

Colorado Children's Health Insurance Program  
Child Health Plan *Plus* (CHP+)

**FY 2012–2013 SITE REVIEW REPORT**  
*for*  
**Rocky Mountain Health Plans**

June 2013

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



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### Overview of FY 2012–2013 Compliance Monitoring Activities

Public Law 111-3, The Children’s Health Insurance Program Reauthorization Act of 2009, requires that each state’s Children’s Health Insurance Program (CHIP) applies several provisions of Section 1932 of the Social Security Act in the same manner as the provisions apply under Title XIX of the Act. This requires managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the Balanced Budget Act of 1997, Public Law 105-33 (BBA). The BBA requires that states conduct a periodic evaluation of their MCOs and PIHPs to determine compliance with regulations and contractual requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado’s Child Health Plan *Plus* (CHP+) managed care health plans by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the second annual external quality review of compliance with federal managed care regulations performed for the CHP+ program by HSAG. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

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

This report documents results of the FY 2012–2013 site review activities for the review period—July 1, 2012, through December 31, 2012. Section 2 contains summaries of the findings, strengths, opportunities for improvement, and required actions for each standard area. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the credentialing and recredentialing record reviews. Appendix C lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the health plan will be required to complete for FY 2012–2013 and the required template for doing so.

## Methodology

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

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

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

## Objective of the Site Review

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

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

## Summary of Results

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

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

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III Coordination and Continuity of Care	9	9	8	1	0	0	89%
IV Member Rights and Protections	5	5	2	3	0	0	40%
VIII Credentialing and Recredentialing	50	48	47	1	0	2	98%
X Quality Assessment and Performance Improvement	11	11	8	3	0	0	73%
<b>Totals</b>	<b>75</b>	<b>73</b>	<b>65</b>	<b>8</b>	<b>0</b>	<b>2</b>	<b>89%</b>

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

Description of Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Credentialing Record Review	80	75	75	0	5	100%
Recredentialing Record Review	80	76	76	0	4	100%
<b>Totals</b>	<b>160</b>	<b>151</b>	<b>151</b>	<b>0</b>	<b>9</b>	<b>100%</b>

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

### Overall Summary of Performance

For the four standards reviewed by HSAG, **RMHP** earned an overall compliance score of 89 percent. **RMHP**'s strongest performances were in Standard III—Coordination and Continuity of Care, and in Standard VIII—Credentialing and Recredentialing, which earned compliance scores of 89 percent and 98 percent, respectively. HSAG identified several required actions in Standard IV—Member Rights and Protections (40 percent compliant) and Standard X—Quality Assessment and Performance Improvement (73 percent compliant).

## Standard III—Coordination and Continuity of Care

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

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

During the on-site review, **RMHP** presented two coordination of care cases: (1) an infant male with “failure to thrive” and suspected neurofibromatosis, who was referred by the parent for developmental difficulties, the desire to obtain a new PCP, and the need for referral to specialists; and (2) a one-year-old male with “low oxygen syndrome” who required a pulmonologist, home oxygen equipment, and speech therapy, and who was identified through the pre-authorization process. Case presentations demonstrated that **RMHP** designated a PCP and a care coordinator; coordinated with multiple providers and services; and completed a comprehensive needs assessment that included an assessment of high-risk health problems, language and comprehension problems, mental health status, and functional problems. The presentations also demonstrated that **RMHP** completed an individual treatment plan with member goals, planned interventions, barriers, detailed progress/contact notes, and planned follow-up. The cases demonstrated parental involvement in developing and implementing the plans.

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

Due to the age and relative wellness of the CHP+ members, the CHP+ case management program experienced fewer and less-complex cases than **RMHP**'s other lines of business. **RMHP** accepted referrals from multiple sources to identify members who were appropriate for complex case management.

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

### **Summary of Strengths**

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

### **Summary of Required Actions**

**RMHP** had not implemented a process to consistently conduct a needs assessment for all CHP+ members upon enrollment. **RMHP** must implement a mechanism for initial screening of all CHP+ members upon enrollment to identify members with special health care needs.

## Standard IV—Member Rights and Protections

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

**RMHP** had several policies in place that addressed member rights and protections in accordance with federal health care requirements and described how member rights were communicated to members and providers. **RMHP**'s staff members articulated processes during which care management staff members worked closely with providers and members to ensure the members receive the appropriate services and understood their rights, and that those rights were taken into consideration during the episode of care. The CHP+ Member Rights Policy included a definitive policy statement that articulated **RMHP**'s intention to provide equal opportunity and to prevent discrimination based on race, color, national origin, age, or disability in access to treatment or employment. The same policy statement was found in the member benefits booklet and the provider manual.

### *Summary of Strengths*

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

### *Summary of Required Actions*

The provider manual had two lists of member rights: One was labeled Member Rights and one was labeled Medicaid Member Rights. During the on-site interview, the staff clarified that the CHP+ population had been aligned with the commercial line of business and that the Member Rights list had previously applied to CHP+ members. This list did not include all the rights as stated in 42CFR438.100, or in the CHP+ managed care contract. **RMHP** must revise the provider manual to clearly describe member rights applicable to the CHP+ population. HSAG further recommends that **RMHP** develop additional communications, such as e-mail announcements or articles for the provider newsletters, to inform providers of the changes in federal health care requirements for the CHP+ population and the resultant implications.

The Child Health Plan+ Member Rights Policy described most of the rights as stated in 42CFR438.100 and in the CHP+ managed care contract; however, it was missing the right to be free from restraint or seclusion, and the member's right to request and receive a copy of his or her medical records and have them amended or corrected. **RMHP** must revise the CHP+ member rights policy to include all rights afforded CHP+ members by federal regulations or the CHP+ contract with the State. **RMHP** must ensure that the staff, providers, and members are made aware of changes in policies or practices related to CHP+ member rights.

The member handbook provided for review included the right to freely exercise rights without being treated differently; however, this right was not listed in the handbook on the Web site. In addition, the provider manual did not clearly inform providers of CHP+ member rights. In order for

members to understand their benefits and rights and be empowered to exercise those rights under the CHP+ program, members and providers must receive clear and consistent information from all sources regarding those benefits and rights. **RMHP** must revise its Web site to include current and accurate information.

## Standard VIII—Credentialing and Recredentialing

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

The Credentialing Criteria and Process Policy and the Recredentialing Process Policy provided an overview of **RMHP**'s credentialing and recredentialing processes, referring to other pertinent policies for details. Processes reviewed on-site were consistent with the policies and provided evidence of **RMHP**'s well-defined credentialing and recredentialing processes. **RMHP**'s policies for delegation and oversight of delegates who credential and recredential practitioners on behalf of **RMHP** included a review of the delegates' credentialing/recredentialing policies and procedures and a predelegation audit of files.

**RMHP**'s Quality Improvement Program Guide described expectations and required conduct for staff and committee members involved in quality improvement (QI) activities and committees. HSAG reviewed a template agreement that members of **RMHP**'s Medical Practice Review Committees (MPRC) must sign and that included attestation and agreement to conduct nondiscriminatory decision-making. The Credentialing Criteria and Process Policy stated that the credentialing manager tracked denials and terminations and annually audited the credentialing files of providers who had been denied or terminated for noncompliance with the nondiscriminatory standards and guidelines.

### *Summary of Strengths*

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

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

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

## Summary of Required Actions

Two of the organizations reviewed were reassessed at approximately four years rather than three. **RMHP** must develop a mechanism to ensure that organizational providers are reassessed within the NCQA-required time frames.

## Standard X—Quality Assessment and Performance Improvement

### Summary of Findings and Opportunities for Improvement

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

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

**RMHP**'s health information system collected and integrated data from multiple sources, included information on provider and member characteristics and services furnished to members, and generated multiple reports for QI monitoring activities and studies.

### **Summary of Strengths**

**RMHP** implemented an active QI program of diverse monitoring and improvement initiatives relative to the overall **RMHP** membership. **RMHP** had personnel expertise and systems to support a comprehensive QI program, and had made significant progress transitioning applicable CHP+ programs and processes to be consistent with the Medicaid rather than commercial population. The corporate-wide QI program appeared to be transitioning as **RMHP** developed strategies for improvement in operational approaches designed to support and integrate with other **RMHP** initiatives, such as the physician practice enhancement program and integration with the health information exchange. These initiatives were intended to improve the overall quality of services to members and enhance population-based outcomes. **RMHP** views CHP+ members as an important, but integral, component of the overall population and **RMHP** membership.

### **Summary of Required Actions**

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

**RMHP** must adopt clinical practice guidelines applicable to CHP+ members with disabilities or special health care needs.

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

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

The completed compliance monitoring tool follows this cover page.



*Appendix A. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

<b>Standard III—Coordination and Continuity of Care</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>1. The Contractor has written policies and procedures to ensure timely coordination with any of a member’s other providers of the provision of Covered Services to its members and to ensure:</p> <ul style="list-style-type: none"> <li>◆ Service accessibility.</li> <li>◆ Attention to individual needs.</li> <li>◆ Continuity of care to promote maintenance of health and maximize independent living.</li> </ul> <p>Contract: Exhibit A—2.7.4.1</p>	<p>Case Management Policy and Procedure.doc pp. 1, 11</p> <p>Continuity, Coordination and Transition of Medical Care</p> <p>San Juan Basin Health Department Contract</p> <p>Delta County Health Department Contract</p> <p>Delta County Business Associate Agreement</p> <p>Care Management Assessments</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></p> <p>The CHP+ Access Plan described the RMHP process for providing members with geographic access to providers, including targeted provider/member ratios and distances from members to providers. The plan also addressed appointment and wait time standards for various types of services, obtaining services for members with special health care needs, and continuity of care for a member whose provider was terminating from the plan.</p> <p>The Case Management Policy (applicable to all lines of business) stated that RMHP would use the case management process to ensure timely coordination of services, service accessibility, attention to individual needs, and continuity of care, as defined in the requirement. The policy explained that the case manager would assess members’ needs and refer them to an appropriate program, such as transition of care, disease management, or complex care management.</p> <p>The CHP+ Access Plan and the Continuity, Coordination, and Transition of Care Policy outlined the procedures for members transitioning into or out of the plan to have access to continued care with an existing medical provider when the member is undergoing an active course of treatment. During the on-site interview, the RMHP staff stated that members who were transitioning from an inpatient setting to another level of care were identified through the concurrent utilization review and received discharge planning to maintain continuity of care. RMHP staff members also stated that members transitioning from one outpatient care setting to another may also be referred to care management to develop a transition plan.</p>		
<p><b>Required Actions:</b></p> <p>None.</p>		



*Appendix A. Colorado Department of Health Care Policy and Financing*  
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<b>Standard III—Coordination and Continuity of Care</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>2. The Contractor’s procedures are designed to address those members who may require services from multiple providers, facilities, and agencies; and require complex coordination of benefits and services and those members who require ancillary, social, or other community services.</p> <p>The Contractor coordinates with the member’s mental health providers to facilitate the delivery of mental health services, as appropriate.</p> <p align="right"><i>42CFR438.208(b)(2)</i></p> <p>Contract: Exhibit A—2.7.4.2, 2.7.4.3.2, 2.7.4.3.3</p>	<p>Case Management Policy and Procedure.doc pg. 1</p> <p>Continuity, Coordination and Transition of Medical Care</p> <p>San Juan Basin Health Department Contract</p> <p>Delta County Health Department Contract</p> <p>Delta County Business Associate Agreement</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></p> <p>The Case Management Policy stated that procedures are designed to address members who require services from multiple entities (specifically as defined in the requirement), and that RMHP coordinates with mental health providers, as appropriate. The policy outlined the procedures for a comprehensive assessment, definition of a care plan, and coordination of services with multiple providers and community-based organizations. The policy also stated that RMHP contracts with the Delta County and San Juan Basin health departments to provide comprehensive case management for children with special health care needs.</p> <p>The delegated case management agreements with the Delta County Health Department and the San Juan Basin Health Department outlined the terms and conditions for the subcontractors to provide comprehensive case management services for qualified children with special health care needs. The agreements specifically outlined the required case management processes, documentation requirements, compensation for services by RMHP to the contractor, and contractor reporting requirements to RMHP. During the on-site interview, the staff stated that RMHP also tracked these members through the RMHP case management department and communicated frequently with the health department case managers concerning member needs and services. HSAG recommended that RMHP consider a more detailed audit for oversight of the delegated entities to ensure that the delegated functions were being adequately monitored.</p> <p>During the on-site review, RMHP presented two care coordination cases: (1) an infant male with “failure to thrive” and suspected neurofibromatosis who was self-referred by the parent for developmental difficulties, need for assistance with obtaining a new primary care provider (PCP), and referral to specialists; and (2) a one-year-old male with “low oxygen syndrome” who required a pulmonologist, home oxygen equipment, and speech therapy, and who was identified through the pre-authorization process. Both cases demonstrated coordination of necessary providers and services for the member’s assessed needs.</p>		



*Appendix A. Colorado Department of Health Care Policy and Financing*  
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<b>Standard III—Coordination and Continuity of Care</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<b>Required Actions:</b> None.		
<p>3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member.</p> <p>If a member does not select a primary care physician (PCP), the Contractor assigns the member to a PCP or a primary care facility and notifies the member, by telephone or in writing, of his/her facility's or PCP's name, location, and office telephone number.</p> <p align="right"><i>42CFR438.208(b)(1)</i></p> <p>Contract: Exhibit A—2.5.8.2</p>	<p>Case Management Policy and Procedure.doc pg. 2</p> <p>PCP Change in Facets Standard Operating Procedure (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 CHP+ Benefits Booklet informed members that they must pick a PCP and directed them to the provider directory to select a participating PCP or to call customer services for assistance. The Primary Care Physician Assignment for HMO Members Policy stated that members are encouraged to select a PCP upon enrollment and that if a member fails to select a PCP, RMHP has an automated process to assign a PCP for the member based on prior claims history, family PCP history, or geographic location. The member is informed of the assigned PCP through the member ID card. The policy outlined the detailed operating procedures for each department related to assigning the member to the most appropriate PCP. The CHP+ Access Plan also described the PCP selection and assignment process. The RMHP provider manual informed providers that members would select a PCP and that the member may request a change in PCP at any time. The manual stated that the PCP was responsible for the patient's total care and coordinated all medical care provided to the member. During the on-site interview, RMHP presented two coordination of care cases that documented the member had a designated PCP, as well as a designated care coordinator.</p>		
<b>Required Actions:</b> None.		



*Appendix A. Colorado Department of Health Care Policy and Financing*  
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<b>Standard III—Coordination and Continuity of Care</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals.</p> <p align="right"><i>42CFR438.208(c)(2)</i></p> <p>Contract: Exhibit A—2.7.4.3.1.1</p>	Case Management Policy and Procedure.doc pp. 2-3	<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 Case Management Policy stated that a potential case management member may be identified through data, internal departments (e.g., disease management and member services), member self-referral, or provider referral. The case management nurse conducts an initial screening with the member within one to three days of being identified or referred to case management. The policy stated that upon enrollment into complex case management, nurses perform a comprehensive assessment of the member’s needs, including assessment for the special health care needs outlined in the requirement. RMHP provided sample data reports that documented the use of claims information to assign a risk score and identify members with potential need for complex case management services. During the on-site interview, the staff confirmed that RMHP had not implemented a process for conducting an initial needs assessment after enrollment for all CHP+ members.</p> <p>The two members whose cases were presented during the on-site interview received a comprehensive needs assessment that included assessment of high-risk health problems, language and comprehension problems, mental health status, and functional problems. The assessments were performed by a registered nurse case manager. The staff confirmed that all case managers were licensed nurses.</p>		
<p><b>Required Actions:</b>            RMHP must implement a mechanism for initial screening of all CHP+ members upon enrollment to identify members with special health care needs.</p>		
<p>5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member’s needs, to prevent duplication of those activities.</p> <p align="right"><i>42CFR438.208(b)(3)</i></p> <p>Contract: Exhibit A—2.7.5.2</p>	Case Management Policy and Procedure.doc pp. 7, 11	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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Standard III—Coordination and Continuity of Care		
Requirement	Evidence as Submitted by the Health Plan	Score
<p><b>Findings:</b>            The Case Management Policy stated that for members enrolled in complex case management, RMHP would coordinate with other health care organizations providing services to the member and would notify health care organizations serving members with special health care needs of the results of RMHP’s needs assessments to prevent duplication of services and activities. The policy outlined the process for communicating with county health departments that have been delegated by RMHP to perform needs assessment and case management for children with special health care needs. During the on-site interview, the staff described several examples of communicating and coordinating member needs with other health care organizations, such as foundations providing charity funding for services, the region’s behavioral health organization, or facilitating transfer of records to out-of-state providers. Staff members stated that information may be shared verbally or through the electronic referral process, as appropriate.</p>		
<p><b>Required Actions:</b>            None.</p>		
<p>6. The Contractor implements procedures to develop an individual treatment plan as necessary.   <i>42CFR438.208(c)(3)</i>             Contract: Exhibit A—2.7.4.3.1.2</p>	<p>Case Management Policy and Procedure.doc. 5</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 Case Management Policy explained that the case management plan was designed to help the member meet his or her clinical, functional, and social health care goals, while treatment plans were developed by the member's PCP for members who needed a specific course of treatment. The policy stated that the complex case manager would develop an individualized case management plan with the participation of the member and providers, based on the identified needs of the member. The care plan would include the member/caregiver’s prioritized measurable goals, defined interventions, barrier analysis, and regularly scheduled follow-up and re-evaluation.</p> <p>During the on-site interview, staff members stated that the provider’s responsibility to develop a treatment plan was referenced in the office records section of the provider manual, which listed the required components of the medical record. The staff described the periodic office record review process as including an audit to document the required medical record components in physician office records and providing practice quality management coaching as mechanisms to ensure that an appropriate member treatment plan was developed. The Physician Medical Record Audit Tool confirmed that the audit included a review of the physician’s documentation of a care plan based on the medical condition of the member. HSAG recommended that RMHP consider enhancing its provider communications to inform them of the responsibility to develop an individual treatment plan based on an assessment of the member’s medical, functional, and social needs.</p> <p>The on-site presentation of care coordination cases demonstrated that each member had an individual treatment/care plan with member goals, planned interventions, barriers, detailed progress/contact notes, and scheduled follow-up.</p>		
<p><b>Required Actions:</b>            None.</p>		



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<b>Standard III—Coordination and Continuity of Care</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>7. The Contractor’s procedures for individual needs assessment and treatment planning are designed to:</p> <ul style="list-style-type: none"> <li>◆ Accommodate the specific cultural and linguistic needs of the members.</li> <li>◆ Allow members with special health care needs direct access to a specialist as appropriate to the member’s conditions and needs.</li> </ul> <p align="right"><i>42CFR438.208(c)(3)(iii)</i></p> <p>Contract: Exhibit A—2.7.4.3.1.4</p>	<p>Case Management Policy and Procedure.doc pp. 4,5,8</p> <p>RMHP Annual Cultural and Linguistics Needs Report 112812.pdf</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 Case Management Policy and Procedure stated that the case manager would evaluate the cultural norms, practices, language proficiency, and preferences of members. The case manager was also responsible for identifying cultural or language barriers to meet the goals of the treatment plan. The on-site presentation of two care coordination cases demonstrated that the members’ cultural and language needs were included in the assessment and the individual care plan. The RMHP Cultural and Linguistic Needs Report identified a number of initiatives related to the cultural and language needs of the RMHP population, including the assessment of member cultural barriers to following the recommended course of treatment based on the disease management programs and materials.</p> <p>The CHP+ Benefits Booklet, the RMHP provider manual, and the CHP+ Access Plan stated that members did not need a referral to see an in-network specialist, and that access to an out-of-network specialist may be allowed when authorized by RMHP.</p>		
<p><b>Required Actions:</b>            None.</p>		
<p>8. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable.</p> <p>In all other operations as well the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR</p>	<p>Case Management Policy and Procedure.doc pg. 4</p> <p>Confidentiality and Retention of Member Records Policy 1.7.13.doc</p> <p>Provider Manual (see bookmarks)</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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<p>parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.</p> <p align="center"><i>42CFR438.208(b)(4)</i> <i>42CFR438.224</i></p> <p>Contract: Exhibit A—2.7.4.1, 3.1.4.3 (RMHP—3.1.3.3)</p>		
<p><b>Findings:</b>            RMHP submitted a list of all HIPAA privacy policies and procedures that addressed physical record security, training, violations and work force sanctions, notice of privacy practices, use and disclosure of protected health information (PHI), obtaining release of information authorizations, verification of identity/authority, de-identification of PHI, and minimum necessary use. RMHP submitted several policies from the list that demonstrated compliance with HIPAA regulations. The Confidentiality and Retention of Members Record Policy stated that no member PHI would be disclosed without the member’s prior written consent. The policy also defined processes for maintaining confidentiality of all RMHP records and materials, and stated that access to PHI or other confidential information was restricted to individuals or committees with the need to know based on defined responsibilities. The RMHP provider manual described the maintenance of confidentiality in all communications and records related to care management. The manual described the general RMHP policies related to confidentiality of member information in accordance with HIPAA regulations, including obtaining a member’s routine consent for access to information from other providers/entities and the member’s right to release information through specific consents. The manual also informed providers that they must comply with all applicable HIPAA regulations.</p>		
<p><b>Required Actions:</b>            None.</p>		
<p>9. The Contractor’s procedures include a strategy to ensure that all members and/or authorized family members are involved in treatment planning and consent to medical treatment.</p> <p>Contract: Exhibit A—2.7.4.3.4</p>	<p>Case Management Policy and Procedure.doc pg. 4</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 Case Management Policy stated that the case management plan’s goal development should include member and family participation and that a relevant note should be entered if the member/family chose not to participate. The policy also stated that self-management goals were a component of the care plan. The two care coordination cases presented on-site demonstrated that the case manager obtained the member’s consent to participate in case management and the active involvement of the member/parent in developing and implementing the plan.</p>		



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The provider manual described the role of RMHP case management to support providers and members/families for compliance with the treatment plan. The manual did not explicitly define the provider’s responsibility to develop a treatment plan with the member’s involvement and consent. Although case management documentation clearly indicated that the member/family participated in case management activities, HSAG recommended that RMHP define a mechanism to consistently document the member’s consent to the individual care coordination plan in the case management record.		
<b>Required Actions:</b> None.		

<b>Results for Standard III—Coordination and Continuity of Care</b>					
<b>Total</b>	Met	=	<u>8</u>	X	1.00 = <u>8</u>
	Partially Met	=	<u>1</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>9</u>	<b>Total Score</b>	= <u>8</u>

<b>Total Score ÷ Total Applicable</b>		=	<u>89%</u>
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<b>Standard IV—Member Rights and Protections</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
1. The Contractor has written policies and procedures regarding member rights.  <i>42CFR438.100(a)(1)</i>  Contract: Exhibit A—3.1.1.1	CHP+ Member Rights CHP+ Benefits Booklet (See bookmarks)  Provider Manual (see bookmarks)	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> RMHP had several policies in place that addressed member rights and protections in accordance federal health care requirements. RMHP’s CHP+ Member Rights Policy described how member rights are communicated to members and providers. In addition, RMHP had several policies that addressed topic-specific issues, such as confidentiality and handling PHI, nondiscrimination, and grievances and appeals. As CHP+ requirements evolve to mirror Medicaid managed care regulations, RMHP should consider reviewing each CHP+ policy to ensure changes have been addressed adequately.		
<b>Required Actions:</b> None.		
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members.  <i>42CFR 438.100(a)(2)</i>  Contract: Exhibit A—3.1.1.1	Provider Manual (see bookmarks)	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> During the on-site interview, RMHP staff members described the “Bridges out of Poverty” training program and stated that this program was offered to the Mesa County Independent Providers Association. The staff described this training as an excellent opportunity for providers to understand barriers to accessing care and the different needs and communication styles common to some of the assistance population. Provider newsletters included topics regarding cultural competency and available cultural competency training. On-site, the staff also described a project recently initiated whereby the RMHP Member Experience Advisory Committee will evaluate customer “touch points” (defined as points within the RMHP system wherein members will interact in some way with RMHP or its staff members), to evaluate both the member’s experience with RMHP and opportunities to improve the member experience. Staff members reported that this project involved all departments and regions served by RMHP and could impact members within all lines of business. The provider manual had two lists of member rights: one was labeled “Member Rights” and the other “Medicaid Member Rights.” During the on-site interview, the staff clarified that the CHP+ population has been aligned with the commercial line of business and that the Member Rights list had previously applied to CHP+ members. This list did not include all the rights as stated in 42CFR438.100 or in the CHP+ managed care contract.		
<b>Required Actions:</b> RMHP must revise the provider manual to clearly describe member rights applicable to the CHP+ population. HSAG further recommends that RMHP develop additional communications, such as e-mail announcements or articles for the provider newsletters, to inform providers of the changes in federal health care requirements for the CHP+ population and the resultant implications.		



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<p>3. The Contractor’s policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights:</p> <ul style="list-style-type: none"> <li>◆ Receive information in accordance with information requirements (42CFR438.10).</li> <li>◆ Be treated with respect and with due consideration for his or her dignity and privacy.</li> <li>◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member’s condition and ability to understand.</li> <li>◆ Participate in decisions regarding his or her health care, including the right to refuse treatment.</li> <li>◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.</li> <li>◆ Request and receive a copy of his or her medical records and request that they be amended or corrected.</li> <li>◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210).</li> </ul> <p align="right"><i>42CFR438.100(b)(2) and (3)</i></p> <p>Contract: Exhibit A—3.1.1.1</p>	<p>CHP+ Benefits Booklet</p> <p>Provider Manual (see bookmarks)</p> <p>Bridges out of Poverty Training</p> <p>Bridges out of Poverty sign up 1</p> <p>Bridges out of Poverty sign up 2</p> <p>Bridges out of Poverty sign up 3</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>
<p><b>Findings:</b>            On site, staff members described RMHP’s care management and utilization management processes, during which the care management staff works closely with providers and members to ensure members receive the appropriate services, understand their rights, and understand that those rights are taken into consideration during the episode of care. The Child Health Plan + Member Rights Policy described most of the rights as stated in 42CFR438.100 and in the CHP+ managed care contract; however, it was missing both the right to be free from restraint or seclusion and the member’s right to request and receive a copy of his or her medical records and have them amended or corrected.</p>		



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Requirement	Evidence as Submitted by the Health Plan	Score
<p><b>Required Actions:</b>            RMHP must revise the CHP+ member rights policy to include all rights afforded to CHP+ members by federal regulations or the CHP+ contract with the State. RMHP must ensure that the staff, providers, and members are made aware of changes in policies or practices related to CHP+ member rights.</p>		
<p>4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member.</p> <p align="right"><i>42CFR438.100(c)</i></p> <p>Contract: Exhibit A—3.1.1.1.7</p>	<p>CHP+ Benefits Booklet (see bookmarks)</p> <p>Provider Manual (see bookmarks)</p> <p>Bridges out of Poverty Training</p> <p>Bridges out of Poverty sign up 1</p> <p>Bridges out of Poverty sign up 2</p> <p>Bridges out of Poverty sign up 3</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>
<p><b>Findings:</b>            The list of member rights included in the member handbook that was provided and posted on the RMHP Web site identified the member’s right to bring complaints to RMHP, the insurance commissioner, and the State of Colorado. The handbook provided also included the right to freely exercise rights without being treated differently; however, this right was not listed in the handbook on the Web site. In addition, the provider manual did not clearly inform providers of CHP+ member rights (see requirement number two of this standard).</p>		
<p><b>Required Actions:</b>            In order for members to understand their benefits and rights and be empowered to exercise those rights under the CHP+ program, members and providers must receive clear and consistent information from all sources regarding those benefits and rights. RMHP must revise its Web site to include current and accurate information.</p>		
<p>5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act.</p> <p align="right"><i>42CFR438.100(d)</i></p> <p>Contract: 21.A</p>	<p>CHP+ Benefits Booklet</p> <p>Provider Manual (see bookmarks)</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>
<p><b>Findings:</b>            The CHP+ Member Rights Policy included a definitive policy statement that articulated RMHP’s intention to provide equal opportunity and to prevent discrimination based on race, color, national origin, age, or disability in access to treatment or employment. The same policy statement was found in the member benefits booklet and the provider manual. The spring 2012 provider newsletter included an affirmation statement of nondiscrimination. During the on-site interview, RMHP staff members reported that information regarding these federal laws was part of new-employee orientation and was revisited</p>		



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Requirement	Evidence as Submitted by the Health Plan	Score
during annual Compliance Week activities during which staff members engaged in games, activities, and training to remind them of these and other federal laws and requirements in a nonthreatening manner that encourages learning.		
<b>Required Actions:</b> None.		

Results for Standard IV—Member Rights and Protections					
<b>Total</b>	Met	=	<u>2</u>	X	1.00 = <u>2</u>
	Partially Met	=	<u>3</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
<b>Total Applicable</b>		=	<u>5</u>	<b>Total Score</b>	= <u>2</u>

<b>Total Score ÷ Total Applicable</b>				=	<u>40%</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>CR-Credentialing Process CR.1.12.pdf            CR-Recredentialing Process RC.1.12.pdf</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 Criteria and Process Policy and the Recredentialing Process Policy provided an overview of RMHP’s credentialing and recredentialing processes, referring to other pertinent policies for specific details. Processes reviewed on-site were consistent with the policies and provided evidence of RMHP’s well-defined credentialing and recredentialing processes.</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 doctors of medicine [MDs], doctors of osteopathy [DOs], podiatrists, and each type of behavioral health provider).</p> <p align="right"><i>42CFR438.214(a)</i></p> <p>NCQA CR1—Element A1</p>	<p>CR-Credentialing Process CR.1.12.pdf– Pg 4-6            CR-Recredentialing Process RC.1.12.pdf– Pg 4-6</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 Criteria and Process Policy and the Recredentialing Process Policy included tables that depicted the types of practitioners that RMHP credentials and recredentials and the criteria for credentialing each type of practitioner. Examples included medical doctors, doctors of osteopathic medicine, physician assistants, and certified registered nurse anesthetists, as well as others.</p>		
<p><b>Required Actions:</b>            None.</p>		



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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>
2.B. The verification sources used.  NCQA CR1—Element A2	CR-Credentialing Process CR.1.12.pdf – Pg 8-9 CR-Recredentialing Process RC.1.12.pdf– Pg 9-10	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> The primary verification sources described in RMHP’s policy met NCQA requirements for primary-source verification. RMHP used primary sources such as the Colorado Department of Regulatory Agencies (DORA) to verify State licenses and the National Practitioner Data Bank to verify eligibility to participate in federal health care programs.		
<b>Required Actions:</b> None.		
2.C. The criteria for credentialing and recredentialing.  NCQA CR1—Element A3	CR-Credentialing Process CR.1.12.pdf– Pg 2-6 CR-Recredentialing Process RC.1.12.pdf- Pg 2-6	<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 Criteria and Process Policy and the Recredentialing Process Policy described the credentialing criteria for each type of practitioner credentialed and recredentialed.		
<b>Required Actions:</b> None.		
2.D. The process for making credentialing and recredentialing decisions.  NCQA CR1—Element A4	CR-Credentialing Process CR.1.12.pdf– Pg 10-12 CR-Recredentialing Process RC.1.12.pdf– Pg 10-13 CR-Credentialing Recredentialing Approval Workflow.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> RMHP’s policy described processes for making credentialing and recredentialing decisions and delineated the role of the Medical Practice Review Committees (MPRCs). RMHP uses five distinct MPRCs in its regions throughout the state to carry out credentialing committee activities and use local physicians to accomplish the tasks in each region. The policy described three categories of files and the process for sending files to the medical director for approval or to one of the MPRCs for discussion. The policy described the committee process to make decisions against established RMHP criteria. The credentialing and recredentialing work flow diagram depicted the process of determining the category and approval process.		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<b>Required Actions:</b> None.		
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor’s established criteria.  NCQA CR1—Element A5	CR-Credentialing Process CR.1.12.pdf– Pg 10 CR-Recredentialing Process RC.1.12.pdf– Pg 10-11	<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 Criteria and Process Policy and the Recredentialing Process Policy listed the documents that must be present for the credentialing and recredentialing files to be complete and described three categories of files with circumstances that require review by one of the MPRC committees. During the on-site interview, RMHP staff members confirmed that, for clean files, the medical director (or designee) approval date was the credentialing/recredentialing date, and the MPRC date was the credentialing date for providers reviewed by the MPRC.		
<b>Required Actions:</b> None.		
2.F. The process for delegating credentialing or recredentialing (if applicable).  NCQA CR1—Element A6	CR-Delegated Cred-Recred Process DEL.1.12.pdf	<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 and Recredentialing Policy described processes for delegation and oversight of delegates who recredentialled and recredentialled practitioners on behalf of RMHP. The policy described activities that may be delegated and the required provisions for the content of the delegation agreement. Processes to delegate credentialing included a review of the delegate’s credentialing/recredentialing policies and procedures and pre-delegation audit of files.		
<b>Required Actions:</b> None.		



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<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>CR-Non-Discriminatory Credentialing 14.12.pdf            CR-Non-Discriminatory Review thru 12-31-12.pdf</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 Non-discriminatory Credentialing Policy stated that members of the MPRCs made decisions in accordance with the guidelines specified in the Quality Improvement (QI) Program. During the on-site interview, RMHP staff members stated that the QI Program Guide described expectations and required conduct for staff and committee members involved in QI activities and committees. On-site, the staff provided a template agreement that MPRC members signed and that included attestation and agreement to conduct nondiscriminatory decision-making. The policy also stated that the credentialing manager tracked denials and terminations and annually audited the credentialing file of providers who had been denied or terminated for compliance with the nondiscriminatory standards and guidelines.</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>CR-Credentialing Process CR.1.12.pdf – Pg 8            CR-Recredentialing Process RC.1.12.pdf – Pg 9</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 Credentialing Criteria and Process Policy and the Recredentialing Process Policy described the process for notifying the applicant by phone of discrepancies in information, and for providing the applicant the opportunity to provide additional information or clarify the discrepancy.</p>		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<b>Required Actions:</b> None.		
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee’s decision.  NCQA CR1—Element A9	CR-Credentialing Process CR.1.12.pdf – Pg 11 CR-Recredentialing Process RC.1.12.pdf– Pg 12 CR-Guidelines to notify within 60 days.pdf	<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 Criteria and Process Policy and the Recredentialing Process Policy stated that the time frame for notifying practitioners of the credentialing decision was 60 days. The on-site review of credentialing and recredentialing records demonstrated that notifications were made within the time frame, often within 30 days.		
<b>Required Actions:</b> None.		
2.J. The medical director’s or other designated physician’s direct responsibility and participation in the credentialing/ recredentialing program.  NCQA CR1—Element A10	CR-Credentialing Process CR.1.12.pdf– Pg 1, 10-11 CR-Recredentialing Process RC.1.12.pdf– Pg 1, 10-11	<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 Criteria and Process Policy and the Recredentialing Process Policy described the process for medical director review and sign-off on the list of clean files. On-site, RMHP staff members reported that either the medical director or a designee was the designated chairperson for each of the MPRCs.		
<b>Required Actions:</b> None.		



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<p>2.K. The process for ensuring the ` of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law.</p> <p>NCQA CR1—Element A11</p>	<p>CR-Credentialing Process CR.1.12.pdf– Pg 12            CR-Recredentialing Process RC.1.12.pdf– Pg 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>            The Credentialing Criteria and Process Policy and the Recredentialing Process Policy described processes to ensure the confidentiality of credentialing records, which included limited electronic and physical access based on job category and the need for the information. The need for the information was related to completion of the credentialing or recredentialing processes. Limited physical access included maintaining applications in a locked file cabinet. Electronic security included password protections based on job category.</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>CR-Practitioner Specialties CR.12.12.pdf – Pg 12            CR-Directory Validation process.pdf</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 Practitioner Specialties Policy stated that the provider directory was created from the FACETS tables using information that was entered during the credentialing process. The Physician Directory Updates Policy stated that the provider relations staff reviewed the provider panel biannually and entered updates to the FACETS tables as needed. During the on-site interview, RMHP staff members clarified that two times per year (fall and spring), the provider network staff performed a review to verify the accuracy of the provider directory. The staff reported that the on-line provider directory was refreshed/updated daily. The staff also stated that the database tables were sent to the vendor annually for the printing of hard-copy directories.</p>		
<p><b>Required Actions:</b>            None.</p>		



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2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request.  NCQA CR1—Element B1	CR-Credentialing Process CR.1.12.pdf– Pg 7 CR-Recredentialing Process RC.1.12.pdf– Pg 7	<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 Criteria and Process Policy and the Recredentialing Process Policy described the process for providing information to applicants upon request. RMHP informed applicants of this right via the provider application.		
<b>Required Actions:</b> None.		
2.N. The right of practitioners to correct erroneous information.  NCQA CR1—Element B2	CR-Credentialing Process CR.1.12.pdf– Pg 7 CR-Recredentialing Process RC.1.12.pdf– Pg 7	<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 Criteria and Process Policy and the Recredentialing Process Policy addressed the applicant’s right to correct erroneous information. RMHP informed applicants of this right via the provider application.		
<b>Required Actions:</b> None.		
2.O. The right of practitioners, upon request, to receive the status of their application.  NCQA CR1—Element B3	CR-Credentialing Process CR.1.12.pdf– Pg 7 CR-Recredentialing Process RC.1.12.pdf– Pg 7	<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 Criteria and Process Policy and the Recredentialing Process Policy stated that applicants may request and receive the status of their credentialing or recredentialing application. RMHP informed applicants of this right via the provider application.		
<b>Required Actions:</b> None.		



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2.P. The right of the applicant to receive notification of their rights under the credentialing program.  NCQA CR1—Element B4	CR-Credentialing Process CR.1.12.pdf– Pg 7 CR-Recredentialing Process RC.1.12.pdf– Pg 7 CR-App Attestation Notification of Rights.pdf CR-Website screenshot practitioner rights.pdf	<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 Criteria and Process Policy and the Recredentialing Process Policy stated that applicants were notified of their rights under the credentialing program via the application process. The Colorado credentials application informed applicants of their rights under the credentialing program.		
<b>Required Actions:</b> None.		
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: <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> NCQA CR9—Element A	CR-On-going Monitoring CR.7.12.pdf CR-OIG-CBME-CAQH Mid-cycle monitoring sample reports.pdf CR-QA process workflow diagram.pdf CR-MPRC Meeting Minutes.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> The Ongoing Monitoring Policy described the process for using the federal and State licensing databases monthly to ensure that RHMP providers were eligible for federal health care participation. RMHP provided sample documentation that demonstrated how RMHP’s data system compared the RMHP provider list to the queries for sanctions. Any providers on the list were terminated per RMHP policy.		



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



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<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 which includes:</p> <ul style="list-style-type: none"> <li>◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process.</li> <li>◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request.</li> <li>◆ Allowing at least 30 days after the notification for the practitioner to request a hearing.</li> <li>◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner’s choice.</li> <li>◆ Appointing a hearing officer or panel of the individuals to review the appeal.</li> <li>◆ Providing written notification of the appeal decision that contains the specific reasons for the decision.</li> </ul> <p>NCQA CR10—Element A3and C</p>	<p>CR-Reduction, Suspension, Termination RC.4.12.pdf– Pg 2-3            CR-Initial Denial Letter example.pdf</p> <p>RMHP did not suspend or terminate any practitioners for quality reasons within the look-back period.</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 Reduction, Suspension, or Termination Policy described the appeal process, which included all the required elements.</p>		
<p><b>Required Actions:</b>            None.</p>		



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2.U. Making the appeal process known to practitioners.  NCQA CR10—Element A4	CR-Reduction, Suspension, Termination RC.4.12.pdf– Pg 4	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> The policy stated that the appeal process was outlined in the letter informing the provider of the action taken.		
<b>Required Actions:</b> None.		
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners.  NCQA CR2—Element A	CR-Credentialing Committee CR.13.12. pdf CR-MPRC Member List and Attendance.2012.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> The on-site review of MPRC meeting minutes demonstrated the use of the peer review process to make credentialing and recredentialing decisions. Physicians participating in the MPRCs represented physicians from a variety of specialty areas. RMHP used five regional MPRCs to ensure representation within the large geographic area that RMHP serves.		
<b>Required Actions:</b> None.		



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<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>	<p>CR-Credentialing Process CR.1.12.pdf – Pg 10-11            CR-Recredentialing Process RC.1.12.pdf – Pg 10-11            CR-MPRC Meeting Minutes.pdf            CR-Medical Director Review of Clean files.pdf</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 on-site review of MPRC meeting minutes demonstrated the review of providers who did not initially meet established criteria. The on-site review of 10 credentialing and 10 recredentialing records demonstrated medical director (or designee) review and approval of a list of providers with clean files meeting RMHP’s credentialing criteria.</p>		
<p><b>Required Actions:</b>            None.</p>		
<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 (verification time limit = 180 calendar days).</li> <li>◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision).</li> <li>◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/</li> </ul>	<p>CR-Credentialing Process CR.1.12.pdf– Pg 8-9            CR-Recredentialing Process RC.1.12.pdf– Pg 8-9            CR-State Licensing Agency Verification Letters.pdf</p>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> Not Applicable</p>



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professional school, residency, or board certification [board certification time limit = 180 calendar days]). <ul style="list-style-type: none"> <li>◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years).</li> <li>◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days).</li> </ul>		
NCQA CR3—Elements A and B		
<b>Findings:</b> RMHP’s policies stated that all credentials would be verified within 180 days prior to the medical director or MPRC approval date. The on-site review of credentialing and recredentialing records demonstrated that all primary-source verification, credentialing, and recredentialing for individual practitioners was completed within the NCQA required time frames.		
<b>Required Actions:</b> None.		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: <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> </ul>	CR-Credentialing Process CR.1.12.pdf– Pg 7 (reference to State App) CR-Recredentialing Process RC.1.12.pdf– Pg 8 (reference to State App) CR-State Credentialing Application.pdf Pg 26 Pg 25 Pg 19-20 Pg 19 Pg 17 Pg 21 RMHP utilizes the Department of Public Health & Environment State Board of Health 6CCR 1014-4 Colorado Health Care Professional Credentialing Application or the Council for Affordable Quality Healthcare’s (CAQH) Universal Provider Datasource for credentialing and recredentialing applications.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable



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<ul style="list-style-type: none"> <li>◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil),</li> <li>◆ The correctness and completeness of the application.</li> </ul> <p>NCQA CR4—Element A            NCQA CR7—Element C            C.R.S.—13-64-301-302</p>		
<p><b>Findings:</b>            RMHP’s policies stated that RMHP required all practitioners to complete the Colorado Health Care Professional Credentials Application. The application included each of the required attestations. The on-site review of 10 credentialing and 10 recredentialing files provided evidence that each file contained a completed and signed application and attestation from the provider.</p>		
<p><b>Required Actions:</b>            None.</p>		
<p>7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing:</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 align="right"><i>42CFR438.610(b)(3)</i></p> <p>NCQA CR5—Element A            NCQA CR7—Element D</p>	<p>CR-Credentialing Process CR.1.12.pdf– Pg 7, 9            CR-Recredentialing Process RC.1.12.pdf– Pg 10            CR-NPDB CR.5.12.pdf            CR-OIG Check pre-cred.pdf</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>            RMHP’s policies stated that an appropriate database search is completed prior to initiating the credentialing process to ensure eligibility to participate in federal health care programs. The on-site review of credentialing and recredentialing records demonstrated that RMHP used the NPDB to verify sanction or exclusion activity.</p>		
<p><b>Required Actions:</b>            None.</p>		



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<p>8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for:</p> <ul style="list-style-type: none"> <li>◆ Physical accessibility.</li> <li>◆ Physical appearance.</li> <li>◆ Adequacy of waiting and examining room space.</li> <li>◆ Adequacy of treatment record-keeping.</li> </ul> <p>NCQA CR6—Element A</p>	<p>CR-Office Site Visit Standards CR.10.12.pdf            CR-Office Site Visit Evaluation Form.pdf</p> <p>Note – Credentialing maintains the P&amp;P and partners with PR if a Site visit needs to be conducted.</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 Office Site Quality Policy stated that RMHP’s criterion for complaints that triggered a site visit (for individual practitioners) was three complaints within a 12-month period related to office site quality. The policy also stated that site visits could be performed after one complaint or when RMHP staff members were on-site for a medical record audit. On-site RMHP staff members reported that there had been no site visits based on office site quality.</p>		
<p><b>Required Actions:</b>            None.</p>		
<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 a complaint threshold was met.</li> </ul>	<p>CR-Office Site Monitoring CR.4.12.pdf            CR-Office Site Visit Evaluation Form.pdf</p> <p>Note – The threshold for triggering a site visit was not met during the review period.</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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<ul style="list-style-type: none"> <li>◆ Documenting follow-up visits for offices that had subsequent deficiencies.</li> </ul> <p>NCQA CR6—Element B</p>		
<p><b>Findings:</b>            RMHP’s policy stated that if an office site did not meet RMHP’s standards, RMHP would request in writing that the site correct the issue. A re-visit would be performed in six months and subsequent site visits would continue until the deficiencies were corrected. The policy included all required elements.</p>		
<p><b>Required Actions:</b>            None.</p>		
<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 (verification time limit = 180 calendar days).</li> <li>◆ A valid DEA or CDS certificate (effective at the time of recredentialing).</li> <li>◆ Board certification (verification time limit = 180 calendar days).</li> <li>◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days).</li> </ul> <p>NCQA CR7—Elements A and B            NCQA CR8— Element A</p>	<p>CR-Recredentialing Process RC.1.12.pdf Pg 2, 9-10</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 Recredentialing Process Policy described recredentialing independent practitioners at least every 36 months, using primary-source verification and all required processes. The on-site review of 10 practitioner recredentialing records demonstrated that practitioners were recredentialled within the required 36-month time frame.</p>		



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



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<p>11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status.</p> <p>NCQA CR11—Element A3</p>	<p>CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3-4            CR-Mechanism for Evaluation of Co State Ops Manual.pdf</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 RMHP did not contract with organizations that either were not accredited by an acceptable accrediting body or certified by CMS. The on-site review of five organizational provider files demonstrated that the organizations reviewed were either accredited or were surveyed by the Colorado Department of Public Health and Environment (CDPHE), which uses the CMS survey form and provides CMS certification for organizations that successfully complete the CDPHE survey.</p>		
<p><b>Required Actions:</b>            None.</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 has no accreditation status.</p> <p>NCQA CR11—Element A</p>	<p>CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 4</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>            RMHP’s policy addressed re-assessment of organizational providers every three years. The on-site review of organizational providers demonstrated that RMHP had not successfully reassessed all organizational providers at the 36-month time frame. Two of the organizations reviewed were reassessed at approximately four years rather than three.</p>		
<p><b>Required Actions:</b>            RMHP must develop a mechanism to ensure that organizational providers are reassessed within the NCQA-required time frames.</p>		



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<p>11.E. The Contractor’s policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.)</p> <p>NCQA CR11—Element A</p>	<p>CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3</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 listed acceptable accrediting bodies, which included The Joint Commission (TJC), the Accreditation Association of Ambulatory Health Care (AAAHC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Community Health Accreditation Program (CHAP), and the Healthcare Facilities Accreditation Program (HFAP). The on-site review of organizational provider files included three organizations accredited by TJC.</p>		
<p><b>Required Actions:</b>            None.</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>NCQA CR11—Element A</p>	<p>CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3-4            CR-Mechanism for Evaluation of Co State Ops Manual.pdf</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 policy listed the selection criteria for participation in the RMHP provider network and stated that RMHP adopted the quality standards set forth in Colorado’s State Operations Manual for State surveys.</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>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>CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3-4            CR-Mechanism for Evaluation of Co State Ops Manual.pdf</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></p> <p>The policy stated that RMHP required organization providers to attest to having a process for credentialing its practitioners. During the on-site interview, RMHP staff members reported that RMHP’s staff had reviewed the Colorado Department of Public Health and Environment’s State Operations Manual for site visits and verified that CDPHE surveyed organizations for credentialing practices. In addition, RMHP recently put in place a process to have organizations’ executive directors attest to having credentialing processes in place. The attestations were found in organizational provider files assessed following the implementation of this process.</p>		
<p><b>Required Actions:</b></p> <p>None.</p>		
<p>14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization’s standard.</p> <p>NCQA CR11—Element A</p>	<p>CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 3-4            CR-Mechanism for Evaluation of Co State Ops Manual.pdf</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></p> <p>The Mechanism for Evaluation document stated that the RMHP credentialing team maintained pertinent sections of the State Operations Manual and reviewed it annually to note any modifications and reports to the chief medical officer and ensure ongoing acceptance and adoption of the standards. The on-site review of organizational provider records demonstrated that files included either the CDPHE site survey report or evidence of having passed the</p>		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
CDPHE survey printed from the CDPHE Web site. On-site, RMHP’s staff provided documentation that it had last reviewed the State Operations Manual on October 22, 2012.		
<b>Required Actions:</b> None.		
15. The Contractor’s organizational provider assessment policies and process include assessment of at least the following medical providers: <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> NCQA CR11—Element B	CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 1	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> RMHP’s policy included criteria and processes for hospitals, skilled nursing facilities, surgical facilities, and home health agencies. The on-site review of organizational provider files included two hospitals, a free-standing surgical center, and two home health agencies.		
<b>Required Actions:</b> None.		
16. The Contractor’s organizational provider assessment policies and process include assessment of at least the following behavioral health and substance abuse settings: <ul style="list-style-type: none"> <li>◆ Inpatient.</li> <li>◆ Residential.</li> <li>◆ Ambulatory.</li> </ul> NCQA CR11—Element C	CR-Organizational Providers Credentialing HDO.1.12.pdf– Pg 1	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> RMHP’s policy included criteria and processes for mental health inpatient and residential facilities. There were no examples of mental health facilities in		



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<p>the sample for on-site review of organizational provider files; however, the staff provided examples of mental health facilities to demonstrate that RMHP contracted with and assessed mental health/behavioral health organizations.</p> <p><b>Required Actions:</b> None.</p>		
<p>17. The Contractor has documentation that it has assessed contracted medical health care and behavioral health care (organizational) providers.</p> <p>NCQA CR11—Element D</p>	<p>CR-CHP+ Organizational Providers Credentialing Report.pdf            CR-Sample Accred Facility Cred File.pdf            CR-Sample Non-Accred Facility Cred File.pdf</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 on-site review of organization-specific files demonstrated that RMHP documented assessment and reassessment activities for organizational providers with which it contracted.</p> <p><b>Required Actions:</b> None.</p>		
<p>18. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities.</p> <p>NCQA CR12</p>	<p>CR-Delegated Cred Oversight DEL.2.12.pdf            CR-Delegate Oversight Tool-Montrose 2012.pdf            CR-Delegate Oversight Tool-Physiotherapy 2012.pdf            CR-Delegate Oversight Tool-Southwest 2012.pdf            CR-Delegate Oversight Tool-Vail Valley 2012.pdf</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> On-site, RMHP’s staff reported that five delegates—Montrose Physician Health Organization and Physiotherapy Associates, Southwest Memorial Hospital provider group, Vail Valley Medical Center provider group, and Mercy Medical Center/Centura provider group—provided services to Medicaid members. RMHP submitted reports received from all delegates and completed annual audit reports for all delegates.</p> <p><b>Required Actions:</b> None.</p>		



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>19. 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>CR-Delegated Cred-Recred Process DEL.1.12.pdf Pg 1-2            CR-Delegated Cred Agreement Termination DEL.3.12.pdf            CR-Delegated Cred Agreement – Montrose Community Health Plan.pdf            CR-Delegated Cred Agreement – Physiotherapy Corporation.pdf            CR-Delegated Cred Agreement – Southwest Healthnet.pdf            CRDelegated Cred Agreement – Vail Valley.pdf</p> <p>Note – All Delegated credentialing agreements were updated to a new template/format in 2012. Delegation to Montrose Community Health Plan initiated May 23, 1997; Physiotherapy was initiated in April 15, 2003; Southwest Healthnet August 15, 1997 and Vail Valley July, 23, 2004.</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>            RMHP provided copies of each delegation agreement signed by both parties and included each of the required provisions.</p>		
<p><b>Required Actions:</b>            None.</p>		
<p>20. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes:</p> <ul style="list-style-type: none"> <li>◆ A list of allowed use of PHI.</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> </ul>	<p>As part of our delegated credentialing agreements, member specific PHI is not shared</p>	<p><input type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input checked="" type="checkbox"/> Not Applicable</p>



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<ul style="list-style-type: none"> <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><b>Findings:</b> Not Applicable.</p>		
<p><b>Required Actions:</b> None.</p>		
<p>21. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement.</p> <p>NCQA CR12—Element C</p>	<p>CR-Delegated Cred-Recred Process DEL 1.12.pdf Pg 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> Each delegation agreement included the provision that RMHP retained the right to approve, suspend, or terminate practitioners, providers, and sites. During the on-site interview, RMHP’s staff reported that when RMHP discovered sanctions based on ongoing monitoring, RMHP acted immediately (with sanction or termination) as appropriate and informs the delegate.</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>
22. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed.  NCQA CR12—Element D	CR-Delegated Cred-Recred Process DEL 1.12.pdfPg 3 CR-Delegated Cred Oversight DEL.2.10.pdf Pg 1  RMHP does not have any delegated agreement in effect for less than 12 months in the CHP+ service area.	<input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> Not Applicable
<b>Findings:</b> Not Applicable.		
<b>Required Actions:</b> None.		
23. 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.  NCQA CR12—Element E	CR-Delegate Annual Oversight Tracking Tool 2012.pdf CR-Delegate Oversight File Review-Montrose 2012.pdf CR-Delegate Oversight File Review-Physiotherapy 2012.pdf CR-Delegate Oversight File Review-Southwest 2012.pdf CR-Delegate Oversight File Review-Vail Valley 2012.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> RMHP submitted audit reports that demonstrated review of each delegate’s credentialing files for the review period.		
<b>Required Actions:</b> None.		
24. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations.  NCQA CR12—Element F	CR-Delegate Oversight Tool-Montrose 2012.pdf CR-Delegate Oversight Tool-Physiotherapy 2012.pdf CR-Delegate Oversight Tool-Southwest 2012.pdf CR-Delegate Oversight Tool-Vail Valley 2012.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> RMHP submitted documentation of review of each delegate’s policies and records against NCQA standards during the review period.		
<b>Required Actions:</b> None.		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
25. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually).  NCQA CR12—Element G	CR-Delegate Report Tracking Tool CHP+ 2012.pdf CR-Delegate Semi-Annual Report-Montrose 2012.pdf CR-Delegate Semi-Annual Report-Physiotherapy 2012.pdf CR-Delegate Semi-Annual Report-Southwest 2012.pdf CR-Delegate Semi-Annual Report-Vail Valley 2012.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> RMHP submitted semiannual reports received from each delegate and a tracking spreadsheet that indicated due dates for future semiannual reports.		
<b>Required Actions:</b> None.		
26. The Contractor identifies and follows up on opportunities for improvement, if applicable.  NCQA CR12—Element H	CR-Delegate Annual Oversight Summary Letter-Montrose 2012.pdf CR-Delegate Annual Oversight Summary Letter-Physiotherapy 2012.pdf CR-Delegate Annual Oversight Summary Letter-Southwest 2012.pdf CR-Delegate Annual Oversight Summary Letter-Vail Valley 2012.pdf	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
<b>Findings:</b> RMHP provided communication with Montrose Physician Health Organization that demonstrated the use of the corrective action process with that delegate.		
<b>Required Actions:</b> None.		

<b>Results for Standard VIII—Credentialing and Recredentialing</b>					
<b>Total</b>	Met	=	<u>47</u>	X	1.00 = <u>47</u>
	Partially Met	=	<u>1</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>2</u>	X	NA = <u>NA</u>
<b>Total Applicable</b>		=	<u>48</u>	<b>Total Score</b>	= <u>47</u>

<b>Total Score ÷ Total Applicable</b>	=	<u>98%</u>
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<b>Standard X—Quality Assessment and Performance Improvement</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members.</p> <p align="right">42CFR438.240(a)</p> <p>Contract: Exhibit A—2.9</p>	<p>Corporate QI Program Description 2012_2013.pdf</p> <p>Corporate QI WorkPlan and Eval 2012_021213.xls</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 QI program description (corporate-wide) stated that the QI program conducted systematic monitoring and evaluation of clinical and service-related activities, and acted on opportunities for improvement. Program activities focused on care quality, patient safety, and physician access and availability. The program description stated that the RMHP Board of Directors was accountable for the QI program and designated the responsibility for oversight of quality programs to the chief medical officer and the chief operating officer. The Quality Improvement Committee (QIC) provides program oversight. The Medical Advisory Council (MAC) and Member Experience Advisory Committee (MEAC) are subcommittees of the QIC, with responsibility for clinical initiatives and member experience initiatives respectively. The program description defined numerous other subcommittees with specific QI functions. The corporate QI work plan described all planned QI activities for the year and included a general description of each activity. The work plan did not delineate activities applicable to specific lines of business (e.g., CHP+). During the on-site interview, the staff stated that the relatively small size of the CHP+ population required that it be evaluated as a component of the overall RMHP population in order to obtain meaningful monitoring data. CAHPS data, HEDIS data, and CHP+ performance improvement projects (PIPs) are specific to CHP+. HSAG recommended that the annual work plan designate which QI activities were applicable to the CHP+ population and specify goals or benchmarks for performance whenever appropriate.</p>		
<p><b>Required Actions:</b>            None.</p>		
<p>2. The Contractor’s QAPI Program includes mechanisms to detect both underutilization and overutilization of services.</p> <p align="right">42CFR438.240(b)(3)</p> <p>Contract: Exhibit A—2.9.4.4</p>	<p>Continuity.Coordination and Transition of Medical Care 2012.doc</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 staff provided samples of utilization data trending reports for monitoring over- and under-utilization. During the on-site interview, the staff described several mechanisms for monitoring over- and under-utilization, including prior authorization and concurrent review activities and monthly monitoring reports of patient days per 1,000 members, readmissions within 30 days, and emergency department visit trends. Staff members stated that the Healthcare Effectiveness Data and Information Set (HEDIS) performance measures were reviewed monthly for monitoring of potential under-utilization, and that HEDIS measures were used to generate gaps in care reports. Staff members stated, and a review of QIC meeting minutes verified, that the analysis of utilization trends was reported to the QIC.</p>		



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<b>Required Actions:</b>		
None.		
<p>3. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual QAPI report describes:</p> <ul style="list-style-type: none"> <li>◆ The specific preventive care priorities, and services covered in and goals of the program over the prior 12-month period.</li> <li>◆ The status and results of each PIP started, continuing, or completed during the prior 12-month period.</li> <li>◆ The results of member satisfaction surveys completed during the prior 12-month period.</li> <li>◆ A detailed description of the findings of the program impact analysis.</li> <li>◆ Techniques used by the Contractor to improve performance.</li> <li>◆ The overall impact and effectiveness of the QAPI Program during the prior 12-month period.</li> </ul> <p align="right"><i>42CFR438.240(e)(2)</i></p> <p>Contract: Exhibit A—2.9.4.7, 4.7.2.1 (RMHP—4.6.2.1)</p>	<p>QI Program Annual Report 021213.pdf</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 8.a1Healthy Woman_Activity Analysis.xls</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 8.a2Womens preventive Services.pdf</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 8.b1Healthy Child- Activity Analysis.xls</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 8.b2Wellness_ Weight Assessment Child &amp; Adol.pdf</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 9.a1Diabetes CDC Activity Analysis.xls</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 9.a2Comprehensive Diabetic Care.pdf</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 9.b1Heart and Lung Conditions- Activity Analysis.xls</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 9.b2Heart and Lung Conditions.pdf</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 9.c1Behavioral Health- Activity Analysis.xls</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
	<p>X.3 9.c2 Behavioral Health.pdf</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.3 1b QI Annual Evaluation Memo QIC.pdf</p>	
<p><b>Findings:</b></p> <p>The QI Program Annual Report included a comprehensive assessment of QI work plan objectives, applicable to all lines of business. The program addressed summary analysis of CAHPS data, physician satisfaction data, preventive and disease management HEDIS measures (specific to CHP+), quality of care concerns, the CHP+ PIP, and clinical practice guidelines adopted. The report included a general description of techniques used to improve performance and highlighted areas of improvement and opportunities for continued improvement. HEDIS measures were documented with benchmark goals and performance by line of business, and an analysis included identified barriers to effective interventions. The report included the Staying Healthy preventive care objectives and results of related measures (not specific to CHP+). RMHP also submitted examples of several preventive services initiatives, including healthy child, behavioral health, and diabetes care initiatives. The annual report did not include conclusions related to the overall impact of the QI program. During the on-site interviews, staff members stated that RMHP was working on a revised version of the annual report that would include a summary of the overall impact of the QI program. The staff confirmed that the CHP+ population would continue to be included in the annual QI report for all lines of business.</p> <p>HSAG recommended that the annual report consistently document recommendations or conclusions related to the results of each QI activity, clearly delineate those activities that were applicable to the CHP+ population, and ensure that all elements outlined in the requirement were addressed.</p>		
<p><b>Required Actions:</b></p> <p>RMHP must include an assessment of the overall impact and effectiveness of the QI program in the annual QI report.</p>		
<p>4. The Contractor shall adopt practice guidelines for the following:</p> <ul style="list-style-type: none"> <li>◆ Perinatal, prenatal, and postpartum care for women.</li> <li>◆ Conditions related to persons with a disability or special health care needs.</li> <li>◆ Well child care.</li> </ul> <p>Contract: Exhibit A—2.9.2.1</p>	<p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.4 Prenatal Guideline_ OB.pdf</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.4 AAP Bright Futures Well Child Guideline.pdf</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.4 Guidelines for Identification and COC - Pediatric.pdf</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\QI X.4 Guidelines for Identification and COC -Adult.pdf</p>	<p><input type="checkbox"/> Met</p> <p><input checked="" type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>



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**Standard X—Quality Assessment and Performance Improvement**

Requirement	Evidence as Submitted by the Health Plan	Score
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**Findings:**  
 RMHP provided evidence of prenatal and postpartum care clinical practice guidelines and preventive pediatric care guidelines. The Clinical Guideline Tracking Chart included approval of clinical guidelines for asthma. The staff provided evidence that nationally recognized clinical guidelines for persons with special health care needs were applied in the case management program. HSAG recommended that RMHP formally adopt these guidelines for special health care needs members, as defined in the Clinical Practice Guidelines Policy.

**Required Actions:**  
 RMHP must adopt clinical practice guidelines applicable to CHP+ members with disabilities or special health care needs.

<p>5. The Contractor ensures that practice guidelines comply with the following requirements:</p> <ul style="list-style-type: none"> <li>◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.</li> <li>◆ Consider the needs of the Contractor’s members.</li> <li>◆ Are adopted in consultation with contracting health care professionals.</li> <li>◆ Are reviewed and updated annually.</li> </ul> <p align="right"><i>42CFR438.236(b)</i></p> <p>Contract: Exhibit A—2.9.2.1.2</p>	<p>QI Clinical Guidelines</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\CM X.8 Clinical Policy Development Workflow.vsd</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\CM X.8.2 Clinical Policy Development.doc</p> <p>Standard X CHP+Quality Assessment and Performance Improvement\CM X.8. CM Criteria for UM Decisions.doc</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> Not Applicable
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**Findings:**  
 The Clinical Practice Guidelines Policy stated that practice guidelines must be from a recognized organization that develops evidence-based practice guidelines or must have been developed with input from board-certified physicians. The policy stated that all guidelines must be relevant to the RMHP population and are reviewed and approved by the medical directors, medical practice review committees, and the Medical Advisory Committee. The policy stated that clinical practice guidelines (CPGs) must be reviewed at least every other year. RMHP submitted examples of practice guidelines that were endorsed by nationally recognized professional organizations. The QI program description stated that RMHP adopted clinical practice guidelines for preventive care as well as diagnosis-specific clinical guidelines, and described the process for guideline adoption as outlined in the requirement, with the exception of the requirement for annual review and approval of guidelines. During the on-site interview, staff members described the process to develop and update clinical practice guidelines within the RMHP committee structure. Staff members stated that a previous version of the Clinical Practice Guidelines Policy defined that updates must occur every year.

**Required Actions:**  
 RMHP must modify its policies and procedures to ensure that clinical practice guidelines applicable to CHP+ members are reviewed and approved annually.



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<b>Standard X—Quality Assessment and Performance Improvement</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost.</p> <p align="right"><i>42CFR438.236(c)</i></p> <p>Contract: Exhibit A—2.9.2.1.3</p>	<p>Provider Manual (see bookmarks)</p> <p>Medicaid Handbook p. 12</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 Clinical Practice Guidelines Policy stated that clinical practice guidelines would be disseminated to providers and members at no cost. The policy stated that guidelines were disseminated to providers through the RMHP provider Web site and that provider newsletters would notify providers of the availability of clinical practice guidelines and how to access them. The provider tab of the RMHP Web site included the clinical practice guidelines. The provider manual informed providers that Disease Management Program clinical guidelines were available and how to access them.</p> <p>The CHP+ Benefits Booklet did not inform members of the availability of practice guidelines. The member section of the RMHP Web site did not include access to clinical practice guidelines. During the on-site interview, staff members stated that RMHP incorporated information from clinical practice guidelines into disease management education materials for members, and distributed mailings to members regarding chronic conditions. HSAG recommended that RMHP inform members of the availability of clinical practice guidelines at no cost and how members may access them.</p>		
<p><b>Required Actions:</b>            None.</p>		
<p>7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.</p> <p align="right"><i>42CFR438.236(d)</i></p> <p>Contract: Exhibit A—2.9.2.1.4</p>	<p>The Care Management Department uses Milliman evidence based guidelines, 16<sup>th</sup> edition or RMHP internally developed Clinical Policies.</p> <p>CM X.8 Clinical Policy Development Workflow.vsd</p> <p>CM X.8.2 Clinical Policy Development.doc</p> <p>CM X.8. CM Criteria for UM Decisions.doc</p> <p>RMHP can address this further with HSAG reviewers at the on-site interviews.</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 Clinical Policy Development Policy described the involvement of the New Technology Assessment and Guidelines (NTAG) Physician Advisory Committee in the development of expanded or modified coverage guidelines. The staff stated that RMHP used Milliman criteria or internally developed</p>		



*Appendix A. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

**Standard X—Quality Assessment and Performance Improvement**

Requirement	Evidence as Submitted by the Health Plan	Score
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clinical polices to make utilization review and benefit determinations. During the on-site interview, staff members described the processes for review and integration of clinical practice guidelines into other operational processes. These processes were as follows:

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

**Required Actions:**  
None.

<p>8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data.</p> <p>Contract: Exhibit A—2.9.4.10</p>	<p>1500 Ben Billing Medicaid Form Online            Pharmacy Claims Form            425 Processing            MCE Adding Claims to Facets            MDE Reconciliation            MDE Resubmit Process            MDE            Facets Claims Flow            CSV File</p> <p>QI Data Integration Flowchart</p>	<p><input checked="" type="checkbox"/> Met  <input type="checkbox"/> Partially Met  <input type="checkbox"/> Not Met  <input type="checkbox"/> Not Applicable</p>
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**Findings:**  
 The HEDIS data integration flow chart documented collection of information from multiple claims data sources, along with treatment data, laboratory data, and immunization data sources, all of which were maintained in a data warehouse and integrated into the HEDIS reporting database. During the on-site interview, the staff provided an overview of the hardware and software components of the health information system (HIS), which demonstrated collection and integration of data such as claims, member enrollment, customer services, case management, prior authorization, and treatment records from multiple databases. The staff provided several examples of HIS reports that included analysis and integration of data from multiple databases.

**Required Actions:**  
None.



*Appendix A. Colorado Department of Health Care Policy and Financing*  
**FY 2012–2013 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

<b>Standard X—Quality Assessment and Performance Improvement</b>		
<b>Requirement</b>	<b>Evidence as Submitted by the Health Plan</b>	<b>Score</b>
<p>9. The Contractor collects data on member and provider characteristics and on services furnished to members.</p> <p align="right"><i>42CFR438.242(b)(1)</i></p> <p>Contract: Exhibit A—2.9.4.10.2</p>	<p>1500 Ben Billing Medicaid Form Online            Pharmacy Claims Form            425 Processing            MCE Adding Claims to Facets            MDE Reconciliation            MDE Resubmit Process            MDE            Facets Claims Flow            CSV File</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 HEDIS data integration flow chart and the sample claims forms demonstrated that RMHP collected information on services rendered to members through provider claims databases, as well as treatment, pharmacy, laboratory and immunization databases. The Network Adequacy report provided evidence of information collected on provider characteristics. The staff provided several reports that demonstrated information collected on services rendered to members. RMHP provided sample reports and case management files that demonstrated collection of information on member characteristics. During the on-site interview, staff members stated that member characteristics were collected through enrollment files, with updates based on customer service and case management contacts with members. Staff members stated that provider characteristics were collected through credentialing applications and were updated through provider interactions with the staff, as well as through recredentialing applications. Provider characteristics are used in the on-line provider directory. Information on services furnished to members was obtained primarily through claims, HEDIS medical record reviews, and case management documentation.</p>		
<p><b>Required Actions:</b>            None.</p>		
<p>10. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include:</p> <ul style="list-style-type: none"> <li>◆ Member surveys (Consumer Assessment of Healthcare Providers and Systems [CAHPS]).</li> <li>◆ Anecdotal information.</li> <li>◆ Grievance and appeals data.</li> <li>◆ Enrollment and disenrollment information.</li> </ul> <p>Contract: Exhibit A—2.9.4.3.2, 2.9.4.3.1</p>	<p>QI Program Annual Report pp. 9-14</p> <p>CHP+ Combined 3rd QTR Complaint Reporting</p> <p>These reports are used to monitor member perceptions of accessibility and adequacy of services</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 and Financing*  
**FY 2012–2013 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

**Standard X—Quality Assessment and Performance Improvement**

Requirement	Evidence as Submitted by the Health Plan	Score
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**Findings:**  
 The QI program description stated that RMHP administered a number of member satisfaction surveys, including the annual CAHPS survey, annual disease management and complex case management member surveys, and a patient satisfaction with physician survey. The program description stated that the MEAC reviewed survey results and correlated the results with complaints data to identify opportunities for improvement. The annual grievance report trended member grievances by type (e.g., access and availability, clinical care, customer service) and results of grievance investigations quarterly. The MEAC meeting minutes included a review and discussion of CAHPS results and grievance and appeals trends. The QI Program Annual Report provided a summary analysis of the 2012 CAHPS results but did not specifically identify CHP+ results. HSAG recommended that the QI annual report include the analysis of member grievances and specify CHP+ CAHPS results.

During the on-site interview, the staff provided as an example the Member Experience Dashboard Report that was recently implemented for monthly review by the MEAC. The report included CAHPS data, grievance and appeals data, and enrollment efficiency data, and was specific to CHP+ members. Staff members stated that disenrollments from the CHP+ plan were too small to determine trends.

**Required Actions:**  
 None.

<p>11. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported.</p> <p>Contract: Exhibit A—2.9.4.3.5</p>	<p>QI Program Annual Report pp. 9-14</p> <p>Appeals and Grievances Dept. Complaints P&amp;P</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> Not Applicable</p>
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**Findings:**  
 The Grievance Policy and Procedure stated that all grievances were documented and tracked in the database regarding the substance, investigation, research, any actions taken, and resolution. The policy stated that RMHP reviewed CHP+ grievance trends at least annually to identify and correct any issues, and stated that any individual complaints of potential quality of care concerns (QOCCs) were reviewed by the QI department and medical director for potential peer review and corrective action. RMHP submitted a sample quarterly summary of CHP+ grievances that indicated there were no quality of care complaints during the time period. The QI program description stated that potential QOCCs identified through adverse event criteria were also individually reviewed and tracked. The program description stated that any clinical quality issue identified through satisfaction surveys was forwarded to the chief medical officer and any service quality issue is forwarded to the chief operating officer.



*Appendix A.* **Colorado Department of Health Care Policy and Financing**  
**FY 2012–2013 Compliance Monitoring Tool**  
*for Rocky Mountain Health Plans*

Standard X—Quality Assessment and Performance Improvement		
Requirement	Evidence as Submitted by the Health Plan	Score
During the on-site interview, staff members provided evidence of a quality improvement project initiated by the MEAC to improve the process for resolving member grievances. Staff members stated that targeted provider education was initiated if any trend in grievances was related to a particular provider. The staff confirmed that there were no CHP+ QOCCs during the year that required corrective action.		
<b>Required Actions:</b> None.		

Results for Standard X—Quality Assessment and Performance Improvement					
<b>Total</b>	Met	=	<u>8</u>	X	1.00 = <u>8</u>
	Partially Met	=	<u>3</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>11</u>	<b>Total Score</b>	= <u>8</u>
<b>Total Score ÷ Total Applicable</b>					= <u>73%</u>

*Appendix B.* **Record Review Tools**  
*for* **Rocky Mountain Health Plans**

The completed record review tools follow this cover page.



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

<b>Reviewer:</b>	Barbara McConnell
<b>Participating Plan Staff Member:</b>	Terri Trimm

<b>Review Period:</b>	January 1, 2012–December 31, 2012
<b>Date of Review:</b>	March 20, 2013

SAMPLE	1		2		3		4		5		6		7		8		9		10																																																																																																																																																																																																																																																																																		
	Provider ID#	Provider Type (MD, PhD, NP, PA, MSW)	Application Date	Specialty	Credentialing Date (Committee/Medical Director Approval Date)	11/15/11	Yes	No																																																																																																																																																																																																																																																																																													
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<b>Initial Credentialing Verification:</b> The contractor, using primary sources, verifies that the following are present:																																																																																																																																																																																																																																																																																																					
<ul style="list-style-type: none"> <li>◆ A current, valid license to practice (with verification that no State sanctions exist)</li> <li>◆ A valid DEA or CDS certificate (if applicable)</li> <li>◆ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)</li> <li>◆ Work history</li> <li>◆ Current malpractice insurance in the required amount (with history of professional liability claims)</li> <li>◆ Verification that the provider has not been excluded from federal participation</li> <li>◆ Signed application and attestation</li> <li>◆ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)</li> </ul>																																																																																																																																																																																																																																																																																																					
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<b>Total Record Review Score</b>		<b>Total Applicable: 75</b>	<b>Total Point Score: 75</b>	<b>Total Percentage: 100%</b>
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**Notes:**



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

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

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

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

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

Table D-1—Corrective Action Plan Process	
<b>Step 1</b>	<b>Corrective action plans are submitted</b>
	<p>If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting to HSAG and the Department. The health plan will submit the CAP using the template provided.</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 health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
<b>Step 3</b>	<b>Department approval</b>
	<p>Following review of the CAP, the Department or HSAG will notify the health plan via e-mail whether:</p> <ul style="list-style-type: none"> <li>◆ The plan has been approved and the health plan 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 health plan has received Department approval of the CAP, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
<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 health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

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

The template for the CAP follows.

**Table D-2—FY 2012–2013 Corrective Action Plan for RMHP**

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
<b>Standard III—Coordination and Continuity of Care</b>					
<p>4. The Contractor implements procedures to provide an individual needs assessment after enrollment and at any other necessary time, including the screening for special health care needs (e.g., mental health, high-risk health problems, functional problems, language or comprehension barriers, and other complex health problems). The assessment mechanisms must use appropriate health care professionals.</p>	<p>During the on-site interview, the staff confirmed that RMHP had not implemented a process for conducting an initial needs assessment after enrollment for all CHP+ members. RMHP must implement a mechanism for initial screening of all CHP+ members upon enrollment to identify members with special health care needs.</p>				
<b>Standard IV—Member Rights and Protections</b>					
<p>2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members.</p>	<p>The provider manual had two lists of member rights: one was labeled “Member Rights” and the other “Medicaid Member Rights.” Staff clarified that the CHP+ population has been aligned with the</p>				

**Table D-2—FY 2012–2013 Corrective Action Plan for RMHP**

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
	<p>commercial line of business and that the Member Rights list had previously applied to CHP+ members. This list did not include all the rights as stated in 42CFR438.100 or in the CHP+ managed care contract. RMHP must revise the provider manual to clearly describe member rights applicable to the CHP+ population. HSAG further recommends that RMHP develop additional communications, such as e-mail announcements or articles for the provider newsletters, to inform providers of the changes in federal health care requirements for the CHP+ population and the resultant implications.</p>				
<p>3. The Contractor’s policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified</p>	<p>The Child Health Plan + Member Rights Policy described most of the rights as stated in 42CFR438.100 and in the CHP+ managed care contract; however, it was missing both the right to be free from restraint or</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>rights:</p> <ul style="list-style-type: none"> <li>◆ Receive information in accordance with information requirements (42CFR438.10).</li> <li>◆ Be treated with respect and with due consideration for his or her dignity and privacy.</li> <li>◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.</li> <li>◆ Participate in decisions regarding his or her health care, including the right to refuse treatment.</li> <li>◆ Be free from any form of restraint or</li> </ul>	<p>seclusion and the member's right to request and receive a copy of his or her medical records and have them amended or corrected. RMHP must revise the CHP+ member rights policy to include all rights afforded to CHP+ members by federal regulations or the CHP+ contract with the State. RMHP must ensure that the staff, providers, and members are made aware of changes in policies or practices related to CHP+ member rights.</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>seclusion used as a means of coercion, discipline, convenience, or retaliation.</p> <ul style="list-style-type: none"> <li>◆ Request and receive a copy of his or her medical records and request that they be amended or corrected.</li> <li>◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210).</li> </ul>					
<p>4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member.</p>	<p>The member handbook on the Web site did not include the right to freely exercise rights without being treated differently. RMHP must revise its Web site to include current and accurate information.</p>				

**Table D-2—FY 2012–2013 Corrective Action Plan for RMHP**

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
<b>Standard VIII—Credentialing and Recredentialing</b>					
<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 has no accreditation status.</p>	<p>The on-site review of organizational providers demonstrated that RMHP had not successfully reassessed all organizational providers at the 36-month time frame. RMHP must develop a mechanism to ensure that organizational providers are reassessed within the NCQA-required time frames.</p>				
<b>Standard X—Quality Assessment and Performance Improvement</b>					
<p>3. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual QAPI report describes:</p> <ul style="list-style-type: none"> <li>◆ The specific preventive care priorities, and</li> </ul>	<p>The QI Program Annual Report did not include conclusions related to the overall impact of the QI program. RMHP must include an assessment of the overall impact and effectiveness of the QI program in the annual QI report.</p>				

**Table D-2—FY 2012–2013 Corrective Action Plan for RMHP**

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
<p>services covered in and goals of the program over the prior 12-month period.</p> <ul style="list-style-type: none"> <li>◆ The status and results of each PIP started, continuing, or completed during the prior 12-month period.</li> <li>◆ The results of member satisfaction surveys completed during the prior 12-month period.</li> <li>◆ A detailed description of the findings of the program impact analysis.</li> <li>◆ Techniques used by the Contractor to improve performance.</li> <li>◆ The overall impact and effectiveness of the QAPI Program during the prior 12-month period.</li> </ul>					

**Table D-2—FY 2012–2013 Corrective Action Plan for RMHP**

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
<p>4. The Contractor shall adopt practice guidelines for the following:</p> <ul style="list-style-type: none"> <li>◆ Perinatal, prenatal, and postpartum care for women.</li> <li>◆ Conditions related to persons with a disability or special health care needs.</li> <li>◆ Well child care.</li> </ul>	<p>RMHP must adopt clinical practice guidelines applicable to CHP+ members with disabilities or special health care needs.</p>				
<p>5. The Contractor ensures that practice guidelines comply with the following requirements:</p> <ul style="list-style-type: none"> <li>◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.</li> <li>◆ Consider the needs of the Contractor’s members.</li> <li>◆ Are adopted in consultation with contracting health care professionals.</li> </ul>	<p>The Clinical Practice Guidelines policy stated that clinical practice guidelines (CPGs) must be reviewed at least every other year. RMHP must modify its policies and procedures to ensure that clinical practice guidelines applicable to CHP+ members are reviewed and approved annually.</p>				

**Table D-2—FY 2012–2013 Corrective Action Plan *for* RMHP**

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring and Follow-up Planned	Documents to be Submitted as Evidence of Completion
♦ Are reviewed and updated annually.					

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

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

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

For this step,	HSAG completed the following activities:
<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 to determine the content of the review.</li> <li>◆ HSAG coordinated with the Department and the health plan to set the dates 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 to discuss the FY 2012–2013 compliance monitoring review process and answer questions as needed.</li> <li>◆ HSAG assigned staff to the review team.</li> <li>◆ Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the health plans were prepared for the compliance monitoring review.</li> </ul>
<b>Activity 2:</b>	<b>Obtained Background Information From the Department</b>
	<ul style="list-style-type: none"> <li>◆ HSAG used the federal Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the health plan’s managed care contract with the Department, to develop HSAG’s monitoring tool, on-site agenda, record review tools, and report template.</li> <li>◆ HSAG submitted each of the above documents to the Department for its review and approval.</li> <li>◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific Managed Care regulations or contract requirements.</li> <li>◆ HSAG considered the Department responses when determining compliance and analyzing findings.</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 the health plan in writing of the desk review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested.</li> <li>◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the health plan’s section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.</li> </ul>

<b>Table E-1—Compliance Monitoring Review Activities Performed</b>	
<b>For this step,</b>	<b>HSAG completed the following activities:</b>
	<ul style="list-style-type: none"> <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>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 health plan’s key staff members to obtain a complete picture of the health plan’s compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan’s performance.</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> </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 health plan staff to provide an overview of preliminary findings.</li> <li>◆ HSAG used the FY 2012–2013 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities.</li> <li>◆ HSAG analyzed the findings.</li> <li>◆ HSAG determined opportunities for improvement and recommendations based on the review findings.</li> </ul>
<b>Activity 7:</b>	<b>Reported Results to the Department</b>
	<ul style="list-style-type: none"> <li>◆ HSAG completed the FY 2012–2013 Site Review Report.</li> <li>◆ HSAG submitted the site review report to the health plan and the Department for review and comment.</li> <li>◆ HSAG incorporated the health plan’s and Department’s comments, as applicable and finalized the report.</li> <li>◆ HSAG distributed the final report to the health plan and the Department.</li> </ul>