

Colorado Medicaid and Child Health Plan *Plus* (CHP+)
Managed Care Programs

FY 2013–2014 SITE REVIEW REPORT
for
Rocky Mountain Health Plans

March 2014

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



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Introduction

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their Medicaid managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with federal health care regulations and contractual requirements. Public Law 111-3, The Children's Health Insurance Program Reauthorization Act (CHIPRA) 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 CHP+ managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to comply with specified provisions of the BBA requiring that states also conduct a periodic evaluation of their CHP+ MCOs and PIHPs to determine compliance with federal health care regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's Medicaid and 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 report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013 for the Medicaid and CHP+ lines of business. Although the two lines of business were reviewed concurrently with results reported in this combined compliance monitoring report, the results for the CHP+ and Medicaid managed care lines of business have been differentiated. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the two standard areas reviewed this year for both lines of business. Section 2 contains graphical representation of results for all standards reviewed over the past three years and trending of required actions. Section 3 describes the background and methodology used for the 2013–2014 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2012–2013 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials record review. Appendix C contains details of the provider appointment availability open shopper calls. Appendix D lists HSAG, health plan, and Department personnel who participated in some way in the site review process. Appendix E describes the corrective action plan process the health plan will be required to complete for FY 2013–2014 and the required template for doing so.

Summary of Results

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

CHP+ Results

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

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I Coverage and Authorization of Services	34	34	29	5	0	0	85%
II Access and Availability	22	22	19	2	1	0	86%
Totals	56	56	48	7	1	0	86%

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

Description of Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	101	51	36	15	50	71%
Totals	101	51	36	15	50	71%

Medicaid Results

Table 1-3 presents the Medicaid score for **RMHP** for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-3—Summary of Medicaid Scores for the Standards							
Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I Coverage and Authorization of Services	34	34	29	5	0	0	85%
II Access and Availability	22	21	19	2	0	1	90%
Totals	56	55	48	7	0	1	87%

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

Table 1-4—Summary of Medicaid Scores for the Record Reviews						
Description of Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	59	51	8	41	86%
Totals	100	59	51	8	41	86%

Standard I—Coverage and Authorization of Services

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

Summary of Findings as Evidence of Compliance

The Care Management (CM) Program description stated that the CM Program is designed to ensure that medical services rendered to members are medically necessary and/or appropriate, as well as in conformance with the benefits plan. The scope of the CM Program consisted of a continuum of processes associated with utilization management and care coordination, and it applied to all **RMHP** members.

RMHP had policies and procedures that were applicable to Medicaid and CHP+ and described the process and procedures for:

- ◆ Utilization review (UR) and coverage of medically necessary services
- ◆ The criteria and guidelines used for UR determinations
- ◆ Prospective, concurrent, and retrospective UR
- ◆ Interrater reliability (IRR) (using the Milliman IRR module)
- ◆ Ensuring the same standard of care across eligibility categories
- ◆ Processes for a peer-to-peer consultation with the requesting provider
- ◆ Notices of action content and timelines
- ◆ Clinical expertise of UR decision-makers and medical oversight of the UM program
- ◆ Disease management and case management
- ◆ Member appeals and grievances
- ◆ Trending and analyzing utilization data to identify over- and underutilization
- ◆ Care management of members with transplant needs

On-site, **RMHP** staff members described a variety of methods used to monitor services provided to ensure appropriateness of care. Methods included case management activities, access and quality committee initiatives, and annual reviews of a random sample of providers' member records.

The CHP+ and Medicaid member handbooks defined medical necessity in easy-to-understand language. The covered services sections of the member handbooks specified the extent to which **RMHP** covers services related to prevention, routine wellness care, diagnosis and treatment, and rehabilitation. The CHP+ and Medicaid handbook information regarding emergency services and post-stabilization services was accurate and easy to understand.

RMHP notified members, providers, and the staff (via multiple methods, including newsletters, member and provider handbooks, provider agreements, and staff attestations) that **RMHP** does not provide incentives to deny or limit authorization of covered services.

Summary of Strengths

On-site demonstration of **RMHP**'s electronic authorization system demonstrated **RMHP**'s processes for ensuring that the UR criteria are applied consistently to all **RMHP** pre-service requests regardless of eligibility category. Each benefit package is loaded into the preauthorization system with Milliman UR guidelines.

During the on-site interviews, **RMHP** staff members described and demonstrated the processes to ensure that professionals with the appropriate expertise make authorization or denial decisions. UM nurses may authorize services and physician reviewers make denial determinations in consultation with board-certified specialists and the requesting provider in a peer-to-peer discussion, where appropriate. Staff members also described medical management oversight of medical, pharmacy, and behavioral health preauthorization determinations.

Staff members demonstrated a new program by which physicians may obtain access to the UM authorization system, enter the data required, and obtain immediate authorization. If the requisite information is not present to trigger immediate authorization, the request is submitted to the UM staff for review and normal UM procedures. This program is in the pilot phase with a limited number of providers; it could expedite authorizations and significantly improve both provider and member satisfaction in obtaining services.

On-site, staff members also described on-site concurrent review activities. Staff members stated that **RMHP** does not limit hospitalization authorizations to a specified number of days, but rather reviews hospitalizations concurrently, working with hospital discharge planners and the treating physician to determine the most appropriate length of stay. In addition, staff members reported that readmissions are tracked to evaluate appropriateness of care.

Summary of Findings Resulting in Opportunities for Improvement

Results of on-site denials record reviews demonstrated that claims denial decisions and notifications did not consistently follow established UM criteria and processes for notification. **RMHP** should consider developing process improvement activities to improve the quality of the claims denial process and may want to consider one or more of the following techniques:

- ◆ Develop a work group among claims reviewers and pre-service reviewers to establish consistency of decision criteria for claims denials.
- ◆ Consider applying interrater reliability testing and processes both to the claims denial staff and to the decisions they make.
- ◆ Apply medical staff oversight processes to claims denials.

Summary of Required Actions

RMHP must revise the preauthorization policy to clarify that all authorization decisions will be made within the required time frames, as counted from the date of the request for service (10 calendar days for standard requests and three working days for expedited requests), unless extended.

RMHP must revise the CHP+ member handbook to remove the statement that **RMHP** may deny payment of emergency claims for untimely filing.

During the on-site record review, there were several issues identified that resulted in inappropriate denials of claims payment, or notifications to members that were confusing and inaccurate, or that held members responsible for payment without indicating to them what the member or provider could do to see that the service was covered. Issues included:

- ◆ Denial (with notification to the member) based on inaccurate coding (Medicaid record review) of a service, with the reason given as “not a covered benefit” but which was, in fact, a covered benefit (annual wellness visit) and should have been considered a provider claims coding correction rather than a member denial.

- ◆ Denial of payment (CHP+ record review) for behavioral health services (family therapy/counseling services) for “not a covered benefit” but which was, in fact, a covered benefit, due to inaccurate claims payment system configuration.
- ◆ Denial of payment due to untimely filing on the member’s part (CHP+ member request for reimbursement of a covered medication).

RMHP must:

- ◆ Develop a mechanism to ensure that Medicaid-covered services are not denied for payment with notices of action (NOAs) being sent to the member when the issue is a provider coding issue. Per the BBA—Preamble, provider coding issues do not trigger an NOA to the member.
- ◆ Since it appears that applying the Medicaid claims system configuration to the CHP+ claims process may have resulted in denying CHP+ covered services in error, **RMHP** must evaluate the claims payment configuration against the CHP+ benefit package and the State’s configuration to ensure covered benefits are configured for payment correctly in the **RMHP** claims payment system.
- ◆ Perform an audit of 100 percent of CHP+ behavioral health claims denials up to 411 claims (whichever number is lower) for consistency of determinations based on the CHP+ contract and the CHP+ benefit package.
- ◆ Ensure that members are not held liable for untimely filed claims.
- ◆ Ensure that clinical language or medical jargon used in denial letters and that is unavoidable is kept to a minimum, and is explained to the member wherever possible (strive for 6th grade reading level).
- ◆ Ensure that claims denials clearly state the service being denied and provide complete and accurate information regarding appeal rights so that members may know how to obtain services covered under Medicaid but not under the managed care contract.
- ◆ Remove any language from template NOA letters that indicates members will be held liable for payment of Medicaid services (unless the conditions are met that require members to pay for services—i.e., written agreement between the member and the provider to receive noncovered or out-of-network services available in the network).
- ◆ Evaluate the letters being used for denials of new requests as well as for claims denials in both the CHP+ and Medicaid lines of business, revising processes to ensure that all NOAs (denials) include each of the requirements.
- ◆ Since one Medicaid denial notification was sent outside the required time frames, **RMHP** must ensure that NOAs are sent within the time frames required by Colorado regulations 8.209.

Standard II—Access and Availability

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

Summary of Findings as Evidence of Compliance

Policies and procedures, the provider contract, and Medicaid and CHP+ access plans and analysis substantiated that the provider network was adequately configured to meet the majority of Medicaid and CHP+ provider network requirements. Staff members stated that all **RMHP** providers are contracted for all lines of business through a single contract and that contracts are automatically renewed. Staff members also stated that **RMHP** has contracts with nearly all qualified providers, including essential community providers, in the service area. The Medicaid and CHP+ access plans outlined the provider-to-member ratios and distance goals according to the requirements. Staff members stated that **RMHP** also conducts periodic analysis of specialist utilization by each population to determine specialist needs and utilization trends. The **RMHP** Access Committee reviewed results of CAHPS data, member satisfaction surveys, and member complaints to further assess any provider network deficiencies. The Availability of Practitioners Network Analysis Report stated that the health plan exceeded the distance and ratio requirements for primary care and high-volume specialists for all lines of business. The analysis noted that some rural areas have a Medicaid provider shortage and that much of the **RMHP** service area is considered a primary care shortage area. The Access Committee meeting minutes documented that **RMHP** required its contracted hospitals to notify the health plan of any new practitioners entering the service area, enabling **RMHP** to pursue contracting with those providers. Staff members stated that providers were allowed by contract to close their practices to new patients, but could not selectively limit only new Medicaid or CHP+ patients. Staff members also stated that rapidly increasing enrollments in the Medicaid population presented concerns for providers, but that **RMHP** strategies to support practices have encouraged providers to stay involved and the strategies have met with some success.

Policies and interviews with the **RMHP** staff substantiated that members may obtain services from a women's health provider without a referral and have direct access to specialists within the network. Welcome calls allowed the **RMHP** staff to identify members with special health care needs for referral to case management. Case managers arranged out-of-network services for members whenever necessary. Single-case agreements with negotiated rates for payment were pursued with noncontracted providers. Physician access requirements, such as hours of operation and appointment availability standards, were communicated to providers in the provider manual and to members in the member handbooks. Staff members stated that member complaints were the primary mechanism to monitor provider compliance with access standards.

HSAG conducted a provider appointment survey through open shopper calls prior to the site visit. Calls were completed to 14 provider offices of various primary care specialties and sizes. A total of 34 predefined call scenarios for a cross-section of urgent, nonurgent/symptomatic, and well child/well adult visits were tested. The survey confirmed appointment availability within the required time frames for 100 percent of the calls made by the HSAG staff (see detailed provider survey results in Appendix C).

RMHP's preventive health program was primarily designed to respond to HEDIS rates for preventive health measures and the organization's Staying Healthy initiatives. The HEDIS executive summary (draft) documented extensive analysis of HEDIS measures for the Medicaid and CHP+ populations and corrective actions were planned to educate and facilitate providers in the improvement of HEDIS rates and to send reminders and information to members regarding areas of concern. Staff members stated that effectiveness of interventions was also evaluated through analysis of HEDIS rates. Preventive health initiatives included disease management for targeted chronic diseases, case management of members with chronic diseases identified through risk-stratification reports, and numerous member mailings and reminders regarding a variety of preventive health measures. Welcome call scripts included alerting new members to their preventive health benefits. The 2012 Quality Improvement (QI) Program Annual Report documented the analysis of preventive care and chronic care goals and interventions. Providers participated on the QI Committee and other committees that review HEDIS trends and develop appropriate interventions. The practice quality on-site monitoring tool included an assessment of office-based preventive health practices. Staff members stated that **RMHP** and providers are collaboratively developing alternative, community-based measures of health.

RMHP had policies and procedures, applicable to all lines of business, regarding culturally diverse linguistic needs and the hearing-impaired. **RMHP** had developed materials and services to meet members' linguistic needs for dissemination to physician offices upon request. Policies stated that the case management staff would assist members with special needs or disabilities in obtaining services to maintain independent living. New member welcome calls assisted staff members in identifying members with special health care needs as well as alternative language needs (primarily Spanish). Cultural competency training programs have been provided to the staff and were offered to providers through the **RMHP** Web site. Staff members stated that **RMHP** identified Latino and the "culture of poverty" as the predominant cultures in the service area. **RMHP** purchased the "Bridges out of Poverty" training package, which has been provided to both the staff and selected practitioner offices. Staff members stated that Spanish-speaking providers were available in most area, and that the language line is available to providers for other non-English speaking members. **RMHP** assessed the cultural and linguistic needs of the member population on an annual basis and reported results to the Member Experience Advisory Council (MEAC) and QI Committee.

The HEDIS executive summary included an analysis of the Medicaid HEDIS rates compared to the previous year and to the commercial health plan population. The report stated that the QI team was researching best practices to impact the measures. The 2013 HEDIS Intervention Work Plan indicated that reminder materials related to well-child and well-adolescent visits for all lines of business would continue to be sent to members. **RMHP** provided examples of materials pertaining to those interventions. During on-site interviews, staff members stated and MEAC meeting minutes confirmed that the MEAC reviewed the CAHPS results, monthly grievance and appeals information, and member satisfaction surveys for all lines of business. The council defined action items to address identified areas of concern and reported results to the QI Committee. The MEAC dashboard for Medicaid and CHP+ performance included results of CAHPS surveys and other member satisfaction measures. Results were not differentiated between Medicaid and CHP+.

Summary of Strengths

RMHP has an extensive history and experience building a provider network in the **RMHP** service area, resulting in an established network of providers that includes contracts with nearly all available providers in the service area. In addition, **RMHP** consolidated all lines of business, including Medicaid and CHP+, into one contract, thereby simplifying requirements for providers. **RMHP** stated that all providers are required to participate in serving all **RMHP** contracted populations. **RMHP** staff members stated that specialists from Children's Hospital routinely travel to the **RMHP** service area to provide services for the ongoing care of some of **RMHP**'s members with special needs.

RMHP determined that the culture of poverty is the most prevalent cultural concern impacting the health and health care of populations in the service area. Therefore, **RMHP** implemented the Bridges out of Poverty program, which addresses the attitudes, communication styles, and behaviors associated with poverty and that can affect health care services to members. The training program has been extended to network provider offices and **RMHP** staff members reported that it has been enthusiastically embraced and integrated by providers and their staffs. The Bridges out of Poverty training program has significantly enhanced **RMHP**'s comprehensive efforts to promote the delivery of services in a culturally competent manner.

RMHP established the MEAC as an active, multidisciplinary vehicle to focus on members' experiences and satisfaction levels. The council serves as a forum to maintain a consolidated view of the member experience from a variety of data sources such as CAHPS data, grievances and appeals, and member satisfaction surveys. **RMHP** has been developing the MEAC dashboard, which will facilitate the consolidation of pertinent information for overview and tracking of information from multiple sources.

Summary of Findings Resulting in Opportunities for Improvement

The Availability of Practitioners Network Analysis Report evaluated the ratios and drive times for the Medicare, Medicaid, and commercial populations, but did not specifically address the CHP+ population. **RMHP** should consider adding an analysis of the provider network relative to the CHP+ population to the report.

The CHP+ member handbook did not clearly communicate information to members concerning several areas of access to providers. **RMHP** should update the CHP+ member handbook to clarify communications regarding access, including access to women's health care providers, services for members with special health care needs, and how to obtain assistance with second opinions.

Although policies and procedures accurately described care management responsibilities to assist members with obtaining services, member and provider communications did not clearly convey how members or providers may request assistance. **RMHP** should enhance appropriate member and provider communications to provide information on how members may contact care management to obtain assistance with coordination of services such as obtaining second opinions, gaining timely access to a specialist, or arranging for out-of-network services.

The policies and procedures related to accommodations for persons with hearing impairments or physical disabilities, or to non-English-speaking members, pertained to the **RMHP** customer service staff and there was no evidence that **RMHP** communicated these policies and procedures to providers. Staff members stated that tools to promote cultural competency are communicated in the provider manual. The manual described the provider's responsibility to provide interpreter services or call **RMHP** for assistance. **RMHP** may want to develop mechanisms to more specifically promote provider use of the various cultural competency tools, such as how to access TDD or interpreter services, and promote cultural competency training programs.

RMHP conducted an extensive analysis of HEDIS data pertaining to each line of business and recommended specific interventions to improve all the well-visit measures. However, analysis was focused on comparing Medicaid and CHP+ HEDIS results to the commercial lines of business, and established priorities for areas for improvement tended to blend together approaches for all lines of business. **RMHP** might consider conducting an analysis of Medicaid and CHP+ results compared to the statewide average, other Colorado health plans, or the national 50th percentile for all State-targeted measures. In addition, **RMHP** should consider identifying areas for improvement specific to Medicaid and CHP+ populations to ensure that any significant variations or underperforming areas are addressed. Similarly, data related to monitoring member perceptions, such as member complaints and member satisfaction surveys, did not clearly differentiate between Medicaid or CHP+ results and other lines of business.

Summary of Required Actions

RMHP is required to have an effective mechanism to regularly monitor Medicaid and CHP+ provider scheduling standards. Although **RMHP** has mechanisms to periodically obtain feedback on member dissatisfaction with scheduling times, it must implement an effective mechanism that monitors providers regularly to determine compliance with scheduling standards, and to take appropriate corrective action.

The requirement for the health plan to promote the delivery of services to the Medicaid and CHP+ populations in a culturally competent manner is multifaceted. Although **RMHP** has a relatively comprehensive program of services to address the cultural needs of the members in their service areas, the requirement specifies that the health plan must have policies and procedures in several specific areas. **RMHP** must develop policies and procedures to address cultural characteristics broader than linguistics, such as providing programs and services that incorporate the beliefs, attitudes, and practices of specific cultures, as well as outreach to specific cultures for prevention and treatment of diseases prevalent in those groups. In addition, **RMHP** must develop policies and procedures that ensure compliance with the laws applicable to persons with physical and developmental disabilities.

The CHP+ CAHPS action plan did not define corrective actions for the areas of the 2013 CAHPS survey results below the 50th percentile. **RMHP** must specifically analyze the three areas of the 2013 CAHPS results that performed below the 50th percentile and implement a relevant corrective action plan.

Comparison of CHP+ Results

Review of Compliance Scores for All Standards

Figure 2-1 shows the scores for all standards reviewed over the past two years of CHP+ compliance monitoring. (The Department chose not to assign scores for the FY 2011–2012 site reviews.)

Figure 2-1—RMHP CHP+ Compliance Scores for All Standards

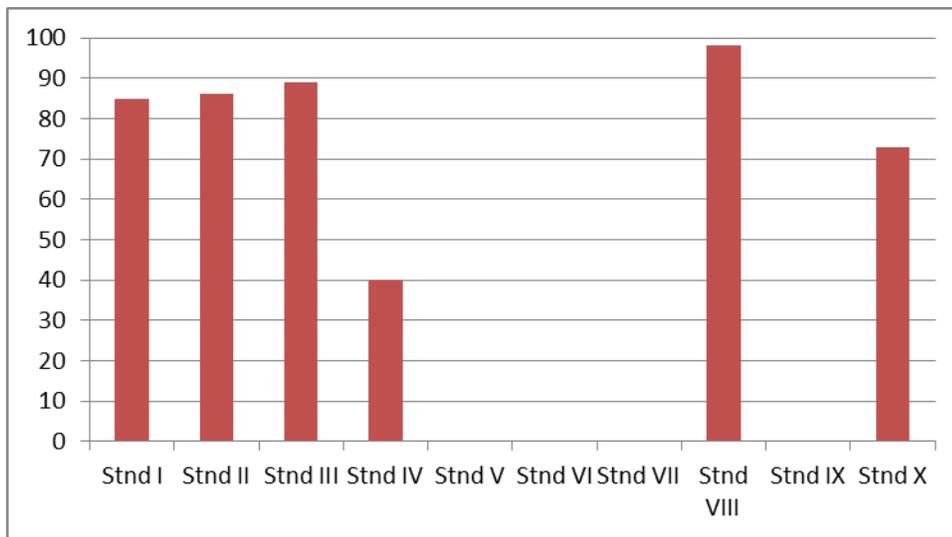


Table 2-1 presents the list of standards by review year.

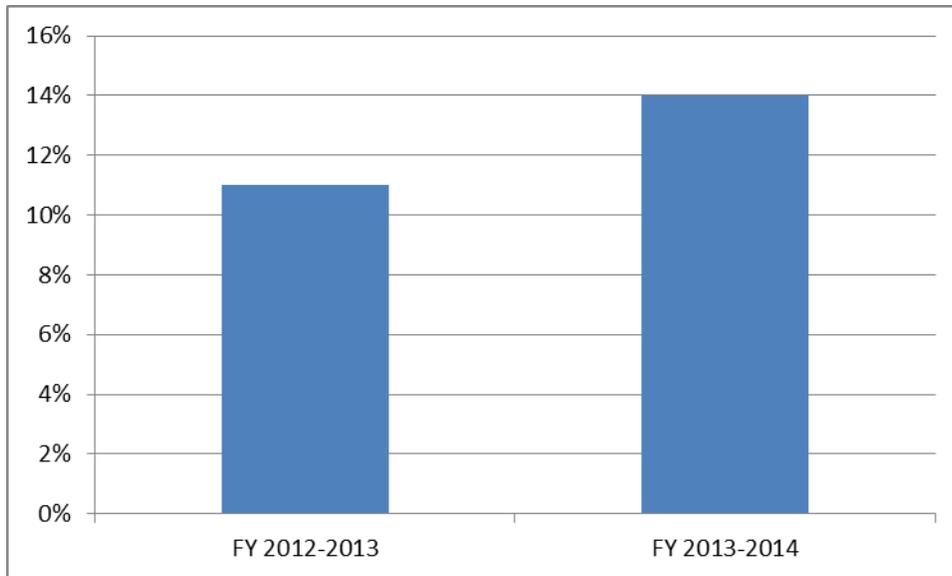
Standard	2011–12	2012–13	2013–14
I—Coverage and Authorization of Services			X
II—Access and Availability			X
III—Coordination and Continuity of Care		X	
IV—Member Rights and Protections		X	
V—Member Information	X*		
VI—Grievance System	X*		
VII—Provider Participation and Program Integrity	X*		
VIII—Credentialing and Recredentialing		X	
IX—Subcontracts and Delegation	X*		
X—Quality Assessment and Performance Improvement		X	

*These standards were reviewed but were not scored.

Trending the Percentage of Required Actions

Figure 2-2 shows the percentage of requirements that resulted in required actions over the past two years of CHP+ compliance monitoring. (The Department chose not to assign scores to the CHP+ plans during the FY 2011–2012 site reviews.) Each year represents the results for review of different standards.

Figure 2-2—Percentage of CHP+ Required Actions—All Standards Reviewed

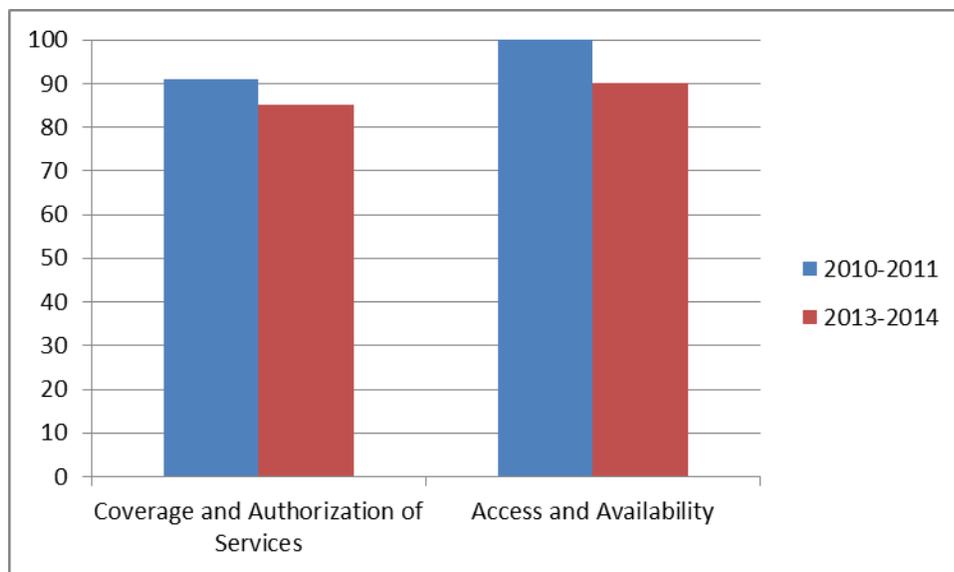


Comparison of Medicaid Results

Comparison of FY 2010–2011 Results to FY 2013–2014 Results

Figure 2-3 shows the scores from the FY 2010–2011 Medicaid site review, when Standard I and Standard II were previously reviewed, compared with the results from this year’s Medicaid review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **RMHP**’s contract with the State may have changed, and may have contributed to performance changes.

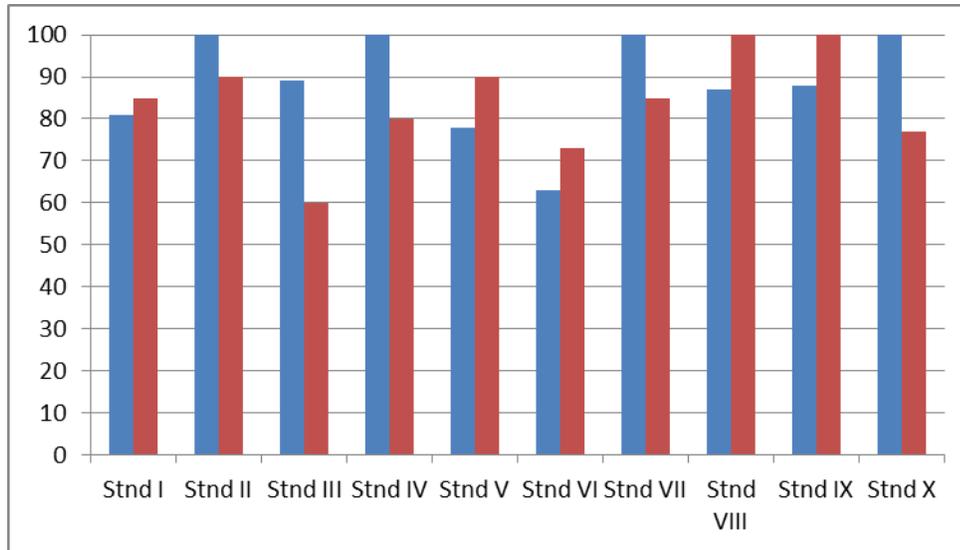
Figure 2-3—Comparison of FY 2010–2011 Results to FY 2013–2014 Results



Review of Compliance Scores for All Standards

Figure 2-4 shows the scores for all standards reviewed over the last two three-year cycles of Medicaid compliance monitoring. The figure compares the score for each standard across two review periods and may be an indicator of overall improvement.

Figure 2-4—RMHP Medicaid Compliance Scores for All Standards



Note: The older results are shown in blue. The most recent review results are shown in red.

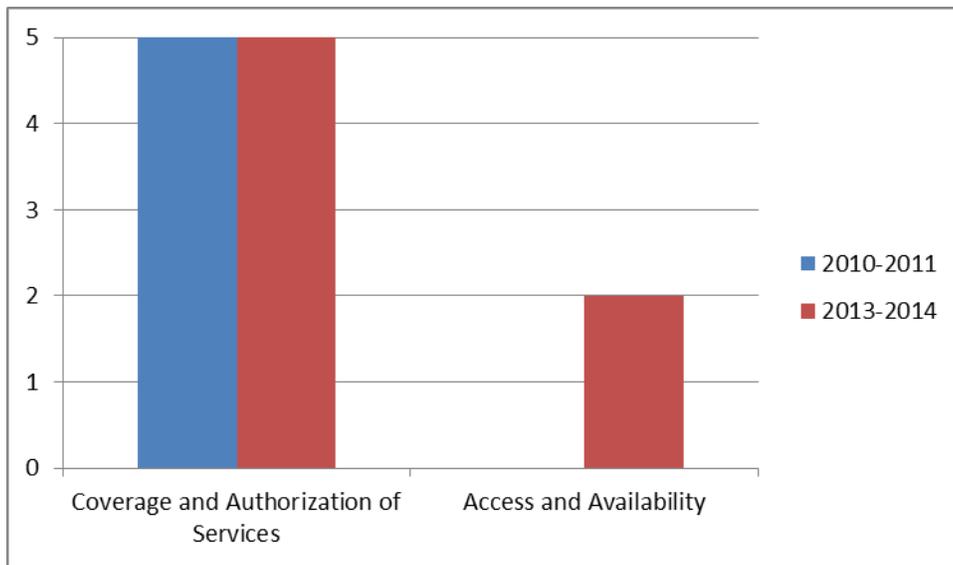
Table 2-2 presents the list of standards by review year.

Standard	2008–09	2009–10	2010–11	2011–12	2012–13	2013–14
I—Coverage and Authorization of Services			X			X
II—Access and Availability			X			X
III—Coordination and Continuity of Care		X			X	
IV—Member Rights and Protections		X			X	
V—Member Information		X		X		
VI—Grievance System		X		X		
VII—Provider Participation and Program Integrity	X			X		
VIII—Credentialing and Recredentialing			X		X	
IX—Subcontracts and Delegation	X			X		
X—Quality Assessment and Performance Improvement		X			X	

Trending the Number of Required Actions

Figure 2-5 shows the number of requirements with required actions from the FY 2010–2011 Medicaid site review, when Standard I and Standard II were previously reviewed, compared to the results from this year’s review. Although the federal requirements did not change for the standards, **RMHP**’s contract with the State may have changed, and may have contributed to performance changes.

Figure 2-5—Number of FY 2010–2011 and FY 2013–2014 Medicaid Required Actions per Standard

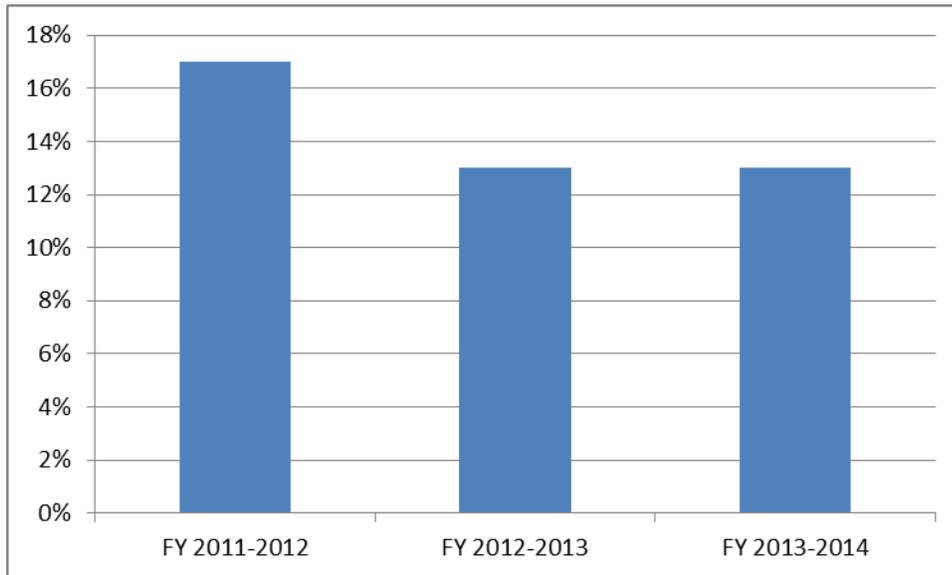


Note: **RMHP** had no required actions assigned for Standard II—Access and Availability during the FY 2010-2011 site review.

Trending the Percentage of Required Actions

Figure 2-6 shows the percentage of requirements that resulted in required actions over the past three year cycle of Medicaid compliance monitoring. Each year represents the results of review of different standards.

Figure 2-6—Percentage of Medicaid Required Actions—All Standards Reviewed



Overview of FY 2013–2014 Compliance Monitoring Activities

For the fiscal year (FY) 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the health plan's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key health plan personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to CHP+ service and claims denials and Medicaid service and claims denials. In addition, HSAG conducted a high-level review of the health plan's authorization processes through a health plan demonstration of its electronic system used to document and process requests for CHP+ services and Medicaid services.

A sample of the health plan's administrative records were also reviewed to evaluate implementation of managed care regulations related to CHP+ and Medicaid service and claims denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG reviewed a sample of 10 records with an oversample of 5 records for Medicaid managed care and a sample of 10 records with an oversample of 5 records for CHP+. Using a random sampling technique, HSAG selected the samples from all applicable health plan CHP+ and Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. For the record review, the health plan received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated overall record review scores for Medicaid and for CHP+.

For the 2013–2014 compliance monitoring reviews, the Department requested that HSAG also review the Access and Availability standard for **RMHP**'s Medicaid line of business in more depth through an open shopper project. HSAG conducted calls to a sample of providers in the **RMHP** Medicaid primary care provider network to verify appointment availability and determine compliance with appointment standards as delineated in the Medicaid managed care contract.

HSAG included in the sample federally qualified health centers (FQHCs) and several independent provider practices that were listed in RMHP's provider directory. HSAG used a call guide to identify potential variations in appointment scheduling at provider locations between time of day or personnel as well as between practices regardless of whether the practice is a primary care or specialty practice and regardless of practice size and location. HSAG used call scripts representing a variety of appointment scenarios and assigned each call script to a specific call time and provider location delineated in the call guide. This ensured that calls represented an adequate cross-section of urgent, non-urgent, and well-care visits for both children and adults. Calls were completed prior to the scheduled compliance monitoring site review, and results were considered in the scoring of applicable requirements in Standard II—Access and Availability. HSAG analyzed the summary of results and noted any patterns in the variables tested. Results are reported in the Executive Summary and call logs and protocols are in Appendix C of this report.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Appendix F contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2013–2014 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

- ◆ The health plan's compliance with federal health care regulations and managed care contract requirements in the two 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 recommended to improve the quality of the health plan's services related to the standard areas reviewed.

4. Follow-up on Prior Year's Corrective Action Plan for Rocky Mountain Health Plans

FY 2012–2013 Corrective Action Methodology

As a follow-up to the FY 2012–2013 site review, each health plan that received one or more *Partially Met* or *Not Met* score was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP** throughout calendar year 2013, reviewing CAP documents on-site during the 2013-2014 site review process.

Summary of 2012–2013 CHP+ Required Actions

As a result of the 2012–2013 site review, **RMHP** was required to implement corrective actions related to each of the four standards reviewed: coordination and continuity of care, member rights and protections, credentialing and recredentialing, and quality assessment and performance improvement. Required actions included:

- ◆ Implementing a mechanism for initial screening of all CHP+ members upon enrollment to identify members with special health care needs and to develop a mechanism that ensures organizational providers are reassessed within the NCQA-required time frames.
- ◆ Revising the provider manual to clearly describe member rights applicable to the CHP+ population and to 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.
- ◆ Revising its CHP+ member rights policy to include all rights afforded CHP+ members by federal regulations or the CHP+ contract with the State. **RMHP** was required to ensure that the staff, providers, and members are made aware of changes in policies or practices related to CHP+ member rights.
- ◆ Ensuring that the member handbook posted on the **RMHP** Web site is current and consistent with the handbooks distributed by other means.
- ◆ Improving mechanisms to ensure organization providers are credentialed within the required 36-month time frame and revising its annual QI report to include conclusions drawn related to the overall impact of the quality program.
- ◆ Adopting clinical practice guidelines applicable to CHP+ members with disabilities or special health care needs and modifying its policies and processes to ensure that clinical practice guidelines are reviewed and approved annually.

Summary of 2012–2013 Medicaid Required Actions

As a result of the 2012–2013 site review, **RMHP** was required to implement corrective actions related to three of the four standards reviewed: coordination and continuity of care, member rights and protections, and quality assessment and performance improvement. Required actions included:

- ◆ Revising and reformatting the member handbook to clearly define the services available under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and where and how to obtain them, as well as wrap-around services. **RMHP** was also required to correct its provider communications regarding EPSDT and wrap-around services.
- ◆ Implementing a process to ensure that all Medicaid members receive an initial screening for special health care needs after enrollment. **RMHP** must develop and approve a policy describing its screening package and the methods used to assure that screening requirements are met.
- ◆ Working with its behavioral health organization partner to ensure accurate presentation of mental health/behavioral health information on **RMHP**'s Web site, since information on the site was outdated by more than seven years.
- ◆ Evaluating its systems and processes for implementing corrective actions and following through with the processes. This was a previous corrective action and HSAG is once again making this recommendation. The annual Medicaid enrollment letter (provided on-site) did not inform members of their right to receive a copy of the member handbook upon request, although staff members stated on-site that it did. In order for members to fully understand benefits guaranteed under the Medicaid program and rights associated with these benefit programs, members must receive accurate and timely information because conflicting information from various sources is confusing. **RMHP** must also ensure that members are notified annually of their right to request and receive a copy of the member handbook.
- ◆ Including an assessment of the overall impact and effectiveness of the quality improvement program in the quality improvement annual report and modifying its policies and processes to ensure that clinical practice guidelines are reviewed and approved annually.
- ◆ Performing an audit of a statistically significant sample of Medicaid encounter claims and including verification of claims information against medical record information.

In addition, **RMHP** had one corrective action continued from the 2011–2012 site review process. The explanation of benefits auto-generated for claims denials had incorrect information and time frames. **RMHP** submitted revised language in April 2013, which was approved by the Department. During the 2013–2014 site review, HSAG reviewed denials records. Claims denials sent after June 2013 included accurate information and time frames. Actions related to this required action have been completed.

Summary of Corrective Action/Document Review

RMHP submitted to HSAG and the Department a CAP for CHP+ and one for Medicaid in July 2013. After requiring that **RMHP** make several revisions to its plans, HSAG and the Department agreed in September 2013 that, if implemented as written, **RMHP** would achieve full compliance with all required actions. In October 2013, **RMHP** began submitting documents to HSAG and the Department to demonstrate implementation of its plan. Unfortunately, it had not achieved full compliance by the end of 2013.

Summary of Continued Required Actions

Continued CHP+ Required Actions

The requirement to adopt clinical practice guidelines for CHP+ members with disabilities remains outstanding. During the 2013–2014 on-site review, **RMHP** staff members reported that the guidelines have been adopted and a policy has been developed, and a review was scheduled for the January 2014 Medical Advisory Council (MAC) meeting. HSAG will review documents when submitted and work with **RMHP** until this required action has been completed.

Continued Medicaid Required Actions

The requirement to develop policies and procedure related to the EPSDT program remains outstanding. During the 2013–2014 on-site review, **RMHP** staff members submitted policy language that met the requirements and reported that the policy would be reviewed by the MAC in January 2014. HSAG will continue to work with **RMHP** until this required action has been completed.

The requirement to perform an audit of a statistically significant sample of Medicaid encounter claims and include verification of claims information against medical record information remains outstanding. During the 2013–2014 on-site review, **RMHP** reported that the audit had been scheduled for March 2014.

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 2013–2014 Compliance Monitoring Tool
for Rocky Mountain Health Plans (Medicaid and CHP+)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.</p> <p align="right"><i>42CFR438.210(a)(3)(i)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.1.1 and Exhibit D, Section 1.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3; Exhibit K, 1.1</p>	<p>Care Management Program Description (Page 1) Medicaid and CHP+ Preauthorization P&P (Page 2)</p> <p>RMHP uses evidence based guidelines to ensure services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>2. The Contractor provides the same standard of care for all members regardless of eligibility category and makes all covered services as accessible in terms of timeliness, amount, duration and scope, to members, as those services are to non-CHP+/non-Medicaid recipients within the same area.</p> <p align="right"><i>42CFR438.210(a)(2)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.1.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3.9</p>	<p>Care Management Program Description (Page 1) Medicaid and CHP+ Preauthorization P&P (Page 2)</p> <p>RMHP ensure that medical services rendered to all Members regardless of line of business are medically necessary and/or appropriate, as well as in conformance with the benefits of the Plan.</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (Medicaid and CHP+)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>3. The Contractor has a Utilization Management (UM) Program. The UM Program includes:</p> <ul style="list-style-type: none"> ◆ Prospective, concurrent, and retrospective review ◆ Preauthorization system ◆ Medical Management Team oversight ◆ Transplant coordination ◆ On-site reviews ◆ Discharge planning ◆ Case management ◆ Appeals and grievances ◆ Mechanisms to detect over- and underutilization <p>Medicaid Contract: Exhibit A, Section 2.7.1, 2.9.2.5, Exhibit D, 1.1.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.9.4.4; Exhibit K, 1.1.1.2</p>	<p>Care Management Program Description: (Pages 8, 11, 10, 2, 13, 1, 8) RMHP Case Management program includes all the procedures, systems and functions described in Standard 1 Requirement 3.</p> <p>Additional Documents Submitted On-site:</p> <ul style="list-style-type: none"> • Utilization Review of Inpatient Hospital Days—Medicaid Members 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>4. Utilization Management shall be conducted under the auspices of a qualified clinician.</p> <p>Medicaid Contract: Exhibit A, Section 2.7.1.6 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.</p>	<p>Appropriate Professionals P&P (Whole Document) Care Management Program Description (Page 2)</p> <p>RMHP Board of Directors (BOD) delegate decision making authority for the CM Program to the RMHP CMO. The CMO, Associate Medical Directors, Medical Advisory Council (MAC) and the Director of CM are responsible for administering the CM Program. The Pharmacy Director is responsible for administering the PM Program and related pharmacy benefits.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



*Appendix A. Colorado Department of Health Care Policy and Financing
 FY 2013–2014 Compliance Monitoring Tool
 for Rocky Mountain Health Plans (Medicaid and CHP+)*

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>5. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.</p> <p align="right"><i>42CFR438.210(a)(3)(ii)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.1.3 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3.10</p>	<p>Medicaid and CHP+ Preauthorization P&P (Page 3)</p> <p>RMHP uses Evidence based guidelines as a basis for determining medical necessity and right setting review to assess the appropriateness of a proposed service.</p> <p>Clinical information used for making benefit coverage and medical necessity determination includes but is not limited to, the following:</p> <ul style="list-style-type: none"> • Office and hospital records • A history of the presenting problem • A clinical exam • Diagnostic testing results • Treatment plans and progress notes • Patient psychosocial history • Information on consultations with the treating practitioner • Evaluations form other health care practitioners and providers • Photographs • Operative and pathological reports • Rehabilitation evaluations • A printed copy of criteria related to the request • Information regarding the local delivery system • Patient characteristics and information • Information from responsible family members. 	<p>Medicaid:</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The Preauthorization of Services Policy (preauthorization policy) and the Care Management (CM) Program Description stated that the CM program uses standardized evidence-based criteria, policies, and procedures to objectively evaluate benefit coverage determinations and medical necessity, and to improve the quality and appropriateness of services. These documents were applicable to Medicaid and CHP+ lines of business. The CM program description stated that the chief medical officer and associate medical directors make all denial decisions or modifications in requests for services based upon medical necessity. During the on-site record review, there was one Medicaid case and two CHP+ cases in which the authorization determination</p>		



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Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>did not appear to follow established guidelines:</p> <ul style="list-style-type: none"> • Medicaid: The claim was denied because the provider submitted the claim using a Medicare code. The provider was an out-of-network geriatrician. Rather than issuing the member a denial, this should have been considered a coding issue between the health plan and the provider, with no notice of action to the member triggered. The notice of action (NOA) indicated that the service (annual wellness/preventive care visit) was not a Medicaid-covered service, which is inaccurate. The denial of a wellness visit is not consistent with established criteria and the Medicaid benefit plan. • CHP+: In one record the member received a notice of denial for family counseling. On-site, staff members verified in the State’s system that this service was listed as payable; however, in the RMHP claims system, the service was listed as not a covered benefit. • In addition, in one CHP+ case, the member submitted a pharmacy receipt for reimbursement and payment was denied due to untimely filing. Timely filing requirements must not be applied to member submissions because of potential issues with retroactive eligibility. 		
<p>Required Actions: RMHP must:</p> <ul style="list-style-type: none"> • Develop a mechanism to ensure that Medicaid covered services are not denied for payment with NOAs being sent to the member when the issue is a provider coding issue. Per the BBA—Preamble, provider coding issues do not trigger an NOA to the member. • Since it appears that applying Medicaid claims system configuration to the CHP+ claims process may have resulted in denying CHP+ covered services in error, RMHP must evaluate the claims payment configuration against the CHP+ benefit package and the State’s configuration to ensure covered benefits are configured for payment correctly in the RMHP claims payment system. • Perform an audit of 100 percent of CHP+ Medicaid behavioral health claims denials up to 411 claims (whichever number is lower) for consistency of determinations based on the CHP+ contract and the CHP+ benefit package. • Ensure that members are not held liable for untimely filed claims. 		
<p>6. If the Contractor places limits on services, it is:</p> <ul style="list-style-type: none"> ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. <p align="right"><i>42CFR438.210(a)(3)(iii)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.2.1.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.2 and 2.6.3</p>	<p>Medicaid and CHP+ Preauthorization P&P (Page 3)</p> <p>Medicaid: RMHP follows the benefit requirement of Attachment A; covered benefits, Exhibit B Section 2.0 Covered Services and Section 3.0 Exclusions and helps member access wrap-around benefits.</p> <p>CHP+: RMHP only covers those benefits described in Exhibit C and Exhibit H. Those benefits excluded in Exhibit C and Exhibit H will not be Covered Services of the Children’s Health Plan Contract.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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for Rocky Mountain Health Plans (Medicaid and CHP+)

Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>7. The Contractor specifies what constitutes “medically necessary services” in a manner that:</p> <ul style="list-style-type: none"> ◆ Is no more restrictive than that used in the State Medicaid/CHP+ program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: <ul style="list-style-type: none"> ● The prevention, diagnosis, and treatment of health impairments. ● The ability to achieve age-appropriate growth and development. ● The ability to attain, maintain, or regain functional capacity. <p align="right"><i>42CFR438.210(a)(4)</i></p> <p>Medicaid Contract: Exhibit B, 1.1.6 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.1 and 1.1.1.56</p>	<p>Medicaid and CHP+ Preauthorization P&P (Page 9)</p> <p>RMHP defines “Medically Necessary”, or medical necessity, as a covered Medicaid service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce or ameliorate the pain and suffering, or the physical, mental, cognitive or developmental effects of an illness, injury, or disability; and for which there is no other equally effective or substantially less costly course of treatment suitable for the client's needs. (I.30) Including the prevention, diagnosis, and treatment of health impairments, the ability to achieve age-appropriate growth and development, the ability to attain, maintain, or regain functional capacity.</p> <p><i>42CFR438.210(a)(4)</i></p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>8. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services.</p> <p align="right"><i>42CFR438.210(b)</i></p> <p>Medicaid Contract: Exhibit A, 2.7.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.2</p>	<p>Medicaid and CHP+ Preauthorization P&P (Whole P&P)</p> <p>RMHP has a Preauthorization of Services Policy and Procedure that address the processing of requests for initial and continuing authorization of services.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>9. The Contractor has in place and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions.</p> <p align="right"><i>42CFR438.210(b)(2)(i)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.7.1.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3</p>	<p>Clinical Criteria for UM Decisions (Whole Document) Medicaid and CHP+ Preauthorization P&P (Page2 & 3)</p> <p>RMHP has a Preauthorization of Services Policy and Procedure to ensure criteria are applied to support consistency in determinations regarding medical necessity</p> <p>Additional Documents Submitted On-site:</p> <ul style="list-style-type: none"> • Inter-rater Reliability Report, November 22, 2013 • Clinical Criteria for UM Decisions policy 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>10. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate.</p> <p align="right"><i>42CFR438.210(b)(2)(ii)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.7.1.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3</p>	<p>Medicaid and CHP+ Preauthorization P&P(Page 8)</p> <p>Rocky Mountain offers providers rendering the service an opportunity to request on behalf of the covered person, a peer-to-peer conversation regarding an adverse determination by the reviewer making the adverse determination.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>11. The Contractor has in place and follows written policies and procedures that include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member’s condition or disease.</p> <p align="right"><i>42CFR438.210(b)(3)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.7.1.5 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.6 and 2.8.1.3.1</p>	<p>Medicaid and CHP+ Preauthorization P&P (Page 2) Appropriate Professionals P&P (Page 3)</p> <p>Adverse determinations based on medical appropriateness are made by a Rocky Mountain Medical Director who holds an unrestricted license in the State of Colorado. The Medical Director may utilize an appropriately credentialed or Board Certified physician(s) consultant as needed.</p> <p>Adverse determinations for pharmaceuticals based on medical appropriateness and necessity are made by a RMHP Clinical Pharmacist and/or Medical Director.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>12. The Contractor has in place and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).</p> <p align="right"><i>42CFR438.210(c)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.7.1.2, 3.1.1.4.4-5, 10CCR2505–10, Sec 8.209.4.A.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.2 and 2.8.1.3.3; 10CCR2505—10, Sec 8.209.4.A.1</p>	<p>Medicaid and CHP+ Preauthorization P&P (Section 20)</p> <p>Rocky Mountain shall make a determination and notify the covered person and the covered person’s provider of the determination within 10 Calendar days after the receipt of the preauthorization request, whether Rocky Mountain determines the request to be a benefit or not.</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>13. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member’s health condition requires not to exceed:</p> <ul style="list-style-type: none"> ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 business days. <p align="right"><i>42CFR438.210(d)</i></p> <p>Medicaid Contract: Exhibit A, Section 3.1.3.2; 10CCR2505–10, Sec 8.209.4.B CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1; 10CCR2505–10, Sec 8.209.4.B</p>	<p>Medicaid and CHP+ Preauthorization P&P (Page 5 & 6)</p> <p>Preservice Elective or Retrospective Requests—determination within 10 Calendar days after the receipt of the preauthorization request</p> <p>All expedited requests with sufficient information will be responded to within 3 working days</p>	<p>Medicaid: <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The Preauthorization P&P accurately depicted the required time frames for making an authorization decision and delineated a process for extending the time frame 14 calendar days if additional information was required. The policy also included a statement that indicated that if additional information were needed, the decision would be made within up to 10 calendar days following the receipt of the additional information rather than within 10 days</p>		



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Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>following the receipt of the request for services. This practice may negatively impact the health plan’s ability to meet the required time frame. During the on-site interview, staff members reported that this was a typographical error in the policy, and that RMHP’s actual practices ensured that determinations were made within the required time frame. On-site demonstration of RMHP’s authorization tracking system demonstrated that authorization determinations were made well within the required time frames.</p>		
<p>Required Actions: RMHP must revise the preauthorization policy to clarify that all authorization decisions will be made within the required time frames as counted from the date of the request from service (10 calendar days for standard requests and three working days for expedited requests), unless extended.</p>		
<p>14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area).</p> <p align="right"><i>42CFR438.404(a)</i></p> <p>Medicaid Contract: Exhibit A, Section 3.1.3.2; 3.1.1.3.3; 10CCR2505–10, Sec 8.209.4.A.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.4.3.1.6; 10CCR2505–10, Sec 8.209.4.A.1</p>	<p>Medicaid and CHP+ Preauthorization P&P (Page 7) Denial Letter Commercial and Medicaid Template Medicaid Appeal Language</p> <p>The Notice of Action will include the following: The reason for the action, The Member’s or provider’s right to file an appeal; The date the appeal is due; The Member’s right to request the right to a fair hearing; The procedure for exercising the right to a fair hearing; The circumstances under which expedited resolution is available and how to request it; The Member’s right to have benefits continue pending resolution of the appeal, and how to request that benefits be continued; and the circumstances under which the Member may be required to pay the cost of these services. (Outstanding from previous site review)</p>	<p>Medicaid: <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The Preauthorization P&P adequately addressed the language and format of NOAs. Templates were written in easy-to-understand language and included information in Spanish informing members that they could call customer services to obtain the information in Spanish. Several of the claims denial letters reviewed on-site were not easy to understand.</p> <p>Three of 10 Medicaid denial letters reviewed were not easy to understand. Issues included:</p> <ul style="list-style-type: none"> ◆ Incorrect appeals information included with the letter. ◆ Extensive clinical terminology used without explanation of meaning. ◆ Incorrectly stating that the service was not a Medicaid covered service (rather than stating that the service was not covered under managed care and how the service could be obtained using Medicaid benefits). ◆ Stating that the member must pay for the service. 		



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>Four of 10 CHP+ claims denial letters reviewed were not easy to understand. Issues included:</p> <ul style="list-style-type: none"> On the claims denial letters, the verbiage “Not a Benefit” or “Not a Covered Service” was entered into each of the following three fields: Claim Received For, We Will Not Pay For, and Because. In one case the denial was for medications dispensed at a physician’s office because the drug had to be dispensed by a pharmacy to be covered by the plan. The denial letter stated the reason as “Not a Benefit” rather than explaining how the member could obtain the prescription and have it be covered. 		
<p>Required Actions: RMHP must ensure that unavoidable clinical language or medical jargon used in denial letters be kept to a minimum and explained to the member wherever possible, striving for 6th grade reading level. In addition, RMHP must ensure that claims denials clearly state the service being denied and provide complete and accurate information regarding appeal rights so that members may know how to obtain services covered under Medicaid but not under the managed care contract. RMHP must remove any language from letters that indicates that members will be held liable for payment of Medicaid services (unless the conditions are met that allow members to pay for services—i.e., written agreement with the provider to receive noncovered or out-of-network services available in the network).</p>		
<p>15. Notices of action must contain:</p> <ul style="list-style-type: none"> The action the Contractor (or its delegate) has taken or intends to take. The reasons for the action. The member’s authorized representative’s, and provider’s (on behalf of the member) right to file an appeal and procedures for filing. The date the appeal is due. The member’s right to a State fair hearing. The procedures for exercising the right to a State fair hearing. The circumstances under which expedited resolution is available and how to request it. The member’s right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. The circumstances under which the member may have to pay for the costs of services (if continued 	<p>Medicaid and CHP+ Preauthorization P&P (Page 7) Denial Letter Commercial and Medicaid Template Medicaid Appeal Language</p> <p>The Notice of Action will include the following: The reason for the action, The Member’s or provider’s right to file an appeal; The date the appeal is due; The Member’s right to request the right to a fair hearing; The procedure for exercising the right to a fair hearing; The circumstances under which expedited resolution is available and how to request it; The Member’s right to have benefits continue pending resolution of the appeal, and how to request that benefits be continued; and the circumstances under which the Member may be required to pay the cost of these services.</p> <p>Additional Documents Submitted On-site:</p> <ul style="list-style-type: none"> NCQA Denial Letter Checklist 	<p>Medicaid:</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
benefits are requested). <i>42CFR438.404(b)</i> Medicaid Contract: Exhibit A, Section 3.1.1.4.2.1; 10CCR2505–10, Sec 8.209.4.A.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.5.5; 10CCR2505–10, Sec 8.209.4.A.2		
Findings: The Preauthorization P&P listed the required components of NOAs. The Medicaid and CHP+ template denial letters with the appeal information insert included all of the components. However, several NOAs that were reviewed on-site did not consistently contain all of the required information. There were several versions of the NOA used in practice. The appeal rights attachment was used in some cases and appeal rights were included in the body of the letter in others. One of 10 Medicaid letters was not compliant with the content requirements because the incorrect appeal rights information was attached to the letter; therefore, the member was not informed of the correct appeal rights and State fair hearing information. None of the 10 CHP+ letters reviewed was compliant with the NOA content requirements. The reasons were primarily related to providing the member with incorrect information regarding the time frames for filing an appeal and not including the State fair hearing information. (See record review documentation in Appendix B.) On-site, staff members described a recently developed audit process to ensure that the correct NOA template and information is used for pre-service denial notification.		
Required Actions: RMHP must evaluate the letters being used for denials of new requests as well as for claims denials in both the CHP+ and Medicaid lines of business, revising processes to ensure that all NOAs (denials) include each of the requirements.		
16. The notices of action must be mailed within the following time frames: <ul style="list-style-type: none"> ◆ For termination, suspension, or reduction of previously authorized Medicaid/CHP+-covered services, within the time frames specified in 431.211: <ul style="list-style-type: none"> ● The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214). ◆ For denial of payment, at the time of any action affecting the claim. 	Medicaid and CHP+ Preauthorization P&P (Page 5, 6, 2, 6) When a treatment or procedure has been authorized by Rocky Mountain, benefits cannot be retrospectively denied except for fraud or abuse. If preauthorization is given for treatment or procedures that are not covered benefits, the benefits shall be provided as authorized with no penalty to the Member. RMHP clearly outlines notice of action time frames in the Determination section of the Medicaid and CHP+ Preauthorization P&P. Note: Claims denial documentation is included with other denial	Medicaid: <input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<ul style="list-style-type: none"> ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member’s health condition requires but within 10 calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire. ◆ For expedited service authorization decisions, as expeditiously as the member’s health condition requires but within 3 business days after receipt of the request for services. <p align="right"><i>42CFR438.404(c)</i> <i>42CFR438.400(b)(5)</i></p> <p>Medicaid Contract: Exhibit A, Section, 3.1.3.2; 10CCR2505–10, Sec 8.209.4.A.3 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2.1; 10CCR2505–10, Sec 8.209.4.A.3</p>	<p>universes submitted with the Desk Review Tool</p>	
<p>Findings: The Preauthorization P&P included the appropriate timelines for sending NOAs. Nine of 10 Medicaid records reviewed demonstrated that authorization determinations were made within the required time frames. In one Medicaid record, an NOA was sent 13 days after the request for service. Each of the records reviewed in the CHP+ sample demonstrated that an NOA was sent within the required time frames.</p>		
<p>Required Actions: RMHP must ensure that NOAs are sent within the time frames required by Colorado regulations in 8.209.</p>		



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>17. The Contactor may extend the authorization decision time frame if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member’s interest. The Contractor’s written policies and procedures include the following time frames for possible extension of time frames for authorization decisions:</p> <ul style="list-style-type: none"> ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. <p align="right"><i>42CFR438.210(d)</i></p> <p>Medicaid Contract: Exhibit A, Section 3.1.1.4.5.1; 10CCR2505–10, Sec 8.209.4.A.3 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3.1 and 2.8.1.3.3.2; 10CCR2505–10, Sec 8.209.4.A.3</p>	<p>Medicaid and CHP+ Preauthorization P&P (page 5, 6)</p> <p>When an extension is requested RMHP allows up to 14 calendar days for both standard and expedited authorization decision.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>18. If the Contractor extends the time frame for making a service authorization decision, it:</p> <ul style="list-style-type: none"> ◆ Provides the member written notice of the reason for the decision to extend the time frame. ◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. ◆ Carries out the determination as expeditiously as the member’s health condition requires and no later than the date the extension expires. <p align="right"><i>42CFR438.404(c)(4) and 438.210(d)(2)(ii)</i></p> <p>Medicaid Contract: Exhibit A, 3.1.3.2; 10CCR2505–10, Section 8.209.4.A.3 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.3.3; 10CCR2505–10, Section 8.209.4.A.3</p>	<p>Medicaid and CHP+ Preauthorization P&P (Page 5)</p> <p>If the time period for making the determination is extended, Rocky Mountain sends the notification of the extension to the Member within 10 calendar days of the receipt of the original request: RMHP will issue its decision and notify the Member’s and the Member’s Providers as expeditiously as the member’s conditional requires but not later than the date that the extension expires.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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<p>19. The Contractor has in place and follows written policies and procedures that provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.</p> <p align="right"><i>42CFR438.210(e)</i></p> <p>Medicaid Contract: Exhibit A, 2.7.1; Exhibit D, Section 1.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.8.1.1</p>	<p>Care Management Program Description (Page 2) Appropriate Professionals P&P (Page 4)</p> <p>There are no financial incentives within the CM program or Physician, Practitioner and Provider contracts for denial of healthcare services.</p> <p>Additional Documents Submitted on-site:</p> <ul style="list-style-type: none"> • RMHP Employee Acknowledgement—Receipt of Compliance Plan • RMHP Employee Acknowledgement—Receipt of Employee Handbook • RMHP Code of Conduct • RMHP Compliance Plan—December 2013 • Compliance Newsletter—June 2013 • Member Newsletter—Fall 2013 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>20. The Contractor provides pharmacy medical management.</p> <p>Medicaid Contract: Exhibit D, Section 1.1 CHP+ Contract: Amendment 02, Exhibit K, 1.1</p>	<p>Pharmaceutical Management P&P Pharmacy DUR P&P Appropriate Professionals</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>21. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:</p> <ul style="list-style-type: none"> ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ◆ Serious impairment to bodily functions. ◆ Serious dysfunction of any bodily organ or part. <p align="right"><i>42CFR438.114(a)</i></p> <p>Medicaid Contract: Exhibit B, Section 1.1.3 CHP+ Contract: Amendment 02, Exhibit A-2, 1.1.1.27</p>	<p>Emergency Services Claim Review Policy (Section I)</p> <p>The <u>Claims Examiner Processing Manual</u> is housed on the Claims Department SharePoint Site. The RMHP Claims Department will provide Reviewer access and demonstration during the on site visit.</p> <p>Medicaid: Medicaid Handbook—In Case of Emergency Pages 2 & 3</p> <p>CHP+: CHP+ EOC—Emergency and Urgent Care Services Page 16</p> <p>RMHP assumes medical services are appropriate based on Prudent layperson definition that a Member acting reasonably, would have believed that an emergency medical condition existed.</p> <p>Additional Documents Submitted On-site:</p> <ul style="list-style-type: none"> • Claims Medical Processing Manual—Emergency Room, Urgent Care, Professional Services Section 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>22. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition.</p> <p align="right"><i>42CFR438.114(a)</i></p> <p>Medicaid Contract: Exhibit B, Section 2.1.13.1 CHP+ Contract: Amendment 02, Exhibit A-2, 1.1.1.28</p>	<p>Emergency Services Claim Review Policy (Section III)</p> <p>Medicaid: Medicaid Handbook—In Case of Emergency Pages 2 & 3</p> <p>CHP+: CHP+ EOC—Emergency and Urgent Care Services Page 16</p> <p>RMHP covers emergency services until the attending emergency physician, or the provider actually treating the Member, determines that the Member is sufficiently stabilized for transfer or discharge.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.</p> <p align="right"><i>42CFR438.114(c)(1)(i)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.1.4 CHP+ Contract: Amendment 02, Exhibit A-2,2.6.6.1.4</p>	<p>The <u>Claims Examiner Processing Manual</u> is housed on the Claims Department SharePoint Site. The RMHP Claims Department will provide reviewer access and demonstration during the on site visit.</p> <p>Preauthorization of Services P&P (Page 2)</p> <p>CHP+: CHP+ EOC—Emergency and Urgent Care Services Page 16</p> <p>Preauthorization is not required in medically urgent/emergent situations, nor is a contract with the provider of urgent emergent situations required.</p> <p>Additional Documents Submitted on-site:</p> <ul style="list-style-type: none"> Retrospective Review of Out of Network Claims policy 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The Emergency Services Claim Review Policy, the Claims Processing Manual, and the Retrospective Review of Out-of-Network Claims Policy all clearly stated that RMHP covers emergency services by participating and nonparticipating providers. The CM program description stated that all emergency room claims are paid without review through the normal claims payment processes.</p> <p>The Medicaid and CHP+ member handbooks stated that emergency care is covered for true emergencies only, may be obtained from an RMHP hospital or the nearest hospital, and will be covered outside of the service area; however, the CHP+ member handbook also stated that members must send a bill from a nonparticipating hospital to RMHP within 60 days or “RMHP has no obligation to pay for such care.” During the on-site interview, RMHP staff members reported that the system is not configured to deny emergency claims for the reason of untimely filing.</p>		
<p>Required Actions: RMHP must revise the CHP+ member handbook to remove the statement that RMHP may deny payment of emergency claims for untimely filing.</p>		



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<p>24. The Contractor does not require prior authorization for emergency or urgently needed services.</p> <p align="center"><i>42CFR438.10(f)(6)(viii)(B)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.1.3 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.1.3</p>	<p>Preauthorization of Services P&P (Page 2)</p> <p>The <u>Claims Examiner Processing Manual</u> is housed on the Claims Department SharePoint Site. The RMHP Claims Department will provide reviewer access and demonstration during the on site visit.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>25. The Contractor may not deny payment for treatment obtained under the following circumstances:</p> <ul style="list-style-type: none"> ◆ A member had an emergency medical condition, and the absence of immediate medical attention would have had the following outcomes: <ul style="list-style-type: none"> ● Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ● Serious impairment to bodily functions. ● Serious dysfunction of any bodily organ or part. ◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would not have had the following outcomes: <ul style="list-style-type: none"> ● Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ● Serious impairment to bodily functions. ● Serious dysfunction of any bodily organ or part. 	<p>The <u>Claims Examiner Processing Manual</u> is housed on the Claims Department SharePoint Site. The RMHP Claims Department will provide reviewer access and demonstration during the on site visit.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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<ul style="list-style-type: none"> A representative of the Contractor’s organization instructed the member to seek emergency services. <p align="center"><i>42CFR438.114(c)(1)(ii)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.1; 2.5.4.3 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.1.4, 2.6.6.3.1, and 2.6.6.4.1.3</p>		
<p>26. The Contractor does not:</p> <ul style="list-style-type: none"> Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member’s primary care provider, the Contractor, or State agency of the member’s screening and treatment within 10 days of presentation for emergency services. <p align="center"><i>42CFR438.114(d)(1)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.3.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2.1 and 2.6.6.1.6</p>	<p>The <u>Claims Examiner Processing Manual</u> is housed on the Claims Department SharePoint Site. The RMHP Claims Department will provide reviewer access and demonstration during the on site visit.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>27. The Contractor will be responsible for Emergency Services when:</p> <ul style="list-style-type: none"> ◆ The member’s primary diagnosis is medical in nature, even when the medical diagnosis includes some psychiatric conditions or procedures. (Medicaid and CHP+). ◆ The primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. (CHP+ only). <p>Medicaid Contract: Exhibit A, Section 2.5.4.6.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.6.2</p>	<p>The <u>Claims Examiner Processing Manual</u> is housed on the Claims Department SharePoint Site. The RMHP Claims Department will provide reviewer access and demonstration during the on site visit.</p>	<p>Medicaid:</p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>28. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.</p> <p align="right"><i>42CFR438.114(d)(2)</i></p> <p>Medicaid Contract: None CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.1.7</p>	<p>The <u>Claims Examiner Processing Manual</u> is housed on the Claims Department SharePoint Site. The RMHP Claims Department will provide reviewer access and demonstration during the on site visit.</p> <p>Additional Documents Submitted On-site:</p> <ul style="list-style-type: none"> • Physician Medical Services Agreement • Hospital Services Agreement 	<p>Medicaid:</p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>29. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.</p> <p align="right"><i>42CFR438.114(d)(3)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.1.5 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.1.5</p>	<p>The <u>Claims Examiner Processing Manual</u> is housed on the Claims Department SharePoint Site. The RMHP Claims Department will provide reviewer access and demonstration during the on site visit.</p> <p>CHP+: CHP+ EOC—Emergency and Urgent Care Services Page 16</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>30. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member’s condition.</p> <p align="right"><i>42CFR438.114(a)</i></p> <p>Medicaid Contract: Exhibit B, Section 1.1.11 CHP+ Contract: Amendment 02, Exhibit A-2, 1.1.1.67</p>	<p>Medicaid Member Financial Responsibility for Post Stabilization Care Services P&P</p> <p>Post-stabilization care services” means covered services, related to an emergency medical condition, that are provided after an enrollee is stabilized in order to maintain the stabilized condition.</p> <p>CHP+: CHP+ EOC—Emergency and Urgent Care Services Page 16</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>31. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that <i>have been</i> pre-approved by a plan provider or other organization representative.</p> <p align="right"><i>42CFR438.114(e)</i> <i>42CFR422.113(c)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.4 and Exhibit B, Section 1.1.11 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.4</p>	<p>Medicaid Member Financial Responsibility for Post Stabilization Care Services P&P</p> <p>RMHP is financially responsible for post-stabilization care services obtained within or outside RMHP that are not pre-approved by a plan provider or other RMHP representative,</p> <p>CHP+: CHP+ has been operating according to the Medicaid P&P shown above and will be added to the P&P to make the process formal.</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>32. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that <i>have not been</i> pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances:</p> <ul style="list-style-type: none"> ◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. ◆ The Contractor does not respond to a request for pre-approval within 1 hour. ◆ The Contractor cannot be contacted. ◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it <i>has not</i> pre-approved ends. <p align="right"><i>42CFR438.114(e)</i> <i>42CFR422.113(c)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.4 and Exhibit B, Section 1.1.11 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.5 and 6</p>	<p>Medicaid Member Financial Responsibility for Post Stabilization Care Services P&P</p> <p>RMHP is financially responsible for post-stabilization care services obtained within or outside RMHP that are not pre-approved by a plan provider or other RMHP representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if—</p> <ul style="list-style-type: none"> • RMHP does not respond to a request for pre-approval within 1 hour; • RMHP cannot be contacted; or • RMHP organization representative and the treating physician cannot reach an agreement concerning the enrollee's care, and a plan physician is not available for consultation. In this situation, RMHP must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or when one of the following criteria is met. RMHP's financial responsibility for post-stabilization care services it has not preapproved ends <p>CHP+: CHP+ has been operating according to the Medicaid P&P shown above and will be added to the P&P to make the process formal.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Standard I—Coverage and Authorization of Services		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>33. The Contractor’s financial responsibility for poststabilization care services it has not pre-approved ends when:</p> <ul style="list-style-type: none"> ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care. ◆ A plan physician assumes responsibility for the member's care through transfer. ◆ A plan representative and the treating physician reach an agreement concerning the member’s care. ◆ The member is discharged. <p align="right"><i>42CFR438.114(e) 42CFR422.113(c)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.4 and Exhibit B, Section 1.1.11 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.8</p>	<p>Medicaid Member Financial Responsibility for Post Stabilization Care Services P&P</p> <p>Medicaid: RMHP’s financial responsibility for post-stabilization care services it has not preapproved ends when:</p> <ul style="list-style-type: none"> • An RMHP network physician with privileges at the treating hospital assumes responsibility for the enrollee’s care; • An RMHP network physician assumes responsibility for the enrollee’s care through transfer; • An RMHP representative and the treating physician reach an agreement concerning the enrollee’s care; or • The enrollee is discharged. <p>CHP+: CHP+ has been operating according to the Medicaid P&P shown above and will be added to the P&P to make the process formal.</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>34. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor.</p> <p align="right"><i>42CFR438.114(e) 42CFR422.113(c)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.4 and Exhibit B, Section 1.1.11 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.6.4.1.7</p>	<p>Medicaid Member Financial Responsibility for Post Stabilization Care Services P&P</p> <p>Medicaid: Under no circumstance will RMHP allow in-network or out-of-network providers to bill members for these services.</p> <p>Member liability “will be limited to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.”</p> <p>CHP+: CHP+ has been operating according to the Medicaid P&P shown above and will be added to the P&P to make the process formal.</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Medicaid:					
Results for Standard I—Coverage and Authorization of Services					
Total	Met	=	<u>29</u>	X	1.00 = <u>29</u>
	Partially Met	=	<u>5</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>34</u>	Total Score	= <u>29</u>

Total Score ÷ Total Applicable			=	<u>85%</u>
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CHP+:					
Results for Standard I—Coverage and Authorization of Services					
Total	Met	=	<u>29</u>	X	1.00 = <u>29</u>
	Partially Met	=	<u>5</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>NA</u>
Total Applicable		=	<u>34</u>	Total Score	= <u>29</u>

Total Score ÷ Total Applicable			=	<u>85%</u>
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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
<p>1. The Contractor maintains and monitors a network of providers that is supported by written agreements and is sufficient to provide adequate access to all covered services. In order for the Contractor’s plan to be considered to provide adequate access, the Contractor includes the following provider types and ensures a minimum provider-to-member caseload ratio as follows:</p> <ul style="list-style-type: none"> ◆ Appropriate access to certified nurse practitioners and certified nurse midwives. ◆ 1:2000 primary care physician (PCP)/provider-to-member ratio. PCP includes physicians designated to practice family medicine and general medicine (and for Medicaid: Pediatrics, Nurse Practitioners, and Physician Assistants). ◆ 1:2000 physician specialist-to-members ratio. Physician specialist includes physicians designated to practice cardiology, otolaryngology/ear, nose and throat (ENT), endocrinology, gastroenterology, neurology, orthopedics, pulmonary medicine, general surgery, ophthalmology, and urology (and for Medicaid: Infectious Disease). ◆ Physician specialists designated to practice internal medicine, infectious disease, obstetrics and gynecology (OB/GYN), and pediatrics shall be counted as either PCP or physician specialist, but not both. <p align="right"><i>42CFR438.206(b)(1)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.1.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.1.5, 2.7.1.1.6, and 2.7.1.1.9</p>	<p>Medicaid: Medicaid Member Handbook Medicaid Access Plan Provider Manual Includes CHP+ and Medicaid</p> <p>CHP+: CHP+ Benefits Booklet CHP+ Access Plan</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • Availability of Practitioners Network Analysis • Access Committee Meeting Minutes: May 2013; September 2013 • Physician Medical Services Agreement 	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>2. In establishing and maintaining the network, the Contractor considers:</p> <ul style="list-style-type: none"> ◆ The anticipated CHP+/Medicaid enrollment. ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific CHP+/Medicaid populations represented in the Contractor’s service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted CHP+/Medicaid services. ◆ The numbers of network providers who are not accepting new CHP+/Medicaid patients. ◆ The geographic location of providers and CHP+/Medicaid members, considering distance, travel time, the means of transportation ordinarily used by CHP+/Medicaid members, and whether the location provides physical access for CHP+/Medicaid members with disabilities. <p align="right"><i>42CFR438.206(b)(1)(i) through (v)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.3 and 4.3.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.5.10.1</p>	<p>Medicaid Medicaid Access Plan</p> <p>CHP+: CHP+ Access Plan See Access Plan and Exhibit A in both documents.</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • Availability of Practitioners Network Analysis 	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>3. The Contractor ensures that its members have access to a provider within 30 miles or 30 minutes travel time, whichever is larger, to the extent such services are available and providers are qualified and willing to contract on reasonable terms.</p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.3 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.3.1</p>	<p>Provider Manual</p> <p>Medicaid: Medicaid Access Plan</p> <p>CHP+: CHP+ Access Plan</p> <p>Additional Documents Submitted on Site:</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met</p>

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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
	<ul style="list-style-type: none"> • Availability of Practitioners Network Analysis • Committee Meeting Minutes: May 2013; September 2013 	<input type="checkbox"/> N/A
<p>4. (Medicaid) The Contractor shall attempt to include both Essential Community Providers, as designated at 10 C.C.R. 2505–10, §8.205.5.A, and other providers in its network of providers.</p> <p>(CHP+) The contractor ensures that members have access to an Essential Community Provider, to the extent such services are available:</p> <ul style="list-style-type: none"> ◆ Within 30 minutes or 30 miles in urban counties. ◆ Within 45 minutes or 45 miles in suburban counties. ◆ Within 90 minutes or 90 miles in rural counties. <p>Medicaid Contract: Exhibit A, Section 2.6.1.1.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.3.2</p>	<p>Medicaid: Medicaid Access Plan</p> <p>CHP+: CHP+ Access Plan</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>5. The Contractor provides female members with direct access to a women’s health specialist within the network for covered care necessary to provide women’s routine and preventive health care services. This is in addition to the member’s designated source of primary care if that source is not a women’s health care specialist.</p> <p align="right"><i>42CFR438.206(b)(2)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.1.4 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.1.7</p>	<p>Direct Access for OBGYN Care 2013.doc</p> <p>Medicaid: Medicaid Member Handbook</p> <p>CHP+: CHP+ Enrollment Booklet</p> <p>Note: Rocky Mountain provides for a covered woman to have “direct access” to a contracting obstetrician or gynecologist (OB/GYN) for her reproductive and gynecological care. This applies to reproductive health care and gynecological care for both the normal and abnormal processes of the female reproductive system, including medical and surgical management of disorders, pregnancy, childbirth, related preventive care and family planning services.</p>	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>6. The Contractor allows persons with special health care needs who use specialists frequently to maintain these types of specialists as PCPs or be allowed direct access/standing referrals to specialists.</p> <p align="right"><i>42CFR438.208(c)(4)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.5.4 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.5.4</p>	<p>Medicaid: Medicaid Member Handbook Page 10 Specialty Care</p> <p>CHP+: CHP+ Benefits Booklet</p> <p>RMHP does not require referrals to see contracted specialist.</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • Case Management of Special Health Care Needs • Population P&P • Medicaid Welcome Call Script • CHP+ Welcome Call Script 	
<p>7. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.</p> <p align="right"><i>42CFR438.206(b)(3)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.1.5 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.1.8</p>	<p>Medicaid Member Handbook Medicaid Member Handbook Second Opinion Member's rights.pdf Provider Manual Second Opinions & Out of Network Services P&P CHP+ Benefits Booklet</p> <p>RMHP provides for a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network. If RMHP does not have a participating practitioner to provide a covered benefit in a specific geographic region, RMHP will arrange for another provider with necessary expertise and ensure the Member obtains the benefit at no greater cost to the Member than if the benefit were obtained from a participating provider.</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • Preauthorization of Services P&P 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>8. If the Contractor is unable to provide necessary contract services to a member in-network, the Contractor must adequately and timely cover these services out-of-network for the member for as long as the Contractor is unable to provide them.</p> <p align="right"><i>42CFR438.206(b)(4)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.2.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.2.1</p>	<p>Second Opinions & Out of Network Services P&P Medicaid Member Handbook Out of Network.pdf Medicaid Member Handbook Access Statement.pdf CHP+ Benefits Booklet</p> <p>If the RMHP network is unable to provide necessary services covered under the Member’s Evidence of Coverage (EOC), RMHP will adequately and timely cover these services out of network for the Member, for as long as RMHP is unable to provide the services. RMHP will coordinate payment with the out of network practitioner to ensure that the cost to the member is no greater than it would be if the services were furnished in-network.</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • Preauthorization of Services P&P 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>9. The Contractor works with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network.</p> <p align="right"><i>42CFR438.206(b)(5)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.2.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.2.2.1</p>	<p>Second Opinions & Out of Network Services OON Letter of Agreement</p> <p>When a second opinion is arranged with an out of network practitioner the cost to the Member will be no more than the cost of an in network provider.</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>10. The Contractor ensures that members within the service area have access to emergency services on a 24-hour-a-day, 7 days-a-week basis.</p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.4.1.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3.5</p>	<p>Medicaid: Medicaid Access Plan</p> <p>CHP+: CHP+ Access Plan</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • Preauthorization of Services P&P 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>11. Members temporarily out of the service area may receive out-of-area emergency services and urgently needed services.</p> <p>Medicaid Contract: Exhibit A, Section 2.5.4.1.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.6.3.5</p>	<p>Medicaid: Medicaid Access Plan</p> <p>CHP+: CHP+ Access Plan</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • Retrospective Review of Out of Network Claims • Emergency Services Claims Review Policy 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Requirement	Evidence as Submitted by the Health Plan	Score
<p>12. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members.</p> <p align="right"><i>42CFR438.206(c)(1)(ii)</i></p> <p>Medicaid Contract: None CHP+ Contract: Amendment 02, Exhibit A-2, 2.5.1</p>	<p>Medicaid: Medicaid Access Plan</p> <p>CHP+: CHP+ Access Plan</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • RMHP Provider Manual • Physician Medical Services Agreement 	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>13. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services:</p> <ul style="list-style-type: none"> ◆ Urgently needed services are provided within 48 hours of notification of the primary care physician or the Contractor. <p align="right"><i>42CFR438.206(c)(1)(i)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.5.2.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.1</p>	<p>Medicaid: Medicaid Access Plan</p> <p>CHP+: CHP+ Access Plan</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • RMHP Provider Manual • Physician Medical Services Agreement 	<p>Medicaid: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+: <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>14. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services:</p> <p>Medicaid:</p> <ul style="list-style-type: none"> ◆ Non-urgent, symptomatic care, and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens scheduled within two (2) weeks of the member’s request for services. ◆ Adult, non-symptomatic well care physical examinations scheduled within four (4) months. <p>CHP+:</p> <ul style="list-style-type: none"> ◆ Non-urgent, symptomatic healthcare is scheduled within 2 weeks. ◆ Non-emergent, non-urgent care for a medical problem is provided within 30 calendar days. ◆ Non-symptomatic well care physical examinations are scheduled within 4 months. <p align="right"><i>42CFR438.206(c)(1)(i)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.5.2.3; Exhibit E, 1.1.13 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2–4</p>	<p>Medicaid: Medicaid Access Plan</p> <p>CHP+: CHP+ Access Plan</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • RMHP Provider Manual • Physician Medical Services Agreement 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



Appendix A. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (Medicaid and CHP+)

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>15. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: (CHP+ only)</p> <ul style="list-style-type: none"> ◆ Diagnosis and treatment of a non-emergency, non-urgent mental health condition scheduled within 30 calendar days. ◆ Diagnosis and treatment of a non-emergent, non-urgent substance abuse condition scheduled within 2 weeks. <p align="right"><i>42CFR438.206(c)(1)(i)</i></p> <p>CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.5.2.5 and 2.7.1.5.2.6</p>	<p>CHP+: CHP+ Access Plan</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • RMHP Provider Manual • Physician Medical Services Agreement 	<p>Medicaid:</p> <p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input checked="" type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>16. The Contractor communicates all scheduling guidelines to participating providers and members.</p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.5.4; Exhibit E, 1.1.13 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.5.4</p>	<p>Provider Manual Medicaid Member Handbook CHP+ Benefits Booklet</p>	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



*Appendix A. Colorado Department of Health Care Policy and Financing
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 for Rocky Mountain Health Plans (Medicaid and CHP+)*

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>17. The Contractor maintains an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and takes appropriate action. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, has mechanisms to monitor providers regularly to determine compliance, and to take corrective action if there is failure to comply.</p> <p align="right"><i>42CFR438.206(c)(1)(iv) through (vi)</i></p> <p>Medicaid Contract: Exhibit A, Section 2.6.1.5.4; 3.2.9 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.1.4.1.1.1, and 2.7.1.5.4</p>	<p>Member Satisfaction and PCP Summary Memo Member Satisfaction with PCP Survey Results</p> <p>RMHP did not have any Member complaint related to wait times.</p>	<p>Medicaid:</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The RMHP member satisfaction surveys collected information on members’ perceptions of the length of time between making an appointment and their scheduled visit. The PCP and Specialist Member Satisfaction surveys were performed every two years (alternating between the two). The surveys did not collect information by specific type of appointment and did not delineate responses for Medicaid or CHP+. It was therefore not possible for RMHP to determine whether responses were related to Medicaid and CHP+ access standards. The on-site practice quality monitoring tool did not include an evaluation of physician office appointment availability, but did measure compliance with the requirements for Medicaid and CHP+ and was performed every three years. During on-site interviews, staff members stated that secret shopper calls were performed periodically but only on a limited basis, since RMHP does not consider that mechanism effective. Staff members stated that member complaints were the primary source of identifying access or appointment issues, and that significant complaints were followed up with individual physicians. Member complaints were monitored regularly by the Member Experience Advisory Committee (MEAC).</p>		
<p>Required Actions: RMHP must implement an effective, systematic process to monitor providers regularly for compliance with specific Medicaid and CHP+ scheduling standards.</p>		



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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>18. The Contractor maintains a comprehensive program of preventive health services for members that includes written policies and procedures, involves providers and members in their development and ongoing evaluation, and includes:</p> <ul style="list-style-type: none"> ◆ Risk assessment by a member’s PCP or other qualified professionals specializing in risk prevention who are part of the Contractor’s participating providers or under contract to provide such services, to identify members with chronic or high-risk illnesses, a disability, or the potential for such condition. ◆ Health education and promotion of wellness programs, including the development of appropriate preventive services for members with a disability to prevent further deterioration. The Contractor will also include distribution of information to members to encourage member responsibility for following guidelines for preventive health. ◆ Evaluation of the effectiveness of health preventive services, including monitoring and evaluation of the use of select preventive health services by at-risk members. ◆ Procedures to identify priorities and develop guidelines for appropriate preventive services. ◆ A process to inform and educate participating providers about preventive services, involve participating providers in development of programs and evaluate the effectiveness of participating providers in providing such services. 	<p>Example of available reports with risk stratification. QI & HEDIS Team</p> <p>Medicaid: Risk Stratification—Medicaid</p> <p>CHP+: Risk Stratification—Commercial and CHP+</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • Medicaid Welcome Call Script • CHP+ Welcome Call Script • Examples of member mailings for HEDIS Interventions 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>And for Medicaid only:</p> <ul style="list-style-type: none"> Integration of preventive health programs into the Contractor’s Quality Assurance program and describing specific preventive care priorities, services, accomplishments, and goals as part of required reporting in the Quality Improvement Plan, Program Impact Analysis, and Annual Report. <p>Medicaid Contract: Exhibit A, Section 2.6.7.1; 4.5.2.1.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.8.1</p>		
<p>19. The Contractor participates in the State’s efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by:</p> <ul style="list-style-type: none"> Maintaining policies to reach out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups. Maintaining policies to provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation. Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include: <ul style="list-style-type: none"> Inquiries conducted by the Contractor of the language proficiency of members during the Contractor’s orientation calls. Being served by participating providers. Improving access to health care through community outreach and Contractor 	<p>Accommodation for Members with Disabilities Alternate Language or Larger Print Hearing Impaired Text Telephone TTY Procedure Language Translation with CLI</p> <p>Medicaid: Medicaid Rights and Responsibilities Medicaid Welcome Call Script</p> <p>CHP+: CHP+ Rights and Responsibilities CHP+ Welcome Call Script</p>	<p>Medicaid:</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input type="checkbox"/> Met <input checked="" type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



*Appendix A. Colorado Department of Health Care Policy and Financing
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 for Rocky Mountain Health Plans (Medicaid and CHP+)*

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>publications.</p> <ul style="list-style-type: none"> ◆ Developing and/or providing cultural competency training programs, as needed, to the network providers and Contractor staff regarding: <ul style="list-style-type: none"> ● Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. ● The medical risks associated with the client population’s racial, ethnic, and socioeconomic conditions. ◆ Making available written translation of Contractor materials, including member handbook, correspondence, and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area. ◆ Developing policies and procedures, as needed, on how the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in service areas where language may pose a barrier so that participating providers can: <ul style="list-style-type: none"> ● Conduct the appropriate assessment and treatment of non-English-speaking members (including members with a communication disability). ● Promote accessibility and availability of covered services, at no cost to members. ◆ Developing policies and procedures on how the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or 		



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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>publications in alternative formats.</p> <ul style="list-style-type: none"> ◆ Making a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse, and culturally competent clinical providers that represent the racial and ethnic communities being served. ◆ Providing access to interpretative services by a qualified interpreter for members with a hearing impairment in such a way that it shall promote accessibility and availability of covered services. ◆ Developing and maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. ◆ Arranging for covered services to be provided through agreements with non-participating providers when the Contractor does not have the direct capacity to provide covered services in an appropriate manner, consistent with independent living, to members with disabilities. ◆ Providing access to Telecommunications Device for the Deaf (TDD) or other equivalent methods for members with a hearing impairment in such a way that it will promote accessibility and availability of covered services. ◆ Making member information available upon request for members with visual impairments, including, but not limited to, Braille, large print, or audiotapes. For members who cannot read, member information shall be available on audiotape. <p style="text-align: right;"><i>42CFR438.206(c)(2)</i></p>		



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Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
Medicaid Contract: Exhibit A, Section 2.6.6.3 CHP+ Contract: Amendment 02, Exhibit A-2, 2.7.7.2		
<p>Findings: RMHP policies and procedures addressed processes related to culturally diverse linguistic needs and to the hearing and visually impaired. Policies were applicable to all lines of business. RMHP developed materials and services to accommodate non-English-speaking members and members with hearing impairment, including a translation service vendor and a TTY/TTD line. RMHP notified members and providers of the availability of interpreter services in the member handbook and provider manual. Staff members stated that Spanish-speaking providers were available in most areas, and the language line was available to providers for other non-English-speaking members. Policies stated that case management staff members would assist members with special needs or disabilities to obtain out-of-network services, as necessary, in order to maintain a member’s ability to live independently. New member welcome call scripts were used to screen for Spanish-speaking members and members with special health care needs and who were referred to case management. Cultural competency training was required for RMHP staff members and training resources were offered to providers on the RMHP Web site. The provider manual communicated the provider’s responsibility to provide interpreter services for members, and “urged” providers to ensure that facilities accommodated persons with disabilities. Staff members stated that RMHP identified the Latino culture and the “culture of poverty” as the primary needs in the service area. RMHP invested in the “Bridges out of Poverty” training, which was offered to both the staff and provider offices. RMHP annually assessed and documented the cultural and linguistic needs of the member populations and related services in the Annual Member Cultural and Linguistic Needs Report. Results were reported to the MEAC and Quality Improvement Committee. RMHP’s policies and procedures did not address cultural needs beyond linguistic needs and the special needs of members with visual and hearing impairment. While HSAG acknowledges that RMHP had many processes that addressed the culture of poverty, RMHP’s policies and processes did not address cultural values, behaviors, beliefs, diseases, and health care needs associated with other cultures. RMHP also did not have a policy and procedure that addressed compliance with the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.</p>		
<p>Required Actions: RMHP must develop policies and procedures that address outreach to specific cultural or ethnic groups for prevention or treatment of diseases prevalent in those groups. It must also develop policies and procedures that address provider training regarding health care attitudes, beliefs, and practices of members affiliated with specific cultures and potential associated health risks. RMHP must also develop policies and procedures that address compliance with the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.</p>		

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>20. (CHP+) The Contractor analyzes and responds to results of HEDIS measures. HEDIS measures under review during the 2013–2014 review year:</p> <ul style="list-style-type: none"> ◆ Well-Child Visits in the First 15 Months of Life ◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ◆ Adolescent Well-Care Visits <p>(Medicaid) The Contractor analyzes and responds to results of HEDIS measures. HEDIS measures under review during the 2013–2014 review year:</p> <ul style="list-style-type: none"> ◆ Well-Child Visits in the First 15 Months of Life ◆ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life ◆ Adolescent Well-Care Visits ◆ Percentage of members 20–44 years of age with a preventive/ambulatory visit ◆ Percentage of members 45–64 and 65+ years of age with a preventive/ambulatory visit <p>Medicaid Contract: Exhibit A, Section 2.9.2.3.1.2 CHP+ Contract: Amendment 02, Exhibit A-2, 2.9.4.1.2</p>	<p>QI HEDIS Executive Summary Medicaid HEDIS Evaluation CHP+ HEDIS Evaluation</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • 2013 HEDIS Intervention Workplan 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>21. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor uses tools including member surveys, anecdotal information, grievance and appeals data, and enrollment and disenrollment information.</p> <p>Medicaid Contract: Exhibit A, Section 2.9.2.4.1 CHP+ Contract: Amendment 02, Exhibit A-2, 2.9.4.3.2</p>	<p>MEAC Dashboard Medicaid @ CHP+ II</p> <p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • MEAC meeting minutes 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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 FY 2013–2014 Compliance Monitoring Tool
 for Rocky Mountain Health Plans (Medicaid and CHP+)*

Standard II—Access and Availability		
Requirement	Evidence as Submitted by the Health Plan	Score
<p>22. The Contractor develops and implements a corrective action plan for all areas of the CAHPS survey that report a score that is less than the 50th percentile. (CHP+)</p> <p>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. (Medicaid)</p> <p>Medicaid Contract: Exhibit A, Section 2.9.2.4.3 CHP+ Contract: Amendment 02, Exhibit A-2, 2.9.4.3.5</p>	<p>Additional Documents Submitted on Site:</p> <ul style="list-style-type: none"> • MEAC meeting minutes • RMHP CHP+ CAHPS Action Plan 	<p>Medicaid:</p> <p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p> <p>CHP+:</p> <p><input type="checkbox"/> Met <input type="checkbox"/> Partially Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The 2013 Medicaid CAHPS results did not report significant levels of dissatisfaction. The 2013 CHP+ CAHPS results fell below the 50th percentile in three areas. During on-site interviews, staff members stated that the MEAC evaluated the 2013 CAHPS results for all lines of business, together with provider satisfaction survey and member grievances, and determined that the CHP+ poor performance results could not be substantiated with any other source of data. Staff members reported that RMHP may consider additional supplemental questions for CHP+ and Medicaid surveys to further investigate these findings, but that no final decision about action had been made. The CHP+ CAHPS action plan stated that RMHP “will continue to monitor reported member satisfaction with the CHP+ product and will continue to dialogue with the State.” The 2012 QI annual report (most recent available) demonstrated that an analysis of both Medicaid and CHP+ CAHPS results was reported to the QI Committee.</p>		
<p>Required Actions: RMHP must develop and implement a specific action plan for the three measures in the CHP+ CAHPS survey that performed below the 50th percentile.</p>		



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Medicaid:					
Results for Standard II—Access and Availability					
Total	Met	=	<u>19</u>	X	1.00 = <u>19</u>
	Partially Met	=	<u>2</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>1</u>	X	NA = <u>0</u>
Total Applicable		=	<u>21</u>	Total Score	= <u>19</u>

Total Score ÷ Total Applicable			=	<u>90%</u>
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CHP+:					
Results for Standard II—Access and Availability					
Total	Met	=	<u>19</u>	X	1.00 = <u>19</u>
	Partially Met	=	<u>2</u>	X	.00 = <u>0</u>
	Not Met	=	<u>1</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>0</u>
Total Applicable		=	<u>22</u>	Total Score	= <u>19</u>

Total Score ÷ Total Applicable			=	<u>86%</u>
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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
 FY 2013–2014 Denials Record Review Tool
 for Rocky Mountain Health Plans (CHP+)*

Review Period:	January 1, 2013–December 31, 2013
Date of Review:	January 7, 2014
Reviewer:	Barbara McConnell
Participating Plan Staff Member:	Sandy Dowd, Carol Ann Hendrikse, Heather Carwin , Tammy Tway

Requirement	File 1	File 2	File 3	File 4	File 5
1. Member ID	*****	—	*****	*****	*****
2. Date of initial request	NA	—	4/2/13	NA	NA
3. What type of denial? (termination [T], new request [NR], or claim [CL])	CL	—	NR	CL	CL
4. Standard (S) or Expedited (E)	S	—	S	S	S
5. Date notice of action sent	8/22/13	—	4/9/13	11/27/13	5/1/13
6. Notice sent to provider and member? (C or NC)	C	—	C	C	C
7. Number of days for decision/notice	NA	—	7	NA	NA
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	—	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	—	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	—	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	—	NA	N	NA
10. Notice of Action includes required content? (C or NC)	NC	—	NC	NC	NC
11. Authorization decision made by qualified clinician? (C or NC, or NA)	NA	—	C	NA	NA
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	—	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	—	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	NC	—	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	—	C	C	NC
Total Applicable Elements	5	—	6	5	5
Total Compliant Elements	3	—	5	4	3
Score (Number Compliant / Number Applicable) = %	60%	—	83%	80%	60%

C = Compliant; NC = Not Compliant (scored items)
 Y= Yes; N = No (Not a scored item—informational only)

NA = Not Applicable
 Cal = Calendar; Bus = Business



Appendix B. Colorado Department of Health Care Policy and Financing
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for Rocky Mountain Health Plans (CHP+)

Requirement	File 6	File 7	File 8	File 9	File 10
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	NA	NA	NA	NA	NA
3. What type of denial? (termination [T], new request [NR], or claim [CL])	CL	CL	CL	CL	CL
4. Standard (S) or Expedited (E)	S	S	S	S	S
5. Date notice of action sent	6/12/13	1/24/13	2/13/13	3/28/13	11/27/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	NA	NA	NA	NA	NA
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	NC	NC	NC	NC	NC
11. Authorization decision made by qualified clinician? (C or NC, or NA)	NA	NA	NA	NA	
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	NC	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	NC	NC	C	C	C
Total Applicable Elements	5	5	5	5	5
Total Compliant Elements	3	2	4	4	4
Score (Number Compliant / Number Applicable = %)	60%	40%	80%	80%	80%

C = Compliant; NC = Not Compliant (scored items)
 Y = Yes; N = No (Not a scored item—informational only)

NA = Not Applicable
 Cal = Calendar; Bus = Business



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Rocky Mountain Health Plans (CHP+)

Requirement	OS 1	OS 2	OS 3	OS 4	OS 5
1. Member ID	*****				
2. Date of initial request	NA				
3. What type of denial? (termination [T], new request [NR], or claim [CL])	CL				
4. Standard (S) or Expedited (E)	S				
5. Date notice of action sent	11/20/14				
6. Notice sent to provider and member? (C or NC)	C				
7. Number of days for decision/notice	NA				
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C				
9. Was authorization decision timeline extended? (Y or N)	N				
a. If extended, extension notification sent to member? (C or NC, or NA)	NA				
b. If extended, extension notification includes required content? (C or NC, or NA)	NA				
10. Notice of Action includes required content? (C or NC)	NC				
11. Authorization decision made by qualified clinician? (C or NC, or NA)	NA				
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA				
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA				
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C				
15. Was correspondence with the member easy to understand? (C or NC)	C				
Total Applicable Elements	5				
Total Compliant Elements	4				
Score (Number Compliant / Number Applicable = %)	80%				

C = Compliant; NC = Not Compliant (scored items)
 Y= Yes; N = No (Not a scored item—informational only)

NA = Not Applicable
 Cal = Calendar; Bus = Business

Total Record Review Score	Total Applicable Elements: 51	Total Compliant Elements: 36	Total Score: 71%
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Comments:

Records #1, 4, 5, 6, 7, 8, 9, 10 and Oversample 1 (OS1) included appeal rights information in the notice of action (NOA) that was based on Division of Insurance (DOI) information and did not incorporate CHP+ requirements, such as the CHP+ time frames for filing an appeal and State fair hearing information.

Record #1: The letter stated that the member was responsible for paying for the medication due to untimely filing. The member had sent pharmacy receipts requesting a reimbursement. Untimely filing is not an acceptable criterion for denying payment under the CHP+ benefit plan.

Record #2: This record was removed from the sample as it was a denial due to the member's ineligibility for CHP+ at the time of the service. The first oversample record was reviewed in its place.

Record #3: The incorrect appeal rights attachment was included with this NOA. The attachment was titled "Grandfathered Group Plan Information for Commercial Members." The information was not applicable for the CHP+ population and therefore did not include the required CHP+ appeal and State fair hearing information.

Records #5, 6, and 7: These claims denial letters included either "Not a Covered Benefit" or "Not a Covered Service" in each of the following three fields: Claim Received For, We Will Not Pay For, and Because. This made the letters confusing and did not explain to the member what was being denied.

Record #7: Upon review of the claims system, staff members determined that the service denied was family counseling. The RMHP staff member was able to access the State's system and determine that the service was covered under the CHP+ benefit package, and then accessed RMHP's system and determined that this system was configured—in error—to deny family counseling services as noncovered services.

Record #10: The denial was for medications dispensed at a physician's office because the drug had to be dispensed by a pharmacy to be covered by the plan. The denial letter stated the reason as "Not a Benefit" rather than explaining to the member how to obtain the prescription and have it covered.



*Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Rocky Mountain Health Plans (Medicaid)*

Review Period:	January 1, 2013–December 31, 2013
Date of Review:	January 7, 2014
Reviewer:	Katherine Bartilotta
Participating Plan Staff Member:	Sandy Dowd, Carol Ann Hendrikse, Heather Carwin, Tammy Tway

Requirement	File 1	File 2	File 3	File 4	File 5
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	1/17/13	6/7/13	—	4/25/13	4/9/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR Pharm	NR Pharm	—	NR Service	NR Service
4. Standard (S) or Expedited (E)	S	S	—	E	S
5. Date notice of action sent	1/30/13	6/10/13	—	4/26/13	4/18/13
6. Notice sent to provider and member? (C or NC)	C	C	—	C	C
7. Number of days for decision/notice	13	3	—	1	9
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	NC	C	—	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	—	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	—	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	—	NA	NA
10. Notice of Action includes required content? (C or NC)	C	C	—	NC	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	—	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	—	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	—	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	—	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	—	NC	C
Total Applicable Elements	6	6	—	6	6
Total Compliant Elements	5	6	—	4	6
Score (Number Compliant / Number Applicable) = %	83%	100%	—	67%	100%

C = Compliant; NC = Not Compliant (scored items)
Y = Yes; N = No (Not a scored item—informational only)

NA = Not Applicable
Cal = Calendar; Bus = Business



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Rocky Mountain Health Plans (Medicaid)

Requirement	File 6	File 7	File 8	File 9	File 10
1. Member ID	*****	*****	*****	*****	*****
2. Date of initial request	NA	NA	NA	NA	NA
3. What type of denial? (termination [T], new request [NR], or claim [CL])	CL	CL	CL	CL	CL
4. Standard (S) or Expedited (E)	S	S	S	S	S
5. Date notice of action sent	9/3/13	7/23/13	6/11/13	9/24/13	3/12/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	NA	NA	NA	NA	NA
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	C	C	C	C	NC
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	NA	NA	NA	NA
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	C	NA	NA	C	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	NC	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	NC	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	NC	C	C
Total Applicable Elements	7	5	6	6	5
Total Compliant Elements	7	5	4	5	4
Score (Number Compliant / Number Applicable = %)	100%	100%	67%	83%	80%

C = Compliant; NC = Not Compliant (scored items)
 Y = Yes; N = No (Not a scored item—informational only)

NA = Not Applicable
 Cal = Calendar; Bus = Business



Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Rocky Mountain Health Plans (Medicaid)

Requirement	OS 1	OS 2	OS 3	OS 4	OS 5
1. Member ID	*****				
2. Date of initial request	10/4/13				
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR Pharm				
4. Standard (S) or Expedited (E)	S				
5. Date notice of action sent	10/7				
6. Notice sent to provider and member? (C or NC)	C				
7. Number of days for decision/notice	3				
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C				
9. Was authorization decision timeline extended? (Y or N)	N				
a. If extended, extension notification sent to member? (C or NC, or NA)	NA				
b. If extended, extension notification includes required content? (C or NC, or NA)	NA				
10. Notice of Action includes required content? (C or NC)	C				
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C				
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA				
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA				
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C				
15. Was correspondence with the member easy to understand? (C or NC)	NC				
Total Applicable Elements	6				
Total Compliant Elements	5				
Score (Number Compliant / Number Applicable = %)	83%				

C = Compliant; NC = Not Compliant (scored items)
 Y = Yes; N = No (Not a scored item—informational only)

NA = Not Applicable
 Cal = Calendar; Bus = Business

Total Record Review Score	Total Applicable Elements: 59	Total Compliant Elements: 51	Total Score: 86%
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Comments:

Record #1: The request for services was 1/17/13. While the authorization decision was made on 1/24/13 (within time frame), the notice of action was not sent to the member until 1/30/13.

Record #3: This record was removed from the sample because the request was for duplicate reimbursement. The member was directed to contact the provider for reimbursement since both the health plan and the member had paid the provider. A duplicate payment situation does not constitute a denial of service or payment.

Record #4: The incorrect appeal rights information was attached to the notice of action. The document titled Grandfathered Group Plan Information for Commercial Members contained inaccurate information for Medicaid recipients. Furthermore, the reason for the denial included extensive clinical terminology that would be difficult for a member to understand.

Record #8: The service request was for skilled nursing services. The notice of action stated that the service was “not a Medicaid covered service.” However, those services are provided as a component of hospice care, which is a Medicaid wrap-around benefit. This was not clearly explained in the notice of action. The member should have been informed that, while this service was not covered by RMHP, it could be covered by fee for service Medicaid. The member should have been informed of how to obtain coverage for a wrap-around Medicaid service. The reason for the denial was stated in a code that was inaccurate and therefore confusing and incomplete information.

Record #9: The claim was denied because the provider submitted the claim using a Medicare code. The provider was an out-of-network geriatrician. Rather than issuing the member a denial, this should have been considered a coding issue between the health plan and the provider. The notice of action indicated that the service (annual wellness/preventive care visit) was not a Medicaid covered service, which is inaccurate. The denial of a wellness visit is not consistent with established criteria and the Medicaid benefit plan. In addition, the letter communicated that the member would have to pay for the denied service.

Record #10: The notice of action letter used a 20-day time frame to calculate the date the member appeal was due. The accurate time frame is 30 calendar days. In addition, the reason for denial stated that the member was responsible for paying the provider, which is not permitted under Medicaid rules.

Record #OS1: The notice of action contained excessive clinical terminology that would be difficult for a member to understand.

Methodology

The Department requested that HSAG perform open shopper calls to verify compliance with Medicaid managed care appointment access standards in a sample of provider offices within the **RMHP** network. HSAG developed the methodology for the provider survey and met with the Department to confirm the objectives and the approach that HSAG callers would use. HSAG selected the sample of provider offices from the on-line **RMHP** provider directory. A variety of practice sizes, primary care specialty types, and rural and urban (Grand Junction) geographic locations were selected in order to gather information on variables that may contribute to appointment scheduling processes and results. HSAG developed numerous hypothetical scenarios that represented urgent, symptomatic nonurgent, and well-visit appointment types. HSAG callers tested a cross section of appointment types using a call guide that instructed callers on the specific hypothetical scenarios they would use and that ensured an adequate sample of each type of appointment was tested. Callers made one call to each of the selected independent practices and two calls to each of the FQHCs in the provider network sample.

HSAG conducted the provider access survey prior to the **RMHP** site visit. Callers identified themselves upon contact with the practice, described the purpose of the call, and requested to speak with the person who scheduled appointments. They tested multiple call scenarios within a single call and documented the results in an individual call log. The results of the appointment times offered for each hypothetical scenario were evaluated as met/not met using the following appointment standards:

- ◆ Urgently needed services are provided within 48 hours of notification of the primary care physician.
- ◆ Nonurgent health care is scheduled within 30 days.
- ◆ Adult nonsymptomatic well care physical examinations are scheduled within four months.

Summarized results of the survey were shared verbally with **RMHP** during the on-site visit. Results of the survey of each appointment type were considered in the applicable Access and Availability (Standard II) compliance review requirements.

Summary of Results

Successful calls were made to 14 provider offices of various primary care specialties and sizes. Callers were unable to complete the survey successfully in three practices. The profile of practice characteristics included: 10 rural and four urban practices; three pediatrics, seven family medicine, three internal medicine, and two multidisciplinary FQHCs; eight small (one to four physicians), three medium (five to 10 physicians), two large (11 to 15 physicians) practices and the FQHCs. A total of 34 predefined call scenarios representing a cross section of appointment types were tested as follows: seven for urgent care, 10 for nonurgent/symptomatic care, and 17 for well-child/well-adult

visits. The survey confirmed appointment availability within the respective required time frames for 100 percent of the appointments requested.

Because all access standards were met in all provider practices, variations in practice size, geographic location, or specialty were not found to be relevant factors in the appointment scheduling processes. However, HSAG reviewers made other observations that were incidental to the survey process. Details of each call can be viewed in the individual call records.

Observations

In two offices, the HSAG caller was informed that the provider is no longer accepting new Medicaid patients, but is still seeing existing Medicaid clients. The reviewers confirmed that the on-line **RMHP** provider directory accurately reflected this information.

In two cases, HSAG callers were unable to locate the provider due to inaccurate information in the on-line **RMHP** provider directory. In one case, HSAG was informed that the provider was no longer practicing and the provider directory listed the local hospital number as the office number. In the second example, the provider directory listed a hospice program number as the physician's family practice office number.

In seven practices (five rural and two in Grand Junction), the front office schedulers were hesitant to speak with the reviewers and referred the call to a supervisor. It was unclear what the reason was for this process, or whether the referral of calls to someone other than the daily scheduler impacted the results of the survey.

One small rural practice refused to cooperate with the survey, citing time constraints, and did not accept an alternative time to complete the call.

The completed open shopper call logs begin on page C-5.

Scripts for Appointment Access Calls

Introduction

Hello. My name is _____. I am calling on behalf of Health Services Advisor Group. We are doing a study for the Colorado Medicaid program, and would like to get some information on your scheduling process.

Ask for name/position (i.e. scheduler, receptionist, nurse, etc.)

I would like to give you two hypothetical scenarios of someone calling for an appointment, and would like to know the appointment time that you would offer this person.

Urgent Scenarios

1. (Adult): A 32-year-old woman on Medicaid describes that she has had some abdominal pain, burning when urinating, and has some pink color in her urine. What is the appointment time you can offer her? (What if this were a child?)
2. (Child): A mother describes that her daughter got a big cut on her leg while playing at school. It has been several days, and the leg is still painful and swollen and kind of oozy. They have Medicaid. What is the appointment time you would offer her? (Adult: A 60-year-old woman says that she banged into something, and has a big cut on her lower leg that is painful and swollen/red, and kind of oozy).
3. (Child): A mother with a 24-month-old states that the child has a wet cough, is very fussy, is not sleeping, and feels feverish. They have Medicaid. What is the appointment time that you would offer the mother?
4. (Adult): A 45-year-old man on Medicaid is complaining of stomach pain, vomiting, and diarrhea, and can't even keep fluids down. What is the appointment time you would offer this man? (Child: An 8-year-old child is complaining of the same symptoms).

Non-urgent Scenarios

1. (Adult): A 55-year-old man on Medicaid has a large bruise on his thigh and reports a lot of on-and-off aching in his leg over several days. Says ibuprofen is not helping, and would like the doctor to see him and prescribe something else. What is the appointment time you would offer? (What if this were a child?)
2. (Adult): A 40-year-old woman on Medicaid describes that she tweaked her back lifting something and it is really stiff. It has been about four days and she can't sleep very well. She would like to have the doctor evaluate her back. When can she get an appointment?
3. (Child): Mother states that her son woke up with a sore throat and a snuffle and a slight fever and is really miserable. They have Medicaid. When would she be offered an appointment? (What is this were an adult)
4. (Child): Mother describes that her teenage daughter has had watery eyes and sneezing for several days, and she thinks she may have allergies. They have Medicaid. What is the first appointment available for her? (What if this were an adult?)
5. (Child): Mother describes that her 10-year-old has seemed really tired and complains that he doesn't "feel good." There is no fever or pain, but she says he doesn't eat much, and he is always thirsty and drinks lots of water. She wants to have someone evaluate what is going on. They have Medicaid. When could she get an appointment for her son? (Adult: 30-year-old calls with same symptoms).
6. (Adult): A 30-year-old woman on Medicaid sees doctor on periodic basis for her asthma. She says she is doing OK most of the time, but needs to schedule an appointment to talk to the

doctor. When is the next available appointment for her? (Child: Same circumstances, but is an 8-year-old child).

7. (Adult): A 50-year-old man on Medicaid calls to set up an initial appointment because he just moved to town, and his other doctor told him to get set up with someone right away to monitor his diabetes and high blood pressure. What is the appointment time available for him?
8. (Adult): A 50-year-old man on Medicaid describes that he has ongoing back problems and on-and-off pain. He has been doing some physical therapy and taking medication, but would like to have the doctor re-evaluate him. What is the first appointment you could offer him?
9. (Adult): A 35-year-old woman on Medicaid states that she thinks she may be pregnant, and has had “all the symptoms” for a couple of months. When can she get an appointment? (Child: What if this were a 15-year-old?)

Well-child

1. Mother calls and says her Medicaid handbook said that her son is supposed to have a well-child exam under the EPSDT program. (He is 7 years old and hasn't had a physical exam since he was around 4). When can you get her an appointment for that?
2. Mother states that she received a card in the mail that her 2-year-old daughter needs some immunizations and should have a physical exam. They have Medicaid. When can she get an appointment?
3. Mother calls and states she would like to have her 16-year-old daughter have a physical and possibly get birth control. They have Medicaid. What is the appointment time that you could offer to her?

Well-adult

1. A 60-year-old female on Medicaid states she got a card in the mail that it is time for her annual physical. What is the appointment time that you offer?
2. A 50-year-old male on Medicaid needs an annual physical for his work. When can he get an appointment?
3. Any Medicaid adult calls and just states he/she would like an appointment for a physical—has not had one in three years. When can he or she get an appointment?

Call # 1

Name of Provider/Clinic: Craig FQHC **Phone Number:** 970.824.8233

Person who made call: Rachel Henrichs

Person you spoke with: K

Call Date: November 7, 2013 **Time:** 3:40 p.m.

Type of Appointment Requested:

Non urgent (Scenario 9)

Well-child/well-adult exam

Date and Time Appointment Offered (nonurgent scenario): No appointment needed for a pregnancy test. If pregnancy was confirmed, several appointments were available on November 9, 2013.

Date and Time Appointment Offered (well-child or adult): 3 p.m. on November 8, 2013.

Reviewer's Comment:

The reviewer read Scenario 9 and asked for the next available appointment. K said that I could just walk in for a pregnancy test. If it's positive they would schedule an appointment for me within a couple days. She said, "That's the way it's usually done." The reviewer asked her about well-child appointments and adult annual exams. She said, probably next week. I asked, "What day next week? What is the next available appointment?" She said, actually, we had a cancellation and I can get you in tomorrow at 3.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Multiple specialties

Geographic Location: Rural (Craig)

Size of Practice: Large (FQHC)

Call # 2**Name of Provider/Clinic:** Craig FQHC **Phone Number:** 970.824.8233**Person who made call:** Katherine Bartilotta**Person you spoke with:** B**Call Date:** November 15, 2013 **Time:** 9:30 a.m.**Type of Appointment Requested:**

Nonurgent (Scenario 5)

Well- adult exam (Scenario 5)

Date and Time Appointment Offered (nonurgent scenario): November 15, 2013, at 2:45 p.m.**Date and Time Appointment Offered (well-child or adult):** November 15, 2013, at 12:45 p.m. if an existing patient, 1:45 p.m. if patient has never been seen in this clinic.**Reviewer's Comment:**

The reviewer called three times. The first two times she was transferred to voice mail for the person responsible for Medicaid eligibility. The third time, after the reviewer explained who she was and the reason for her call, the front office person said, "Oh, I can help you with that." The reviewer described the nonurgent scenario and was offered an appointment time the same day. When the reviewer described the annual physical scenario, B asked whether the caller was an existing patient or a new patient. The reviewer asked if it made a difference, and she said it could, based on the time available in the schedule. However, several providers were available, so a same-day appointment was available for an existing or a new patient.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Multiple specialties.**Geographic Location:** Rural (Craig)**Size of Practice:** Large (FQHC)

Call # 3

Name of Provider/Clinic: Nederveld **Phone Number:** 970.248.5880

Person who made call: Katherine Bartilotta

Person you spoke with: K

Call Date: November 14, 2013 **Time:** 10:00 a.m.

Type of Appointment Requested:

Urgent (Scenario 4)

Well-child/well-adult exam (Scenario 5)

Date and Time Appointment Offered (urgent scenario): November 14, 2013, at 1:00 p.m.

Date and Time Appointment Offered (well-child or adult): December 3, 2013, at 7:20 a.m.

Reviewer's Comment:

K explained that the office was no longer accepting new Medicaid patients, so the reviewer said for her to assume she was an existing patient. K stated they had certain spots reserved in each doctor's schedule for well-adult physicals, so the reviewer asked for an appointment with Dr. Nederveld. The reviewer confirmed that the provider directory posted on the RMHP Web site reflected that the doctor was no longer accepting Medicaid.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Internal medicine

Geographic Location: Urban (Grand Junction)

Size of Practice: Small (one provider)

Call # 4

Name of Provider/Clinic: Steamboat Springs FQHC **Phone Number:** 970.879.1632

Person who made call: Katherine Bartilotta

Person you spoke with: M

Call Date: November 14, 2013 **Time:** 2:20 p.m.

Type of Appointment Requested:

Urgent adult (Scenario 4) and urgent child (Scenario 4)

Well-child (Scenario 3)

Date and Time Appointment Offered (urgent scenario): See comments for explanation

Date and Time Appointment Offered (well-child or adult): November 19, 2013, at 2:00 p.m.

Reviewer's Comment:

The reviewer called at 11:30 a.m. and got a voice mail recording that said to leave a number and someone would return the call. She did not leave a message.

The reviewer called again at 2:20 and talked to "one of many" schedulers. She read the urgent scenario and the scheduler said she would normally refer such a situation to her triage nurse. After talking to the patient, the triage nurse would schedule a same-day appointment. The scheduler explained that this process would apply for both children and adults. Next, the scheduler offered an appointment time for the well-child scenario.

Did appointment offered meet standard? Nonurgent: Yes
Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Multiple specialties

Geographic Location: Rural (Steamboat Springs)

Size of Practice: Large (FQHC)

Call # 5

Name of Provider/Clinic: Rebecca Tolby **Phone Number:** 970.241.7484

Person who made call: Katherine Bartilotta

Person you spoke with: S

Call Date: November 14, 2013 **Time:** 9:30 a.m.

Type of Appointment Requested:

Urgent adult (Scenario 1)

Well-adult exam (Scenario 4)

Date and Time Appointment Offered (urgent scenario): November 14, 2013, at 3 p.m.

Date and Time Appointment Offered (well adult): November 15, 2013, at 11:20 a.m.

Reviewer's Comment: None

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Internal medicine

Geographic Location: Urban (Grand Junction)

Size of Practice: Small (one provider)

Call # 6**Name of Provider/Clinic:** Delta Pediatrics **Phone Number:** 970.874.3191**Person who made call:** Katherine Bartilotta**Person you spoke with:** K on November 14 and M and B on November 15, 2013**Call Date:** November 14 and November 15, 2013 **Time:** 10:15 a.m. and 9:45 a.m. (respectively)**Type of Appointment Requested:**

Nonurgent (Scenario 4)

Well-child (Scenario 1)

Date and Time Appointment Offered (nonurgent scenario): November 15, 2013, at 1:45 p.m.**Date and Time Appointment Offered (well-child or adult):** November 18, 2013, at 2:45 p.m.**Reviewer's Comment:**

The reviewer called the office on November 14. The scheduler was very pleasant, but thought it would be better if I spoke with the office manager, who had just gone across the street to the hospital. She asked if she could call back after speaking with office manager. The scheduler did not call back before the end of the day.

The reviewer called again on November 15. The call was answered by a different scheduler than day before. She said the reviewer should talk to someone who could help me better and transferred me to a number that did not answer. The reviewer called back and was transferred to B, who was very cooperative. B said she did not usually do scheduling but checked appointment availability on computer for scenarios I gave her. For the nonurgent scenario, she explained that they try to get person in on the same day, depending on availability of physician. The reviewer asked for any available physician and was offered an appointment for later the same day. For the well-child exam, B stated she would align the patient with the person's normal physician, and said the first available physician for a well-child exam was in three days.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Pediatrics**Geographic Location:** Rural (Delta)**Practice Size:** Small (two providers)

Call # 7**Name of Provider/Clinic:** Susan Bright **Phone Number:** 970.874.577**Person who made call:** Rachel Henrichs**Person you spoke with:** A**Call Date:** November 11, 2013 **Time:** 2:10 p.m.**Type of Appointment Requested:**

Urgent (Scenario 2)

Well-child/well-adult exam (Scenarios 3 and 4)

Date and Time Appointment Offered (urgent scenario): November 11, 2013, at 3 p.m.**Date and Time Appointment Offered (well-child or adult):** November 18, 2013—multiple appointments available**Reviewer's Comment:**

A answered the phone and said she is the person who schedules appointments. The reviewer told her who she was and why she was calling. A put the reviewer on hold for a few minutes, then came back and said she could help me. The reviewer read the first scenario—child has two-day old cut that is swollen, red, and oozy—and asked for the next available appointment. A said it depended on who the child's PCP was. She said they try to keep patients with their PCP as much as possible. I told her to pick any doctor. She said she had two of the eight doctors available "today" at 3. The reviewer asked for an appointment with Dr. Bright to get a physical for a teenage girl. A said Dr. Bright was available on November 18 in the morning or the afternoon. Those same appointments are available for an annual exam for a 60-year-old woman.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Family medicine**Geographic Location:** Rural (Delta)**Practice Size:** Medium (eight providers)

Call # 8

Name of Provider/Clinic: Elizabeth Buisker **Phone Number:** 970.878.4014

Person who made call: Rachel Henrichs

Person you spoke with: M and C

Call Date: November 11, 2013 **Time:** 10:45 a.m.

Type of Appointment Requested:

Nonurgent (Scenario 6)

Well-child/well-adult exam (Scenario 6)

Date and Time Appointment Offered (nonurgent scenario): November 12, 2013, at 10 a.m.

Date and Time Appointment Offered (well-child or adult): November 12, 2013, at 10 a.m.

Reviewer's Comment:

M answered the phone. The reviewer asked M if she could schedule appointments and she answered yes. The reviewer explained who she was and why she was calling. M said that she was still in training and suggested that the reviewer speak with C. C said that, depending on which doctor the caller wanted to see, she could schedule an asthma medication review as early as 10 "tomorrow" regardless of whether the appointment was for a child or adult. She said they usually schedule that type of appointment three to four days out. The reviewer asked about an annual exam for an adult. C asked, "male or female?" The reviewer answered female and C said she had an appointment at 10 the next morning. She said that, depending on the doctor, they could schedule annual exams within a few days.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Family medicine

Geographic Location: Rural (Meeker)

Practice Size: Small (four providers)

Call # 9

Name of Provider/Clinic: Claudia Jantzer/Grand Junction Pediatrics **Phone Number:** 970.243.5437

Person who made call: Rachel Henrichs

Person you spoke with: On November 11, caller spoke to C and M and left a message for K. On November 14, caller spoke to Y and left a voice mail message for K.

Call Date: November 11 and November 14, 2013 **Time:** 9:45 a.m. and 2:30 p.m., respectively

Type of Appointment Requested:

Urgent (Scenario 3)

Well-child/well-adult exam (Scenario 1)

Date and Time Appointment Offered (nonurgent scenario):

Date and Time Appointment Offered (well-child or adult):

Reviewer's Comment:

After the reviewer explained who she was and why she was calling, C transferred her to M, then M transferred her to K's voice mail. The reviewer left a message, but did not receive a call back by the end of the day. The reviewer called again on November 14 and spoke to Y, who said the reviewer needed to speak with the office manager. Y transferred the reviewer to K's voice mail. The reviewer left a second message for K. K did not return the telephone call.

Did appointment offered meet standard? Nonurgent: Unable to reach

Well exam: Unable to reach

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Pediatrics

Geographic Location: Urban (Grand Junction)

Practice Size: Large (15 providers)

Call # 10**Name of Provider/Clinic:** David West**Phone Number:** 970.244.2874**Person who made call:** Katherine Bartilotta**Person you spoke with:** See comments section**Call Date:** November 14, 2013**Time:** 9:45 a.m.**Type of Appointment Requested:**

Nonurgent (Scenario 8)

Well-child exam (Scenario 3)

Date and Time Appointment Offered (nonurgent scenario):**Date and Time Appointment Offered (well-child or adult):****Reviewer's Comment:**

The first telephone number called (as listed in the RMHP provider directory) was for a hospice program. The person who answered stated that Dr. West was the medical director. The reviewer said she was trying to schedule a regular family medicine appointment with him, and the person at hospice stated that would be a different number. (The reviewer confirmed that the number and address listed for Dr. West in the RMHP directory is incorrect.) The reviewer went online to try to locate a number for Dr. West's family practice office (not through provider directory). The second telephone number she called was answered by an automated voice message saying the caller had reached the St. Mary's Family Practice Residency program. The third number was answered by a confidential voice mail for the hospitalist program. The reviewer called the second number again (family practice residency) and left a message that she was trying to schedule an appointment with Dr. West, whose name she got from the insurer's provider directory. The reviewer never received a return call and never did locate Dr. West or his family practice office, or make contact with anyone who could schedule an appointment.

Did appointment offered meet standard? Nonurgent: Unable to reach

Well exam: Unable to reach

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Family medicine**Geographic Location:** Urban (Grand Junction)**Practice Size:** Small (four providers)

Call # 11

Name of Provider/Clinic: St. Mary Family Medicine (C. Dorman) **Phone Number:** 970.298.2800

Person who made call: Rachel Henrichs

Person you spoke with: J

Call Date: November 11, 2013 **Time:** 9:50 a.m.

Type of Appointment Requested:

Nonurgent (Scenario 5)

Well-child/well-adult exam

Date and Time Appointment Offered (nonurgent scenario): November 11 or 12—several options

Date and Time Appointment Offered (well-child or adult): December 4 or December 5—several options

Reviewer's Comment:

The reviewer spoke to J. She said that annual exams are generally scheduled two to three months out, depending on the doctor. Since it's a residency, the doctors are only in the office part-time. The reviewer asked for the earliest available time and J said she had appointments for well exams on December 4 and 5. When presented with the nonurgent Scenario 5, J said the child could be seen either today or tomorrow.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Family Medicine

Geographic Location: Urban (Grand Junction)

Practice Size: Large (15 providers)

Call # 12

Name of Provider/Clinic: Kent Gaylord

Phone Number: 970.728.3848

Person who made call: Rachel Henrichs

Person you spoke with: C

Call Date: November 11, 2013

Time: 2 p.m.

Type of Appointment Requested:

Nonurgent (Scenario 4)

Well-child/well-adult exam (Scenario 2)

Date and Time Appointment Offered (nonurgent scenario): November 12, 2013, at 9:30 a.m.

Date and Time Appointment Offered (well-child or adult): November 14, 2013, at 8:10 or 9:50 a.m.

Reviewer's Comment: None

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Family medicine

Geographic Location: Rural (Telluride)

Practice Size: Small (one provider)

Call # 13**Name of Provider/Clinic:** David Johansen **Phone Number:** 970.243.3300**Person who made call:** Rachel Henrichs**Person you spoke with:** C and D**Call Date:** November 11, 2013 **Time:** 10:15 a.m.**Type of Appointment Requested:**

Nonurgent (Scenario 7)

Well-child/well-adult exam (Scenario 5)

Date and Time Appointment Offered (nonurgent scenario): November 21, 2013**Date and Time Appointment Offered (well-child or adult):** November 14, 2013**Reviewer's Comment:**

C said she was new and would prefer that the reviewer speak with D. The reviewer explained to D the reason why she was calling and asked for an appointment to get a physical for work. She said it depended on the doctor—they have five. The reviewer asked D to pick the doctor with the earliest available appointment. D said she had an appointment for a physical on November 14. I read the script for nonurgent Scenario 7. D explained, again, that appointment availability depended on which doctor the caller wanted to see. The reviewer said to assume she is new to the area and that she wants an appointment with the doctor who has the most open schedule. D said they could see me on November 21.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Internal medicine**Geographic Location:** Urban (Grand Junction)**Practice Size:** Medium (five providers)

Call # 14

Name of Provider/Clinic: Mary Mebane **Phone Number:** 970.240.0378

Person who made call: Katherine Bartilotta

Person you spoke with: Scheduler did not give name

Call Date: November 14, 2013 **Time:** 11:25 a.m.

Type of Appointment Requested:

Urgent (Scenario 2 for adult and child)

Well-adult exam (Scenario 4)

Date and Time Appointment Offered (urgent scenario): November 14, 2013, at 3:30 p.m.

Date and Time Appointment Offered (well-child or adult): Two weeks to two months (see comments)

Reviewer's Comment:

The reviewer first called at 10 a.m. and got voice mail asking that she leave a message. The reviewer did not leave a message, but called again at 11:25. The person who answered the phone said that two of the doctors in that office accepted Medicaid members and the other two doctors did not (unless you are an existing patient). Dr. Mebane does not accept Medicaid members. The person who answered the phone said that all new patient appointments require a two-week advance notice for review of patient intake information, and then the office called back to schedule an appointment. The reviewer presented the urgent scenario and was told there was a same-day appointment available. When the reviewer asked for an appointment for a physical, the scheduler stated that it depended on the individual doctor. Dr. Osorio had an appointment available in about two weeks and Dr. Sturgeon had an appointment available in January 2014. The person who answered the phone said she was very busy with two calls on hold, so the reviewer discontinued the conversation.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Family medicine

Geographic Location: Rural (Montrose)

Practice Size: Small (four providers)

Call # 15

Name of Provider/Clinic: Rangely Family Med (Chris Adams) **Phone Number:** 970.675.5011

Person who made call: Katherine Bartilotta

Person you spoke with: A

Call Date: November 14, 2013

Time: 2:30 p.m.

Type of Appointment Requested:

Nonurgent (Scenario 6 for adult and child)

Well-child exam (Scenario 1)

Date and Time Appointment Offered (urgent scenario):

Date and Time Appointment Offered (well-child or adult):

Reviewer's Comment:

The reviewer called the number listed in the RMHP provider directory for Dr. Chris Adams. The number turned out to be for the hospital. The reviewer said she was trying to schedule an appointment with Dr. Chris Adams. The woman who answered said Dr. Adams was no longer there, but that other people had assumed his practice. She transferred the reviewer to the clinic. A answered the phone and when the reviewer told her why she was calling, A said she would check with the office manager. A returned and said she was told to tell me that they were too busy with patients to go through the scenarios. The reviewer asked what would be a better time to call back, and she said there wasn't one. The reviewer asked, "What if I was a patient calling?" A said, "Then I would schedule you, but we don't have time to go through mock scenarios." They were very uncooperative, and did not offer to call me back at a more convenient time.

The reviewer double-checked the RMHP provider directory and Dr. Chris Adams is still listed in the directory with the hospital's telephone number, rather than the clinic number.

Did appointment offered meet standard? Nonurgent: declined to participate

Well exam: declined to participate

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Family medicine

Geographic Location: Rural (Rangely)

Practice Size: Small (two providers)

Call # 16**Name of Provider/Clinic:** Steamboat Springs FQHC **Phone Number:** 970.879.1632**Person who made call:** Rachel Henrichs**Person you spoke with:** C and S**Call Date:** November 7 and 8, 2013 **Time:** see narrative**Type of Appointment Requested:**

Nonurgent (Scenario 2 for adult and 3 for child)

Well-adult exam (Scenario 4)

Date and Time Appointment Offered (urgent scenario): November 8, 2013, at 3:20 p.m.**Date and Time Appointment Offered (well-child or adult):** November 8, 2013, at 3:20 p.m.**Reviewer's Comment:**

The reviewer called the office on November 7 at 3:45 p.m. and explained to C why she was calling. C said she needed to speak with S and she transferred the reviewer to S's voice mail. S called back on November 8 at 1:27 p.m. After the reviewer told her why she was calling, S said she needed to speak with someone at the front desk. S explained they were very busy right now, but that she would have someone call me after things settled down. C called me at 2:45 p.m. She acknowledged that we spoke "yesterday" and reminded the reviewer that she needed to speak with S. The reviewer convinced C to listen to the full scenarios and read a nonurgent script. C said they could see me "today at 3:20." The reviewer read another nonurgent script and C repeated that they could see me "today at 3:20." The reviewer also asked for an annual exam for an adult. C repeated that they could see me "today at 3:20." The reviewer asked C if they prioritized appointments based on need, or was it a "first-come first-served" clinic. She said some things are walk-in, but that you do need an appointment for some things. At this point, she became flustered and said the reviewer needed to speak with S (a different person than the first S), who was not available at the moment. The reviewer left a voice mail message for S, but she never returned her call.

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Multiple specialties**Geographic Location:** Rural (Steamboat Springs)**Practice Size:** FHQC

Call # 17

Name of Provider/Clinic: Thomas Waird

Phone Number: 970.249.2421

Person who made call: Rachel Henrichs

Person you spoke with: C

Call Date: November 11, 2013

Time: 10:30 a.m.

Type of Appointment Requested:

Nonurgent (Scenario 4)

Well-adult exam (Scenario 2)

Date and Time Appointment Offered (nonurgent scenario): November 11, 2013, at 3 p.m.

Date and Time Appointment Offered (well-child or adult): November 12, 2013—several options

Reviewer's Comment: None

Did appointment offered meet standard? Nonurgent: Yes

Well exam: Yes

Practice Specialty (Pediatric, Family Medicine, Internal Medicine): Pediatrics

Geographic Location: Rural (Montrose)

Practice Size: Medium (five providers)

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

Table D-1 lists the participants in the FY 2013–2014 site review of **RMHP**.

Table D-1—HSAG Reviewers and Health Plan Participants	
HSAG Review Team	Title
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
RMHP Participants	Title
Jill Bystol	Compliance Coordinator, Quality Improvement
Heather Carwin	Clinical Pharmacist
Mary Lynn Dittmer	Member Benefit Admin—Supervisor
Sandy Dowd	Case Management Director
Candace Duran	Quality Assurance Manager—RMHP
Judi Everett	Claims Manager
Nora Foster	Customer Service
Patrick Gordon	Associate Vice President
Carol Ann Hendrikse	Care Management—Manager
Jackie Hudson	Senior Manager, Quality Improvement
Rhonda Ingram	Claims Operations Manager
David Klemm	Manager Government Programs
Marci O’Gara	Customer Service Director
Dale Renzi	Director—Provider Network Management
Bethany Smith	Provider Relations Manager
Sharon Steadman	Consultant
Kelli Steinkirchner	Provider Relations
Tammy Tway	Care Management—Operations Supervisor
Department Observers	Title
Russell Kennedy	Quality and Health Improvement Unit
Teresa Craig (telephonically)	CHP+ Contract Manager
Jeremy Sax (telephonically)	Medicaid Managed Care Contract Manager

Appendix E. Corrective Action Plan Template for FY 2013–2014 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 E-1—Corrective Action Plan Process	
Step 1	Corrective action plans are submitted
	<p>If applicable, the health plan will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final compliance monitoring site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification to HSAG and the Department. The health plan must submit the CAP using the template provided.</p> <p>For each element 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>
Step 2	Prior approval for timelines exceeding 30 days
	If the health plan is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	Department approval
	<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"> ◆ The plan has been approved and the health plan should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	Documentation substantiating implementation
	Once the health plan has received Department approval of the CAP, the health plan should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	Progress reports may be required
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the health plan to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

Table E-1—Corrective Action Plan Process	
Step 6	Documentation substantiating implementation of the plans is reviewed and approved
	<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 health care regulations and managed care contract requirements.</p>

The template for the CAP follows.

Table E-2—FY 2013–2014 Corrective Action Plan for RMHP CHP+ and Medicaid

Standard I—Coverage and Authorization of Services

Requirement	Findings	Required Action
<p>5. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.</p>	<p>The CM program description stated that the chief medical officer and associate medical directors make all denial decisions or modifications in requests for services based upon medical necessity. During the on-site record review, there was one Medicaid case and two CHP+ cases in which the authorization determination did not appear to follow established guidelines:</p> <ul style="list-style-type: none"> ◆ Medicaid: The claim was denied because the provider submitted the claim using a Medicare code. The provider was an out-of-network geriatrician. Rather than issuing the member a denial, this should have been considered a coding issue between the health plan and the provider, with no notice of action to the member triggered. The notice of action (NOA) indicated that the service (annual wellness/preventive care visit) was not a Medicaid-covered service, which is inaccurate. The denial of a wellness visit is not consistent with established criteria and the Medicaid benefit plan. ◆ CHP+: In one record the member received a notice of denial for family counseling. On-site, staff members verified in the State’s system that this service was listed as payable; however, in the RMHP claims system, the service was listed as not a covered benefit. ◆ In addition, in one CHP+ case, the member submitted a pharmacy receipt for reimbursement and payment was denied due to untimely filing. Timely filing requirements must not be applied to member submissions because of potential issues with retroactive eligibility. 	<p>RMHP must:</p> <ul style="list-style-type: none"> ◆ Develop a mechanism to ensure that Medicaid covered services are not denied for payment with NOAs being sent to the member when the issue is a provider coding issue. Per the BBA—Preamble, provider coding issues do not trigger an NOA to the member. ◆ Since it appears that applying Medicaid claims system configuration to the CHP+ claims process may have resulted in denying CHP+ covered services in error, RMHP must evaluate the claims payment configuration against the CHP+ benefit package and the State’s configuration to ensure covered benefits are configured for payment correctly in the RMHP claims payment system. ◆ Perform an audit of 100 percent of CHP+ Medicaid behavioral health claims denials up to 411 claims (whichever number is lower) for consistency of determinations based on the CHP+ contract and the CHP+ benefit package. ◆ Ensure that members are not held liable for untimely filed claims

Table E-2—FY 2013–2014 Corrective Action Plan *for* RMHP CHP+ and Medicaid

Standard I—Coverage and Authorization of Services

Requirement	Findings	Required Action
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table E-2—FY 2013–2014 Corrective Action Plan for RMHP CHP+ and Medicaid

Standard I—Coverage and Authorization of Services

Requirement	Findings	Required Action
<p>13. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member’s health condition requires not to exceed:</p> <ul style="list-style-type: none"> ◆ For standard authorization decisions— 10 calendar days. ◆ For expedited authorization decisions— 3 business days. 	<p>During the on-site interview, staff members reported that this was a typographical error in the policy, and that RMHP’s actual practices ensured that determinations were made within the required time frame. On-site demonstration of RMHP’s authorization tracking system demonstrated that authorization determinations were made well within the required time frames.</p>	<p>RMHP must revise the preauthorization policy to clarify that all authorization decisions will be made within the required time frames as counted from the date of the request from service (10 calendar days for standard requests and three working days for expedited requests), unless extended.</p>
<p>Planned Interventions:</p>		
<p>Person(s)/Committee(s) Responsible and Anticipated Completion Date:</p>		
<p>Training Required:</p>		
<p>Monitoring and Follow-up Planned:</p>		
<p>Documents to Be Submitted as Evidence of Completion:</p>		

Table E-2—FY 2013–2014 Corrective Action Plan for RMHP CHP+ and Medicaid

Standard I—Coverage and Authorization of Services

Requirement	Findings	Required Action
<p>14. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area).</p>	<p>Three of 10 Medicaid denial letters reviewed were not easy to understand. Issues included:</p> <ul style="list-style-type: none"> ◆ Incorrect appeals information included with the letter. ◆ Extensive clinical terminology used without explanation of meaning. ◆ Incorrectly stating that the service was not a Medicaid covered service (rather than stating that the service was not covered under managed care and how the service could be obtained using Medicaid benefits). ◆ Stating that the member must pay for the service. ◆ Four of 10 CHP+ claims denial letters reviewed were not easy to understand. Issues included: ◆ On the claims denial letters, the verbiage “Not a Benefit” or “Not a Covered Service” was entered into each of the following three fields: Claim Received For, We Will Not Pay For, and Because. ◆ In one case the denial was for medications dispensed at a physician’s office because the drug had to be dispensed by a pharmacy to be covered by the plan. The denial letter stated the reason as “Not a Benefit” rather than explaining how the member could obtain the prescription and have it be covered. 	<p>RMHP must ensure that unavoidable clinical language or medical jargon used in denial letters be kept to a minimum and explained to the member wherever possible, striving for 6th grade reading level. In addition, RMHP must ensure that claims denials clearly state the service being denied and provide complete and accurate information regarding appeal rights so that members may know how to obtain services covered under Medicaid but not under the managed care contract. RMHP must remove any language from letters that indicates that members will be held liable for payment of Medicaid services (unless the conditions are met that allow members to pay for services—i.e., written agreement with the provider to receive noncovered or out-of-network services available in the network).</p>

Planned Interventions:

Person(s)/Committee(s) Responsible and Anticipated Completion Date:

Training Required:

Monitoring and Follow-up Planned:

Documents to Be Submitted as Evidence of Completion:

Table E-2—FY 2013–2014 Corrective Action Plan for RMHP CHP+ and Medicaid

Standard I—Coverage and Authorization of Services

Requirement	Findings	Required Action
<p>15. Notices of action must contain:</p> <ul style="list-style-type: none"> ◆ The action the Contractor (or its delegate) has taken or intends to take. ◆ The reasons for the action. ◆ The member’s authorized representative’s, and provider’s (on behalf of the member) right to file an appeal and procedures for filing. ◆ The date the appeal is due. ◆ The member’s right to a State fair hearing. ◆ The procedures for exercising the right to a State fair hearing. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member’s right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). 	<p>The Medicaid and CHP+ template denial letters with the appeal information insert included all of the components. However, several NOAs that were reviewed on-site did not consistently contain all of the required information. There were several versions of the NOA used in practice. The appeal rights attachment was used in some cases and appeal rights were included in the body of the letter in others. One of 10 Medicaid letters was not compliant with the content requirements because the incorrect appeal rights information was attached to the letter; therefore, the member was not informed of the correct appeal rights and State fair hearing information. None of the 10 CHP+ letters reviewed was compliant with the NOA content requirements. The reasons were primarily related to providing the member with incorrect information regarding the time frames for filing an appeal and not including the State fair hearing information. (See record review documentation in Appendix B.) On-site, staff members described a recently developed audit process to ensure that the correct NOA template and information is used for pre-service denial notification.</p>	<p>RMHP must evaluate the letters being used for denials of new requests as well as for claims denials in both the CHP+ and Medicaid lines of business, revising processes to ensure that all NOAs (denials) include each of the requirements.</p>
<p>Planned Interventions:</p>		
<p>Person(s)/Committee(s) Responsible and Anticipated Completion Date:</p>		
<p>Training Required:</p>		
<p>Monitoring and Follow-up Planned:</p>		
<p>Documents to Be Submitted as Evidence of Completion:</p>		

Table E-2—FY 2013–2014 Corrective Action Plan for RMHP CHP+ and Medicaid

Standard II—Access and Availability

Requirement	Findings	Required Action
<p>17. The Contractor maintains an effective organizational process for monitoring scheduling and wait times, identifying scheduling and wait time issues that do not comply with its guidelines, and takes appropriate action. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, has mechanisms to monitor providers regularly to determine compliance, and to take corrective action if there is failure to comply.</p>	<p>The PCP and Specialist Member Satisfaction surveys were performed every two years (alternating between the two). The surveys did not collect information by specific type of appointment and did not delineate responses for Medicaid or CHP+. It was therefore not possible for RMHP to determine whether responses were related to Medicaid and CHP+ access standards. The on-site practice quality monitoring tool did not include an evaluation of physician office appointment availability, but did measure compliance with the requirements for Medicaid and CHP+ and was performed every three years. During on-site interviews, staff members stated that secret shopper calls were performed periodically but only on a limited basis, since RMHP does not consider that mechanism effective. Staff members stated that member complaints were the primary source of identifying access or appointment issues, and that significant complaints were followed up with individual physicians. Member complaints were monitored regularly by the Member Experience Advisory Committee (MEAC).</p>	<p>RMHP must implement an effective, systematic process to monitor providers regularly for compliance with specific Medicaid and CHP+ scheduling standards.</p>

Planned Interventions:

Person(s)/Committee(s) Responsible and Anticipated Completion Date:

Training Required:

Monitoring and Follow-up Planned:

Documents to Be Submitted as Evidence of Completion:

Table E-2—FY 2013–2014 Corrective Action Plan for RMHP CHP+ and Medicaid

Standard II—Access and Availability

Requirement	Findings	Required Action
<p>19. The Contractor participates in the State’s efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by:</p> <ul style="list-style-type: none"> ◆ Maintaining policies to reach out to specific cultural and ethnic members for prevention, health education, and treatment for diseases prevalent in those groups. ◆ Maintaining policies to provide health care services that respect individual health care attitudes, beliefs, customs, and practices of members related to cultural affiliation. ◆ Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include: <ul style="list-style-type: none"> ● Inquiries conducted by the Contractor of the language proficiency of members during the Contractor’s orientation calls. ● Being served by participating providers. ● Improving access to health care through community outreach and Contractor publications. ◆ Developing and/or providing cultural competency training programs, as needed, to the network providers and Contractor staff regarding: <ul style="list-style-type: none"> ● Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. 	<p>Results were reported to the MEAC and Quality Improvement Committee. RMHP’s policies and procedures did not address cultural needs beyond linguistic needs and the special needs of members with visual and hearing impairment. While HSAG acknowledges that RMHP had many processes that addressed the culture of poverty, RMHP’s policies and processes did not address cultural values, behaviors, beliefs, diseases, and health care needs associated with other cultures. RMHP also did not have a policy and procedure that addressed compliance with the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.</p>	<p>RMHP must develop policies and procedures that address outreach to specific cultural or ethnic groups for prevention or treatment of diseases prevalent in those groups. It must also develop policies and procedures that address provider training regarding health care attitudes, beliefs, and practices of members affiliated with specific cultures and potential associated health risks. RMHP must also develop policies and procedures that address compliance with the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.</p>

Table E-2—FY 2013–2014 Corrective Action Plan for RMHP CHP+ and Medicaid

Standard II—Access and Availability

Requirement	Findings	Required Action
<ul style="list-style-type: none"> • The medical risks associated with the client population’s racial, ethnic, and socioeconomic conditions. ◆ Making available written translation of Contractor materials, including member handbook, correspondence, and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area. ◆ Developing policies and procedures, as needed, on how the Contractor shall respond to requests from participating providers for interpreter services by a qualified interpreter. This shall occur particularly in service areas where language may pose a barrier so that participating providers can: <ul style="list-style-type: none"> • Conduct the appropriate assessment and treatment of non-English-speaking members (including members with a communication disability). • Promote accessibility and availability of covered services, at no cost to members. ◆ Developing policies and procedures on how the Contractor shall respond to requests from members for interpretive services by a qualified interpreter or publications in alternative formats. ◆ Making a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse, and culturally 		

Table E-2—FY 2013–2014 Corrective Action Plan for RMHP CHP+ and Medicaid

Standard II—Access and Availability

Requirement	Findings	Required Action
<p>competent clinical providers that represent the racial and ethnic communities being served.</p> <ul style="list-style-type: none"> ◆ Providing access to interpretative services by a qualified interpreter for members with a hearing impairment in such a way that it shall promote accessibility and availability of covered services. ◆ Developing and maintaining written policies and procedures to ensure compliance with requirements of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. ◆ Arranging for covered services to be provided through agreements with non-participating providers when the Contractor does not have the direct capacity to provide covered services in an appropriate manner, consistent with independent living, to members with disabilities. ◆ Providing access to Telecommunications Device for the Deaf (TDD) or other equivalent methods for members with a hearing impairment in such a way that it will promote accessibility and availability of covered services. ◆ Making member information available upon request for members with visual impairments, including, but not limited to, Braille, large print, or audiotapes. For members who cannot read, member information shall be available on audiotape 		

Table E-2—FY 2013–2014 Corrective Action Plan for RMHP CHP+ and Medicaid

Standard II—Access and Availability

Requirement	Findings	Required Action
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

The following corrective actions apply only to the CHP+ line of business.

Table E-3—FY 2013–2014 Corrective Action Plan for RMHP CHP+

Standard I—Coverage and Authorization of Services

Requirement	Findings	Required Action
23. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.	The CHP+ member handbook stated that members must send a bill from a nonparticipating hospital to RMHP within 60 days or “RMHP has no obligation to pay for such care.”	RMHP must revise the CHP+ member handbook to remove the statement that RMHP may deny payment of emergency claims for untimely filing.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Table E-3—FY 2013–2014 Corrective Action Plan for RMHP CHP+

Standard II—Access and Availability

Requirement	Findings	Required Action
<p>22. The Contractor develops and implements a corrective action plan for all areas of the CAHPS survey that report a score that is less than the 50th percentile. (CHP+)</p>	<p>The 2013 Medicaid CAHPS results did not report significant levels of dissatisfaction. The 2013 CHP+ CAHPS results fell below the 50th percentile in three areas. During on-site interviews, staff members stated that the MEAC evaluated the 2013 CAHPS results for all lines of business, together with provider satisfaction survey and member grievances, and determined that the CHP+ poor performance results could not be substantiated with any other source of data. Staff members reported that RMHP may consider additional supplemental questions for CHP+ and Medicaid surveys to further investigate these findings, but that no final decision about action had been made. The CHP+ CAHPS action plan stated that RMHP “will continue to monitor reported member satisfaction with the CHP+ product and will continue to dialogue with the State.”</p>	<p>RMHP must develop and implement a specific action plan for the three measures in the CHP+ CAHPS survey that performed below the 50th percentile.</p>

Planned Interventions:

Person(s)/Committee(s) Responsible and Anticipated Completion Date:

Training Required:

Monitoring and Follow-up Planned:

Documents to Be Submitted as Evidence of Completion:

The following corrective actions apply only to the Medicaid line of business.

Table E-4—FY 2013–2014 Corrective Action Plan for RMHP Medicaid

Standard I—Coverage and Authorization of Services

Requirement	Findings	Required Action
<p>16. The notices of action must be mailed within the following time frames:</p> <ul style="list-style-type: none"> ◆ For termination, suspension, or reduction of previously authorized Medicaid/CHP+-covered services, within the time frames specified in 431.211: <ul style="list-style-type: none"> ○ The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214). ◆ For denial of payment, at the time of any action affecting the claim. ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member’s health condition requires but within 10 calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire. ◆ For expedited service authorization decisions, as expeditiously as the member’s health condition requires but within 3 business days after receipt of the request for services. 	<p>The Preauthorization P&P included the appropriate timelines for sending NOAs. Nine of 10 Medicaid records reviewed demonstrated that authorization determinations were made within the required time frames. In one Medicaid record, an NOA was sent 13 days after the request for service.</p>	<p>RMHP must ensure that NOAs are sent within the time frames required by Colorado regulations in 8.209</p>

Planned Interventions:

Person(s)/Committee(s) Responsible and Anticipated Completion Date:

Training Required:

Monitoring and Follow-up Planned:

Documents to Be Submitted as Evidence of Completion:

Appendix F. Compliance Monitoring Review Protocol 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' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table F-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	Establish Compliance Thresholds
	<p>Before the site review to assess compliance with federal health care regulations and managed care contract requirements:</p> <ul style="list-style-type: none"> ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	Perform Preliminary Review
	<ul style="list-style-type: none"> ◆ HSAG attended the Department's Medical Quality Improvement Committee (MQuIC) meetings, and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the health plan in writing of the request for desk review documents via 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 two standards, and on-site activities. Thirty days prior to the review, the health plan provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the health plan's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The health plans also submitted a list of all CHP+ and Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. HSAG used a random sampling technique to select records for review during the site visit. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 3:	Conduct Site Visit
	<ul style="list-style-type: none"> ◆ During the on-site portion of the review, HSAG met with the health plan's key staff members to obtain a complete picture of the health plan's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the health plan's performance. ◆ HSAG reviewed a sample of administrative records to evaluate implementation of managed care regulations related to CHP+ and Medicaid service and claims denials and notices of action.

Table F-1—Compliance Monitoring Review Activities Performed	
For this step,	HSAG completed the following activities:
	<ul style="list-style-type: none"> ◆ Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with health plan staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	Compile and Analyze Findings
	<ul style="list-style-type: none"> ◆ HSAG used the FY 2013–2014 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	Report Results to the State
	<ul style="list-style-type: none"> ◆ HSAG populated the report template. ◆ HSAG submitted the site review report to the health plan and the Department for review and comment. ◆ HSAG incorporated the health plan’s and Department’s comments, as applicable and finalized the report. ◆ HSAG distributed the final report to the health plan and the Department.