Plans**

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
<p>13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.</p>	<p>RMHP did not have a process for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners. RMHP must have a process for evaluating whether, or ensuring that, nonaccredited facilities credential their practitioners.</p>				

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

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

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

For this step,	HSAG completed the following activities:
<b>Activity 1:</b>	<b>Planned for Monitoring Activities</b>
	<p>Before the compliance monitoring review:</p> <ul style="list-style-type: none"> <li>◆ HSAG and the Department held teleconferences and a meeting at the Department to determine the content of the review.</li> <li>◆ HSAG coordinated with the Department and the health plans to set the date of the review.</li> <li>◆ HSAG coordinated with the Department to determine timelines for the Department’s review and approval of the tool and report template and other review activities.</li> <li>◆ HSAG staff attended Medical Quality Improvement Committee (MQUIC) meetings and discussed the FY 2010–2011 compliance monitoring review process as needed.</li> <li>◆ HSAG assigned staff to the review team.</li> <li>◆ Prior to the review, HSAG representatives also responded to questions from <b>RMHP</b> via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that <b>RMHP</b> was prepared for the compliance monitoring review.</li> </ul>
<b>Activity 2:</b>	<b>Obtained Background Information From the Department</b>
	<ul style="list-style-type: none"> <li>◆ HSAG used the BBA Medicaid managed care regulations and the <b>RMHP</b>’s Medicaid managed care contract with the Department to develop HSAG’s monitoring tool, desk audit request, on-site agenda, record review tool, and report template.</li> <li>◆ HSAG submitted each of the above documents to the Department for its review and approval.</li> </ul>
<b>Activity 3:</b>	<b>Reviewed Documents</b>
	<ul style="list-style-type: none"> <li>◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified <b>RMHP</b> in writing of the desk audit request via delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk audit request included instructions for organizing and preparing the documents related to the review of the three standards. Thirty days prior to the review, <b>RMHP</b> provided documentation for the desk audit, as requested.</li> <li>◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk audit form, the compliance monitoring tool with <b>RMHP</b>’s section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.</li> <li>◆ 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.</li> </ul>

<b>Table G-1—Compliance Monitoring Review Activities Performed</b>	
<b>For this step,</b>	<b>HSAG completed the following activities:</b>
<b>Activity 4:</b>	<b>Conducted Interviews</b>
	<ul style="list-style-type: none"> <li>◆ During the on-site portion of the review, HSAG met with the <b>RMHP</b>'s key staff members to obtain a complete picture of <b>RMHP</b>'s compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of <b>RMHP</b>'s performance.</li> </ul>
<b>Activity 5:</b>	<b>Collected Accessory Information</b>
	<ul style="list-style-type: none"> <li>◆ During the on-site portion of the review, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.)</li> <li>◆ HSAG reviewed additional documents requested as a result of the on-site interviews.</li> </ul>
<b>Activity 6:</b>	<b>Analyzed and Compiled Findings</b>
	<ul style="list-style-type: none"> <li>◆ Following the on-site portion of the review, HSAG met with MCO/PIHP staff to provide an overview of preliminary findings.</li> <li>◆ HSAG used the FY 2010–2011 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities.</li> <li>◆ HSAG analyzed the findings and assigned scores.</li> <li>◆ HSAG determined opportunities for improvement based on the review findings.</li> <li>◆ HSAG determined actions required of the MCO/PIHP to achieve full compliance with Medicaid managed care regulations.</li> </ul>
<b>Activity 7:</b>	<b>Reported Results to the Department</b>
	<ul style="list-style-type: none"> <li>◆ HSAG completed the FY 2010–2011 Site Review Report.</li> <li>◆ HSAG submitted the site review report to the Department for review and comment.</li> <li>◆ HSAG incorporated the Department's comments.</li> <li>◆ HSAG distributed a second draft report to the MCO/PIHP for review and comment.</li> <li>◆ HSAG coordinated with the Department to incorporate the MCO's/PIHP's comments and finalized the report.</li> <li>◆ HSAG distributed the final report to the MCO/PIHP and the Department.</li> </ul>