COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2018–2019 Site Review Report

for

Rocky Mountain Health Plans

Region 1

April 2019

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Introduction

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

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

Summary of Compliance Results

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

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

Table 1-1—Summary of RAE Scores for Standards

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	12	12	12	0	0	0	100%
IV. Member Rights and Protections	7	7	6	1	0	0	86%
V. Member Information	19	18	15	3	0	1	83%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	8	8	8	0	0	0	100%
Totals	**46**	**45**	**41**	**4**	**0**	**1**	**91%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

RMHP's *Care Coordination Policy and Procedure* defined a comprehensive care management program meeting all Department requirements to assist members with access to needed services. The care management program outlined procedures addressing:

- Access to care coordination 24 hours a day/7 days a week.
- Initial outreach screening and referral to care coordination for comprehensive assessment when indicated.
- Comprehensive assessment of: medical, social, behavioral, developmental, educational, support system, and financial needs.
- Development of a care plan addressing member needs, identified gaps in care, and cultural sensitivity.
- Establishing member goals, and maintaining involvement with member until goals are achieved.
- Establishing a lead coordinator.
- Providing care coordination at the point of care whenever possible—e.g., home, provider office, hospital, care facility.
- Communicating care plan to providers and facilitating provider communications.
- Documentation of assessment, care plan, interventions, and member progress in the Essette care management software (Essette).

RMHP used available claims data and information from intake screenings and comprehensive needs assessments to categorize all members into four levels of potential care coordination interventions as follows: Tier 1—Healthy members/health promotion and prevention; Tier 2—Mitigating emerging risks; Tier 3—Managing outcomes across multiple care settings; Tier 4—Managing multiple chronic illnesses. Stratification methodologies considered medical, behavioral, and social support needs of members. The *Care Coordination Policy and Procedure* defined specific populations targeted for care coordination to include: members stratified in high-risk tiers; inpatient and emergency department transitions; behavioral health (BH) crisis follow-up; pregnancy, diabetes, or pediatric asthma medical conditions; members with SHCN; members identified by the Colorado Overutilization Program (COUP), **RMHP** Drug Safety program, or **RMHP** "Hot-Spotter" program; criminal justice-involved (CJI); foster children; social determinants of health needs.

RMHP's utilization management (UM), care coordination, and customer service staff operations were well integrated within the organizational structure. In addition, 10 integrated care coordination teams (ICCTs) were distributed regionwide to provide care coordination to members in local communities. **RMHP**'s customer service staff conducted an outreach welcome call to all newly enrolled members within 30 to 45 days of enrollment to explain the benefits of the plan, assist members with identifying and changing their assigned primary care medical provider (PCMP), conduct an initial intake screening

of member needs, and identify any continuity-of-care needs for members. **RMHP** received daily files of member health needs surveys conducted by the Department and transferred results into the **RMHP** individual member intake assessment maintained in Essette to prevent duplication of intake screening performed by **RMHP** customer service staff; however, staff reported that the volume of health needs surveys received from the Department had been minimal. **RMHP**'s customer service staff remained available to serve members and providers through the "One-Call Center" and provided ongoing care coordination for Tier 1 members.

All documentation of member-specific care management information, including health needs assessments and service plans, was entered and maintained in Essette, which included all Department-required components. Essette enabled secure sharing of care coordination files among 14 designated health entities, including all community mental health centers (CMHCs), all partner ICCTs, public health departments, large primary care clinics, and others. Staff members confirmed that **RMHP** had a business associate agreement with each participating care coordination partner to protect confidentiality of member information. For providers and organizations unable to directly access Essette, **RMHP** conducted verbal outreach to share assessment and care plan information and provided the information in writing upon request through secure communication channels. Documents and on-site interviews described UM discharge planning, assisting members with transitions of care, and care coordination interaction with other managed care plans, fee-for-service (FFS) providers, and community organizations.

Staff members stated that improved access to BH claims data and to BH providers has made care coordination seamless for members. **RMHP**'s provider network includes numerous practices with embedded behavioral health providers and care coordinators. **RMHP** and Mind Springs Health CMHC have partnered to fund a team of community health workers who provide targeted community-based care coordination to address social determinants of health as well as physical and behavioral needs of members. The RAE provider newsletter communicated that provider incentives were tied to five behavioral health key performance indicators (KPIs).

PCMP and BH provider agreements outlined provider responsibilities for ongoing coordination of services for members, including conducting assessments and developing care plans based on assessments. **RMHP**'s provider agreements, provider manual, and *Behavioral Health RAE Provider Handbook* outlined requirements for maintaining and sharing medical records in a confidential manner in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations. The BH provider handbook described requirements for the BH provider to conduct biopsychosocial needs assessments and develop related treatment plans accordingly. Staff members stated that CMHC intake assessments and related care plans are robust, documented in the Essette system, and audited by the Office of Behavioral Health. **RMHP**'s quality improvement audits of BH independent provider network (IPN) providers included medical record review for required medical record components. PCMP deliberate provider interventions to coordinate services for members were enhanced through information available to providers through the Quality Health Network health information exchange and **RMHP**'s practice transformation program (PTP). The PTP educated providers regarding essential elements of care coordination in transitions of care and in coordination of specialist referrals, promoted care compacts between providers, and had recently expanded to include

compacts with BH providers. Staff stated **RMHP** had implemented a KPI to measure care compacts between providers, including at least one BH entity; and further incented providers to increase levels of care coordination in their practices through PTP tiered payments to providers.

While the Department assigned each RAE member to a PCMP on enrollment, **RMHP** actively monitored monthly PCMP attribution reports received from the Department and worked weekly to confirm and correct inaccurate provider attribution when necessary. **RMHP** matched existing provider electronic medical records data to the attribution list, requested that each practice review its assigned panel of attributed members and correct inaccuracies, and worked with the Department to correct identified inaccuracies.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

RMHP maintained written policies on member rights. Within its policies, **RMHP** delineated the rights and responsibilities for members and included methods for the distribution of these rights to members and providers. Members received information about their rights, including a list of rights and responsibilities, in the *Health First Colorado Member Handbook*. Providers received information on member rights and responsibilities within the provider manual**.** Within its member newsletter, **RMHP** periodically included instructions for accessing a list of member rights and responsibilities, located on the website.

RMHP ensured, primarily through a review of its customer service interactions, that employees and providers afford members their rights. Staff members described the process for monitoring calls received via the customer service phone line. Member calls that described any issue of dissatisfaction that could possibly be related to a rights issue were flagged for further review. During on-site review, **RMHP** provided HSAG with documentation of a summary of member calls categorized as potential rights issues. **RMHP** reviewed these summaries periodically to evaluate and determine whether the issues were actually related to member rights, then responded as needed.

RMHP delineated advance directive information within its policies, the *Health First Colorado Member Handbook*, and the provider manual.

RMHP addressed compliance with federal and State laws that pertain to member rights through its policies. **RMHP** evidenced compliance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E—HIPAA, through its policies, staff procedures, and mandatory in-service trainings. During on-site interviews, staff members described methods, including secured printers and secured emails, used to safeguard protected health information (PHI).

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

HSAG found that **RMHP** did not have provisions for community education regarding advance directives. In the past, **RMHP** had relied on the **RMHP** Foundation to provide advance directive education to the community; however, the Foundation did not conduct this activity during the review period and would not likely be providing this function going forward. **RMHP** did provide an education session to healthcare providers; however, no education was provided to the community at large. **RMHP** must develop provisions for community education regarding advance directives, including what constitutes an advance directive; emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment; and description of applicable State law concerning advance directives.

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

RMHP provided information to members in various formats, including on its website, via the *Getting Started Guide*, and within the *Health First Colorado Member Handbook*. After a member was enrolled with **RMHP**, the member was mailed a copy of the *Getting Started Guide*, a supplement to the member handbook. Through this publication, **RMHP** provided members with a well-illustrated pathway to navigating the **RMHP** healthcare system. Prior to its release, the *Getting Started Guide* and other important member documents were reviewed by the Member Advisory Council (MAC) for feedback. HSAG reviewed email strings between MAC members with suggested changes and revisions. Subsequent to the mailing of the *Getting Started Guide*, **RMHP** contacted members via telephone to establish contact and screen for needs. **RMHP** also mailed a quarterly newsletter to members that reminded members what resources are available and how to access services, and notified members of any significant change to content of the member handbook.

HSAG reviewed a sample of written member information and found that **RMHP** used easily-understood language; employed a font size that met the requirement; and made available various formats, if requested. In addition, **RMHP** included a notice with all important member communications that

directed members to assistance, interpretive services, and auxiliary aids in 18-point font and written in 18 prevalent languages.

RMHP maintained a website that housed information about healthcare services available and how to access them—including a searchable provider directory, drug formulary, a link to the member handbook, community resources, covered benefits, and contact information. **RMHP**'s searchable provider directory included information about individual providers and provider groups. **RMHP** described a newly launched Provider Attributes Survey, through which **RMHP** aims to gather additional information from providers about their facilities and practices. **RMHP** intends to publish information gathered from the survey in the provider directory. This will further enhance the provider information made available to members to potentially increase access to care for members with disabilities; members self-referring for BH specialists who specialize in key areas (e.g., eating disorders and sexual assault); and members who identify as lesbian, gay, bisexual, transgendered, or queer (LGBTQ).

Summary of Findings Resulting in Opportunities for Improvement

RMHP is required to inform the member that information provided electronically is available in paper form without charge upon request and is provided within five business days. While this is noted in the *Health First Colorado Member Handbook*, HSAG suggests that **RMHP** also inform the member in a prominent place on the website.

During the on-site review **RMHP** shared the Section 1557 Grievance Procedure for handling grievances. **RMHP** had not yet updated this policy's applicability from the Regional Care Collaborative Organization (RCCO) to the RAE line of business. HSAG recommends that **RMHP** update the policy to indicate applicability to its RAE line of business and perform a cursory review to ensure that all other applicable policies are up to date.

Summary of Required Actions

HSAG evaluated **RMHP**'s website—rmhp.org—using the WAVE Web accessibility tool and found that a sample of webpages pertaining to the RAE had significant contrast errors—seventy or more—per page. **RMHP** must ensure that its website is fully readily accessible per Section 508 standards.

HSAG evaluated the searchable provider directory on **RMHP**'s website—rmhp.org—for machine-readability using the WAVE Web accessibility evaluation tool and found accessibility and contrast errors. **RMHP** must ensure that its electronic provider directory is fully machine-readable and readily accessible.

HSAG reviewed **RMHP**'s provider directory in paper and in electronic form. HSAG found that the directories did not include information pertaining to whether or not the provider had completed cultural competency training and whether the provider's office has accommodations (including offices, exam rooms, and equipment) for people with physical disabilities. **RMHP** must update its provider directories to include whether or not the provider has completed cultural competency training and whether the

provider's office has accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Summary of Strengths and Findings as Evidence of Compliance

RMHP's *EPSDT Policy and Procedure* (applicable to RAE and Prime) described a comprehensive program for managing and providing EPSDT services for members under 21 years of age, including:

- Definition of "medical necessity" applicable to EPSDT.
- Procedures for coordinating care for: obtaining EPSDT screenings; finding specialists; obtaining wraparound services; coordinating with other agencies; assessing members identified, through developmental screenings, as having SHCN; and assisting members with finding a primary care medical provider (PCMP), making appointments, and arranging for transportation as needed.
- Definition of "comprehensive EPSDT benefits".
- Adoption of the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule as a guide to screenings and immunizations.
- Provision of member notifications regarding EPSDT benefits.
- Mechanisms for informing providers regarding EPSDT services, including provider manuals and newsletters as well as clinical practice guidelines regarding age-appropriate screenings, Centers for Disease Control (CDC) immunization schedules, and contacting Healthy Communities.
- Partnering with Healthy Communities, including **RMHP** referral guidelines.

RMHP notified members of EPSDT benefits through new member welcome calls, the new member *Getting Started Guide,* and referring members to the Health First Colorado member handbook. The **RMHP** website provided RAE members detailed information on types of screenings available at no cost; frequency of screening services; diagnostic and treatment services; age-specific immunizations; and services available through Healthy Communities; and provided links to the Department, Healthy Communities, and the AAP periodicity schedule. **RMHP** educated providers regarding EPSDT benefits through the **RMHP** provider manual, an annual EPSDT provider letter, and provider webinars. **RMHP** provided evidence of three provider webinars—presented September through November 2018—to address specific issues related to EPSDT services. The provider manual informed providers of the EPSDT benefit, Healthy Communities, and wraparound services available to EPSDT-eligible members, as well as listing all EPSDT provider requirements outlined in the RAE contract and Colorado Code of Regulations. **RMHP** had also recently developed the *Behavioral Health RAE Provider Handbook*, which outlined the comprehensive EPSDT benefits available to members and delineated the responsibilities of BH providers related to provision of EPSDT-related services. **RMHP** submitted materials developed for 110 practices enrolled in the **RMHP** PTP to improve skills, processes, and infrastructure related to provision of periodic health screens within practices. Materials addressed six

distinct categories of EPSDT benefits. **RMHP** demonstrated that it assisted providers with resolving barriers related to EPSDT benefits; staff members stated that providers had identified barriers or concerns related to the pediatric periodicity schedule, appropriate Current Procedural Terminology (CPT) coding, genetic testing, lead toxicity screening, understanding what services are provided by whom, and authorization procedures. Staff members stated that UM medical reviewers had been specifically trained in the expanded EPSDT medical necessity authorization criteria.

RMHP provided evidence of a memorandum of understanding (MOU) between **RMHP** and each of the 10 county Health Communities programs across Region 1. The MOU outlined agreement to collaborate to conduct onboarding of new RAE members as well as addressing roles and responsibilities of **RMHP** and the Healthy Communities entity to educate members regarding benefits and coordinate needed EPSDT services for members. Each agreement stated that referrals between **RMHP** and Healthy Communities would be "determined by local care coordination teams and county Healthy Communities staff." **RMHP** staff members stated that **RMHP** maintained both a regional-level relationship with Healthy Communities partners to facilitate inter-agency education, and local-level relationships to define referral processes applicable to each individual community. Staff members stated that within six months **RMHP** planned to share the Essette care coordination documentation platform with each Healthy Communities partner.

RMHP procedures and provider communications addressed provision of EPSDT capitated BH services. Staff members described that mental health and developmental screenings were provided by both BH providers and PCMPs and that provision of BH diagnostic and treatment services was best provided through integrated behavioral and physical health practice settings or through referrals to CMHCs, which were well-versed in EPSDT benefits and prepared to provide a variety of mental health programs for youth—i.e., vocational services, residential care, drop-in centers, and recovery and respite services. **RMHP** care coordinators were available to assist providers and members with referrals for services not covered by the plan, to out-of-network providers, to appropriate State agencies and programs, to CMHCs, and for members with special healthcare needs.

RMHP demonstrated significant attention to administering EPSDT benefits to RAE members through a comprehensive targeted approach involving member communications, provider education and assistance, care coordination activities, integrated operations, and cooperation with Healthy Communities and other EPSDT-related service agencies.

Summary of Findings Resulting in Opportunities for Improvement

HSAG noted that materials distributed to members to remind them of EPSDT benefits and services were more extensive for Prime members than for RAE members. HSAG encouraged **RMHP** to consider extending these EPSDT reminder materials to all RAE members.

HSAG noted that the Healthy Communities MOU described that "RMHP care coordination teams and Healthy Communities contractors will work together at the local level to establish a process for understanding the county-specific resources and services provided by the Healthy Communities

contractor and the Healthy Communities contractor's preferred method of receiving referrals." HSAG recommended that the MOU with each local Healthy Communities program be updated to include the specific referral processes determined at the local level.

Summary of Required Actions

HSAG identified no required actions related to this standard.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

For the FY 2018–2019 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care; Standard IV—Member Rights and Protections; Standard V—Member Information; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated through review of all four standards. In addition, the Department requested that HSAG conduct on-site group interviews with key RAE staff members to explore individual RAE experiences related to one focus topic. The focus topic chosen by the Department for 2018–2019 was *Transitioning and Integrating the Capitated Behavioral Health Benefit Into the RAE*.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met, Partially Met, Not Met, or Not Applicable*. Due to the July 1, 2018, effectiveness date of the RAE contract, the Department determined that the review period was July 1, 2018, through December 31, 2018. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key RAE personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to RAE care coordination.

HSAG also reviewed a sample of the RAE's administrative records related to RAE care coordination to gain insight into the RAE's processes for coordinating care for members with complex needs. Reviewers used standardized monitoring tools to review records and summarize findings. HSAG used a sample of five records with an oversample of three records (to the extent that a sufficient number existed). HSAG selected the samples from 20 complex care coordination cases that occurred between July 1, 2018, and December 31, 2018, and were identified by the RAE. HSAG and the Department collaborated to develop the content and format of the coordination of care case summary tool. Appendix B contains details of the findings for the care coordination record reviews.

To facilitate the focus topic interviews, HSAG used a semi-structured qualitative interview methodology to explore with RAE staff members information pertaining to the Department's interests related to the focus topic selected. The qualitative interview process encourages interviewees to describe experiences,

processes, and perceptions through open-ended discussions and is useful in analyzing system issues and associated outcomes. Focus topic discussions were not scored. HSAG and the Department collaborated to develop the *Focus Topic Interview Guide.* Appendix F contains the summarized results of the on-site focus topic interviews.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The four standards chosen for the FY 2018–2019 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VI—Grievances and Appeals, 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 RAE regarding:

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

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sep 26, 2018.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Behavioral Health Benefits,* the RAE implements procedures to deliver care to and coordinate services for all members. B. *For all RAE members*, the RAE's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 1: Exhibit B1—11.3.1, 11.3.7	*III_CM_Care Coordination Policy and Procedure* This policy and procedure describes the Rocky Mountain Health Plans (RMHP) comprehensive, client and family centered integrated care coordination program. • Is accessible to members: *Access to Care Coordination* on pages 13-14 • Is provided at the point of care whenever possible: *Active Care Plan Maintenance* on page 19 • Addresses both short- and long-term health needs: *Care Plan Development* on page 16 • Is culturally responsive: Found throughout the P&P, e.g., pages14 -16, 19 • Respects member preferences: Found throughout the P&P, e.g., pages 14 -16 • Supports regular communication between care coordinators and the practitioners delivering services to members: *Care Plan Development* on page 16; *Active Care Plan Maintenance and Follow-up* on pages 19-20 • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems: *Initial Care Coordination Outreach and Screening* on page 14; *Care Plan Development* on page 18	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Is documented, for both medical and non-medical activities: *Care Plan Development* on page 17 • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs: *Care Plan Development* on page 16 *III_CM_Comprehensive Needs Assessment* RMHP assesses the Member's health and health behavior risks, medical and nonmedical needs, and social determinants of health needs, including determining if a care plan exists. RMHP uses a comprehensive, client/family centered, integrated approach to assessment of members for care coordination needs. *III_CM_Sample Care Plan Redacted* RMHP care coordination works collaboratively with the Member and caregivers (if applicable) to create an individualized care plan that includes documentation of the Member's desired health outcomes and identifies other providers of that member's care coordination team. *III_CM_RAE Care Coordination Activity & ICCT's* This workflow describes Outreach Populations and how they are placed in a campaign. It illustrates the	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	coverage area of the RAE 1 Care Teams and how they and the Dedicated Outreach Teams feed into the Care Coordination Process. It identifies Regional or Project Based Populations that feed into the Dedicated Outreach Teams. *III_CM_Health Needs Survey Process* *III_CM_Health Needs Survey Workflow* *III_CM_ Health Needs Survey Example* *III_CM_ Health Needs Survey File 071718 Redacted* The Health Needs Survey is a voluntary survey completed by Members enrolling in a Medicaid program such as RAE or Prime. Members indicate when they need help managing their health conditions, are pregnant, would like help with resources or to receive an outreach call from a care coordinator. Survey data is transferred from HCPF to the RAE and helps prioritize Members who could benefit from care coordination. *III_CM_Care Plan Workflow v3* *III_CM_Essette Documentation Screen Shot* *III_CM_Essette Care Plan Example* These documents illustrate how RMHP care coordination works collaboratively with the Member and caregivers (if applicable) to create an individualized care plan that includes documentation of the Member's desired health outcomes and identifies other providers of that Member's care coordination team.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The RAE ensures that each member receiving *capitated behavioral benefits* has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact his or her designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 1: Exhibit B1—None	*III_CM_Care Coordination Policy and Procedure* Pages 13-14 describe Member *Access to Care Coordination.* Page 14 describes *Initial Care Coordination Outreach and Screening.* *CS_RAE_PRIME_Welcome Call Script* *CM_Welcome Call Intake Screener* RMHP Customer Service representatives make outbound Welcome calls to all new members. Whether the Member call is outgoing or incoming, the initial Member conversation introduces care coordination and screens the Member for social, medical and behavioral health needs. When a Member is reached and a Screener is completed, the information is housed in Essette. *CS_RAE_Prime Sorry We Missed You_ENG SP* This letter is sent to all members who are not reached through the Welcome Call. Members are urged to call Customer Service if they need assistance to access appropriate care and/or to connect with community resources. *Getting Started Guide_RAE_Prime_ENG_508* This is mailed to all new Members upon enrollment. In the section *Get Help with Your Care*, Members are advised how to contact a Care Coordinator.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime Member Handbook_ENG_508 Page 11 explains *How to Contact an RMHP Care Coordinator.* *III_CS_Medicaid One Call Flow* This shows the simple process Members can follow to reach a Care Coordinator.	
3. The RAE no less than quarterly compares the Department's attribution and assignment list with member claims activity to ensure accurate member attribution and assignment. The RAE conducts follow-up with members who are seeking care from primary care providers other than the attributed primary care medical provider (PCMP) to identify any barriers to accessing the PCMP and, if appropriate, to assist the member in changing the attributed PCMP. Contract Amendment 1: Exhibit B1—6.8.1	*III_CI_Attribution Validation Description* This document describes the quarterly activity taken by RMHP to ensure accurate member attribution and assignment. *III_CM_RAE PCMP Change Process* This document describes the process for helping RAE Member's identify and change their Primary Care Medical Provider (PCMP). Care Coordinators (CC) offer a three way call with Member, the CC and the Department's enrollment broker to assist the Member in choosing a different PCMP. *Prime Member Handbook_ENG-508* On pages 9-10, Members are advised of the circumstances and timeframe for leaving RMHP. They must call the number for Health First Colorado Enrollment to request disenrollment or to change plans.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Note regarding MCO opt out activity: all MCO enrollment/disenrollment activity is performed by First Health Colorado Enrollment (the enrollment broker).	
4. The RAE ensures that care coordination includes deliberate provider interventions to coordinate with other aspects of the health system or interventions over an extended period of time by an individual designated to coordinate a member's health and social needs. Contract Amendment 1: Exhibit B1—11.3.3.2	*III_CM_Care Coordination Policy and Procedure* This requirement is addressed throughout this P&P mainly in the *Care Plan Development* section at pages16 and 18-20. *III_CM_People with SHCN Policy* Addresses this requirement for people with special health care needs. On page 1, item 2 provides that RMHP coordinates health care services for children with Special Health Care Needs with other agencies or entities. *III_PT_Med Nghbrhd Initiative Summary* This document describes RMHP's work at developing a medical neighborhood, including work to improve communication and coordination between providers and care team members via Practice Transformation Programs described in the document. *III_PT_Care Compact Presentation* This is a PPT presentation that was delivered to providers at the RMHP Summit Learning Collaborative that explains how a care compact supports communication and safe transitions between primary care and specialty providers.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_PT_ Care Compact Element Planner Tool developed by the Practice Transformation Team and distributed during Learning Collaboratives for provider use so that they understand the elements necessary for developing effective care compacts supporting care coordination, *III_PT_ Care Compact Key Components* Tool developed by the Practice Transformation Team and distributed during Learning Collaboratives that describes the key elements of a care compact and includes a care compact template. *III_PT_ Foresight–GV Neurology* *III_PT_ Western Valley FP–Atlas Arch Neurosurgery* Examples of care compacts between primary care and specialty practices.	
5. The RAE administers the *Capitated Behavioral Health Benefit* in a manner that is fully integrated with the entirety of work outlined in the contract, thereby creating a seamless experience for members and providers. Contract Amendment 1: Exhibit B1—14.3	*III_CS_Medicaid One Call Flow* The One-Call Center is at the core of RMHP's communication options for Members. One phone number is maintained, staffed, and published for Members to call regarding customer service or care coordination issues. The One-Call Center serves Members and providers. The call tree is streamlined and well organized, with careful attention paid to minimizing the number of options callers need to listen to, yet covering the primary topics of concern.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_CI_West Slope Member Advisory Council Meeting Agenda 120318 This meeting agenda demonstrates RMHPs commitment to the contractual requirement for Member engagement. At the request of the Member Advisory Council, this meeting was devoted to the Behavioral Health Benefits and network. *III_CM Care Coordination Policy and Procedure* On page 2, 4th paragraph, it is noted that RMHP utilizes a single care management platform, Essette, for all services that allows the many entities that may be providing care/services to a Member to coordinate and share information seamlessly. Integration with BH and PH is further addressed on page 12 and in the *Screener, Assessment and Care Plan Development* sections on pages14-19. *III_PT_RAE Newsletter Nov 2018* *III_PT_Nov 2018 VBC RAE Webinar* *III_PT_Sept 2018 VBCRC RAE Prime Webinar* These documents demonstrate RMHP's communication with providers through Newsletters and Webinars to fully engage them in the work outlined in the contract for RAE and for Prime. The Webinars are presented monthly in the format of "Value Based Contracting Office Hours" where RMHP presents on relevant topics and providers	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	have the opportunity to ask questions and to provide feedback.	
6. The RAE implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 1: Exhibit B1—11.3.10, 11.3.5, 10.3.2, 10.3.4	*III_CM_Care Coordination Policy and Procedure* The 4th and 6th paragraphs under *Care Plan Development* on page 16 describe the procedures to coordinate services to the Member under the circumstances listed. *III_CM_RAE Communication to Effectively Coordinate Care* This policy and procedure describes how communication is facilitated among PCMPs, ICCTs, CMHCs, and other RAEs, including through the use of Essette, between settings of care and with other services the Member is receiving	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The RAE uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The RAE: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP or RAE.	*III_CM_ Health Needs Survey Process* *III_CM_Health Needs Survey Workflow* *III_CM_ Health Needs Survey Example* *III_CM_ Health Needs Survey File 071718 Redacted* The Health Needs Survey is a voluntary survey completed by Members enrolling in a Medicaid program such as RAE or Prime. Members indicate when they need help managing their health conditions, are pregnant, would like help with resources or to receive an outreach call from a care	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
42 CFR 438.208(b)(3) Contract Amendment 1: Exhibit B1—7.5.2–3	coordinator. The policy describes how RMHP processes and stratifies the survey. The Workflow illustrates how RMHP receives, processes and reviews the data to inform member outreach and care coordination activities.	
8. *For the Capitated Behavioral Health Benefits:* The RAE ensures: • That each member receives an individual intake and assessment appropriate for the level of care needed. • Use of the information gathered in the member's intake and assessment to build a service plan. • Provision of continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2-3)* Contract Amendment 1: Exhibit B1—14.7.1.1–3	*CS_RAE_PRIME_Welcome Call Script* *CM_Welcome Call Intake Screener* RMHP Customer Service representatives make outbound Welcome calls to all new members. Whether the Member call is outgoing or incoming, the initial Member conversation introduces care coordination and screens the member for social, medical and behavioral health needs. When a Member is reached and a Screener is completed, the information is housed in Essette. *III_CS_RAE & Prime Welcome Call_Stats* These statistics illustrate the attempts to reach and complete an initial intake Screener for RAE and Prime Members during the months of July-November, 2018. During that time, intake Screeners were completed on 69.12% of Members reached. *III_CM_Care Coordination Policy and Procedure* • That each member receives an individual intake and assessment appropriate for the level of care needed: Pages 1-2 indicate that "All members identified by these activities receive outreach to attempt screening,	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	assessment, coordination and care planning as needed." • Use of the information gathered in the member's intake and assessment to build a service plan: *CarePlan Development* on page 16, first paragraph. • Provision of continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems: *Special Populations* on pages 5-10 describes continuity of care activities for Members in transition and involved in multiple systems. *III_CM_Continuity & Coordination of Care 2018 Intent/Policy* on page 1 indicates RMHP facilitates continuity and coordination of medical care across its delivery system. *III_CI_Care Coordination Report_Q1_FY18-19 v2* This is a report of the care coordination activity in Quarter 1 of 2018-19, submitted to HCPF as a deliverable. Tab 4 describes the type, nature, and relative outcomes of the activities provided to members transitioning across care settings.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. *For the Capitated Behavioral Health Benefits:* The RAE shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 1: Exhibit B1—None	*III_CM_Care Coordination Policy and Procedure* Page 2 explains that RMHP utilizes a care management system platform, Essette, to achieve distribution of all of the Members identified by stratification, ADT alerts, Special Populations and Referrals to RMHP or ICCT staff. Screening, assessment, care planning, and follow up are all managed through Essette. Community Mental Health Centers use the same system for referral and care coordination. This sharing and integration of Essette allows coordination of the many entities that may be providing care/services to members resulting in better member outcomes and less duplication of care and services.	**RAE**: ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. *For the Capitated Behavioral Health Benefits:* The RAE ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract Amendment 1: Exhibit B1—None	*2018-19 Provider Manual* Pages 101-102 describe PCP responsibilities for maintaining and sharing records with specialty physicians and Consultants. Member confidentiality is described at the bottom of page 102. Pages 103-105 details all aspects of *Medical Records* maintenance, including *Release of Information and Transfer of Records.* Detailed information about what office records should include is provided. Providers are responsible for the maintenance of adequate medical records, which are to be secure, complete, legible, accurate, accessible, organized, and maintained in a format that facilitates retrieval of information.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_PNM_Physician Medical Services Agreement Section 2.N.(7), page 11 requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law.	
11. The RAE possesses and maintain an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history, medications, social supports, community resources, and member goals. Contract Amendment 1: Exhibit B1—15.2.1.1, 15.2.1.3, 15.2.1.4	*III_CM_Care Coordination Policy and Procedure* Page 2 explains that RMHP utilizes a care management system platform, Essette, to support communication and coordination among the many entities (members of the provider network and health neighborhood) providing care/services to members. *III_CM_Essette Screen Shot 1* (Name, Age, Gender, Care Coordinator, Stratification Level [Acuity]*)* *III_CM_Essette Screen Shot 2 (*Medicaid ID) *III_CM_Essette Screen Shot* 3 (Lead Care Coordinator) *III_CM_Essette Screen Shot 4* (Assessment, Care Plan, Notes) *III_CM_Essette Documentation Screen Shot* (Care Coordination Notes, activities and member needs; information that can aid in the creation and monitoring of a care plan for the Member; Claims Admissions, ER Visits, Medications, Social Supports*)* These documents illustrate the data that is collected and aggregated in Essette, including the items listed in the requirement.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The RAE ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(6)* Contract: 20.B Contract Amendment 1: Exhibit B1—11.3.7.11, 15.2.1.2.2	*III_CM_Care Coordination Policy and Procedure* Page 19 of *Care Plan Development* provides that "[a]ny communication with a non-member representative will require the appropriate Appointment of Representative/HIPAA paperwork to be filled out." *CM_HIPAA Consent Form 0918* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR requirements to assure member privacy is protected. RMHP uses this *Authorization to Use or Disclose Specific Information* (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *CM_Confidentiality and Retention of Member Records* Section I, page 1 states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our members. All information obtained in an official capacity is confidential and staff will comply with HIPAA Privacy Regulations.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

REA Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	12	**Total Score**		=	12
				Total Score ÷ Total Applicable		=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 1: Exhibit B1—7.3.7.1–2	*IV_CS_Prime RAE CHP+ Member Rights & Responsibilities* This *Policy and Procedure* documents RMHP's written policy regarding a Prime, RAE, or CHP+ Member's Rights and Responsibilities.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The RAE complies with any applicable federal and State laws that pertain to member rights and ensure that employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract Amendment 1: Exhibit B1—7.3.7.3	*2018-19 Provider Manual* Page 107-108 of the Provider Manual describes Member rights to network providers. (Note: *RAE 1 Behavioral Health Provider Manual* will be available onsite). *IV_PNM_LawExhibit to Provider Agreements* See Page 7-8, Section 5 for *Medicaid Recipient Rights.* Page 8, Section 6 lists the federal and State laws with which RMHP, providers and subcontractor shall comply. *IV_Compliance Plan_Corp_Mission and Values* Page 2 of the *Compliance Plan* illustrates RMHP's Mission and Values. RMHP's value statement confirms that "We honor the rights of physicians and patients in medical decision-making."	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The RAE's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 1: Exhibit B1—7.3.7.2.1–6	*IV_CS_Prime RAE CHP+ Member Rights & Responsibilities* Page 2, Section 6 Member rights as specified in state and federal regulation. *Member Newsletter_Fall 2018* Page 3, *RMHP Helpful Resources* advises Members how to find information online to learn more about their Member rights and responsibilities.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the health plan, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 1: Exhibit B1—7.3.7.2.7	*IV_CS_Prime RAE CHP+ Member Rights & Responsibilities* Page 2, bullet #8 indicates that the Member is able to exercise their rights without being treated differently. *2018-19 Provider Manual* Page 107 indicates that Members are able to freely exercise their rights without being treated differently. *Prime Member Handbook_ENG_508* Page 38, bullet #8 indicates to Members that they are able to exercise their rights without being treated differently. *IV_PNM_LawExhibit to Provider Agreements* Page 7-8, Section 5, *Medicaid Recipient Rights,* which states that "Contractor shall ensure that Medicaid Recipients have the rights set forth in 42 C.F.R. section 438.100(b)(2), including but not limited to the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, consistent with 42 C.F.R., section 438.100.(b)(2)(v)."	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The RAE complies with any other federal and State laws that pertain to member rights including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract Amendment 1: 21.U	*IV_Screen Shot_#5_Federal and State Laws* Information about federal and State laws that pertain to Member rights is posted on the RMHP.org website. It is also posted in prominent locations in RMHP physical office locations. *2018-19 Provider Manual* Page 106 informs providers of the RMHP Equal Opportunity Policy Statement. *Prime Member Handbook_ENG_508* Page 44 informs Members of the RMHP Equal Opportunity Policy. *IV_HR_ Law Exhibit_Non-Prov_Ind Contractor_1018* This Law Exhibit is attached to all non-provider contracts that are executed with RMHP. See pages 3-4, #11 for a list of statutes and regulations that RMHP requires the Contractor and any subcontractor to comply. *IV_PNM_LawExhibit to Provider Agreements* Law Exhibit, page 1, Sections I.1. and I.2. present the *Non-Discrimination* and *Equal Opportunity* language found in provider contracts. Page 8, Section III.6 references other federal and state laws that pertain to Member rights.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For medical records and any other health and enrollment information that identifies a particular member, the RAE uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: 20.A Exhibit A—2.c and 3.a	*CM_HIPAA Consent Form 0918* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this *Authorization to Use or Disclose Specific Information* (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *CM_Confidentiality and Retention of Member Records* Page 1, Section I states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our Members. All information obtained in an official capacity is confidential and will comply with HIPAA Privacy Regulations. Section II describes how RMHP protects the confidentiality of all Member records.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The RAE maintains written policies and procedures and provide written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures include: • A clear statement of limitation if the RAE cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians.	*Prime Member Handbook_ENG_508* Pages 42-52 provides written information to Members about advance directives. *2018-19 Provider Manual* Pages 93-94 provides written information to providers about advance directives. 1st bullet	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for the education of staff concerning its policies and procedures on advance directives.	RMHP does not impose any limitations with respect to implementing advance directives as a matter of conscience, therefore no statement to this effect is included in written information to individuals. 2nd, 3rd and 4th bullets *IV_RMHMO Medicare Medicaid Advance Directives _PP* This policy implements advance directives. Page 2, item 3, specifies that the provider's obligations with respect to advance directions must comply with 42 CFR 489, Subpart I and, at a minimum, do the following. • Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians. • Identify the state legal authority permitting such objection. • Describe the range of medical conditions or procedures affected by the conscientious objection. *2018-19 Provider Manual* Page 94 explains practitioner responsibilities around advance directives, including the policies they must have in place to provide information to Members about their rights under state law to create an advance directive, and the policies of	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for community education regarding advance directives that include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 1: Exhibit B1—7.3.11.3–7	their organization to respect implementation of those rights (including any limitations because of conscientious objections). 5th and 6th bullets *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 1 under "Process," paragraphs 1.c. and d. provide that Members rights include that advance directive information is given to the Member's family if he or she is incapacitated at the time of enrollment. Once the Member is no longer incapacitated, the information is given to the individual directly. Page 1, under "Procedure," paragraph 1 requires providers to have and comply with written policies and procedures for advance directives, including requirements in 42 CFR 489.102. Subsection (e) of this regulation sets forth the timing of the provision of advance directive information when the Member is incapacitated. *IV_PR_ Advance Directives_PP* Page 2, third bullet, practitioners must provide advance directive information to incapacitated Members once they are no longer incapacitated. 7th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP*	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 1. Item 4, and page 2, item 2.b sets forth the Member's right to have an advance directive recorded in the medical record. Page 2, item 4 provides that when chart audits occur they will include a review for the presence or absence of advance directives in the medical record. *V_PR_ Advance Directives_PP* Page 1, under "Key Components," a practitioner is required to include a Member's advance directive in the medical record. *2018-19 Provider Manual* Page 94 provides that a practitioner must include a Member's advance directive in the medical record. 8th bullet *Prime Member Handbook_ENG_508* Page 50, *Know the Law*, informs Members that they will not be denied services, treatment or admission to a health care facility if the Member does not sign an advance directive. *IV_PR_ Advance Directives_PP* Under "Purpose" on page 1 of the policy, providers are prohibited from discriminating against Members based on whether the Member has executed an advance directive. Under "Key Components" a practitioner may not condition the	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	provision health or medical care based on whether the Member has signed an advance directive. *2018-19 Provider Manual* Page 94 provides that a practitioner may not condition the provision of health or medical care based on whether or not the Member has signed an advance directive. 9th bullet *Prime Member Handbook_ENG_508* To ensure compliance with state laws regarding advance directives, page 52 provides information to Members about how to complain if an advance directive is not followed. 10th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 2, item 2.a. provides that Members will be informed of changes in state law concerning advance directives no later than 90 days following the change in law. 11th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 2, item 5.c. provides that RMHP will train staff on policies and procedures on advance directives.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	12th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 2, item 5.d. provides that RMHP will provide community education on advance directives, including issues that the education will address.	
Findings: RMHP did not have provisions for community education regarding advance directives. In the past, RMHP had relied on the RMHP Foundation to provide advance directive education to the community; however, the Foundation did not conduct this activity during the review period and would not likely be providing this function going forward. RMHP did provide an education session for healthcare providers; however, no education was provided to the community at large.		
Required Actions: RMHP must develop provisions for community education regarding advance directives—including what constitutes an advance directive, emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and description of applicable State law concerning advance directives.		

RAE Results for Standard IV—Member Rights and Protections							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	7	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	86%

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The RAE ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 1: Exhibit B1—7.2.5, 7.2.7.9	*See also Element #5 for evidence that information is readily accessible by members.* *V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* This Policy and Procedure describes the process to assure that all materials intended for distribution to RMHP RAE and Prime members are reviewed and edited to promote ease of use for RMHP enrollees, and to assure that they are readily accessible. Pages 1-2 also explain the process that RMHP follows to ensure that materials are member tested. *Getting Started Guide_RAE_Prime_ENG_508* *Prime Member Handbook_ENG_508* *V_Prime Directory_ 1118 ENG_ 508* *V_RAE Directory_ENG_508* *Health First Colorado_Member Handbook RMHP Insert_508* *V_Prime-CHP Formulary_ENG_508* The documents listed **above** are examples of materials demonstrating that member information is provided in a manner and format that is easily understood. *V_Accessibility Report_RAE-Prime_Getting Started Guide*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_Accessibility Report_Health First Colorado Handbook_RMHP Insert *V_Accessibility Report_Prime Member Handbook* *V_Accessibility Report_Prime Directory* *V_Accessibility Report_RAE Directory* *V_Accessibility Report_Prime-CHP Formulary* The Accessibility Reports listed **above** show that these required member documents have passed 508 remediation.	
2. The RAE has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 1: Exhibit B1—7.3.6.1.8	*Health First Colorado_Member Handbook_1018* *Health First Colorado_Member Handbook RMHP Insert_508* The Department distributes the *Health First Colorado Member Handbook.* RMHP sends the *Health First Colorado Handbook* and the *RMHP Insert* to Members upon request. *Prime Member Handbook_ENG_508* The *Prime Member Handbook* includes information to help members understand the requirements and benefits of the plan. The RMHP Customer service number is listed on the cover and in the footer of each page of the handbook. *Getting Started Guide_RAE_Prime_ENG_508* This document includes important information to help Member understand the requirements and benefits of the RAE and Prime plans. It also includes information about how to access valuable	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	information on the RMHP website. It is mailed to new Members upon enrollment. *CS_RAE_Prime_ Welcome Call Script* *CM_Welcome Call Intake Screener* *CS_RAE_Prime_ Sorry we Missed You_ENG SP* The documents listed **above** illustrate other mechanisms (e.g., telephone calls, follow-up letter) we use to assist members to understand the requirements and benefits of the plan. *V_Screen Shot_# 2_Understanding Plan* This screen shot provides information about *Understanding the Regional Organization*.	
3. For consistency in the information provided to members, the RAE uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 2, second bullet, indicates that for consistency in the information provided to members, RMHP will use the definitions for managed care terminology developed by the Department as soon as they are made available to RMHP. *Health First Colorado_Member Handbook_1018* The Department distributes this handbook. *V_Screen Shot_#11_Link to HFC Member Handbook*	**RAE:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 1: Exhibit B1—3.6, 7.3.4	RMHP provides a link to the *Health First Colorado Member Handbook* located on the Health First Colorado website. *V_CM_RAE-Prime Medicaid Denial Ltr_Model Adverse Ben Det Template* This is a sample letter that uses the Model Adverse Determination template provided by the Department.	
Findings: The Department has not provided a list of these definitions to the health plans, excepting a few that may appear in the contract. HSAG is unable to review all documents for use of these terms. HSAG alerted the health plans to be aware of this requirement and to consistently use definitions from the Department when available.		
4. The RAE makes written information available in prevalent non-English languages in their service areas and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18-point) and prevalent non-English languages describing how to	*V_CI_ Getting Started Guide_RAE_Prime _SP_508* *V_Prime Member Handbook_SP_508* *V_Prime Directory_1118 SP_508* *V_RAE Directory_SP* *CS_RAE_Prime Sorry We Missed You_ENG SP* *V_ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination_ SP_061418* *V_Prime-CHP Formulary_100118 SP* *V_CM_Grievance Resolution Template_SP* *V_CM_Appeals Resolution Template_SP* The documents listed **above** are examples of member materials that are available to Members in Spanish. Spanish is the prevalent non-English language in the RMHP Prime and RAE service-area.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 1: Exhibit B1—7.2.7.3–9, 7.3.13.3	*Prime Member Handbook_ENG_508* Cover Page (large print) and page iii-iv of the Prime Member Handbook explains how members can access materials in other languages and formats. *V_ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 061418* This document indicates in 18 different languages that language assistance services are available to members free of charge. It includes taglines in large print (18-point) and prevalent non-English languages. The Notice of Nondiscrimination describes how to request free auxiliary aids and services to assist people with disabilities to communicate effectively with us. This notice is inserted in all written materials that are critical to obtaining services. *V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 1-2 states that RMHP will create member material that is easy to use and understand, that RMHP will make materials available in non-English languages and alternative formats without charge, that taglines will be included and that documents will be member tested.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_CS_Process for Large Print Document Request *V_CS_Process for Alternate Language Document Request* These Customer Service processes explain RMHP's process for making written information available in other formats and alternate languages.	
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR 438.10(c)(6)* Contract Amendment 1: Exhibit B1—7.3.14.1	*V_IT_Section 508 Compliance Testing Report CUS-100 HealthSparq One* The searchable, online provider directory is accessible. HealthSparq (online directory vendor) provided this *Compliance Testing Report* with affirmation that the web pages meet 508 compliance mandates. *V_Accessibility Report_RAE-Prime Getting Started Guide* *V_Accessibility Report_Prime Member Handbook* *V_Accessibility Report_Prime Directory* *V_Accessibility Report_RAE Directory* *V_Accessibility Report_Prime-CHP Formulary* *V_Accessibility Report_Health First Colorado Handbook_RMHP Insert* The Accessibility Reports listed above show that these required member documents posted on rmhp.org have passed 508 remediation.	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP Page 3 indicates that required member materials that are accessible electronically to Members online (e.g., member handbooks, provider directory, formulary) will meet the stated requirements. Page 2 indicates that RMHP will make Member materials available to an enrollee in paper form via U.S. mail and without charge within five (5) business days of a request. *Prime Member Handbook_ENG_508* Page iv indicates that the Member Handbook and the Provider Directory are at rmhp.org where the member can view or print these documents. Members are informed that they can also ask RMHP to mail a copy at any time at no cost. *V_Screen Shot_#13_Customized Website* These sample screen shots illustrate examples of content available on the website.	
Findings: HSAG evaluated RMHP's website, RMHP.org, using the WAVE Web accessibility tool and found that a sample of webpages pertaining to the RAE contained significant contrast errors (seventy or more) per page.		
Required Actions: RMHP must ensure that its website is fully readily accessible.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The RAE makes available to members in electronic or paper form information about its formulary. *42 CFR 438.10(i)* Contract Amendment 1: Exhibit B1—None	*Getting Started Guide_RAE_Prime_ENG_508* Page 4 explains how to access the formulary online and how to request a paper copy at no charge. *Prime Member Handbook_ENG_508* Page 18 explains how to access the formulary online. *V_Screen Shot_#6_Drug Formularies* This screen shot shows that RMHP makes information about its formulary available to Members on the website in electronic and paper form.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The RAE makes interpretation services (for all non-English languages) available free of charge, notify members that oral interpretation is available for any language and written translation is available in prevalent languages, and inform about how to access those services. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. • The RAE notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities and inform how to access such services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 1: Exhibit B1—7.2.6.2–4	*V_CS_Accommodations for Mem w Disabilities_PP* This P&P describes how RMHP accommodates Members with communication barriers. Customer Service provides the following services: • Members who are hearing impaired can access TTY; 711 or use Live Chat or email. • For non-English speaking Members, CS utilizes LanguageLine Solutions interpreters. • Auxiliary aids and services (e.g., large print, braille, non-English written materials are available. • These services are provided at no cost to the Member.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime Member Handbook_ENG_508 Pages 3 & 14 explain that for callers who do not speak English, RMHP uses Certified interpreters. RMHP provides interpretation services at no cost to members, and advises members to tell Customer Service if they need interpreter services or help in other languages. *V_ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 061418* This document indicates in 17 different languages that language assistance services are available to members free of charge. The *Notice of Nondiscrimination* informs Members that RMHP provides free auxiliary aids and services to people with disabilities to communicate effectively with us. This notice is inserted in all written materials that are critical to obtaining services. *V_CS_Handle Language Line Calls* *V_CS_Handle Relay Colorado Calls* These documents describe the process that Customer Service Representatives follow to handle Language Line and Relay Colorado phone calls with Members.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The RAE ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 1: Exhibit B1—7.2.6.1, 7.2.6.5	*Prime Member Handbook_ENG_508* Cover Page (large print) and page iii-iv of the Prime Member Handbook explains how members can access materials in other languages and formats. Hours of operation for customer service are specified. *V_ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 061418* This document indicates in 17 different languages that language assistance services are available to members free of charge. The *Notice of Nondiscrimination* informs Members that RMHP provides free auxiliary aids and services to people with disabilities to communicate effectively with us. This notice is inserted in all written materials that are critical to obtaining services. *V_CS_Handle Language Line Calls* *V_CS_Handle Relay Colorado Calls* These documents describe the process that Customer Service Representatives follow to handle Language Line and Relay Colorado phone calls with Members.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The RAE provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10 (g)(1)* Contract Amendment 1: Exhibit B1—None	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 2-3 state that the *Getting Started Guide* is mailed to all new RAE members within a reasonable timeframe after notification of a member's enrollment. The *Getting Started Guide* advises members how to access the Member Handbook on the website or request a paper copy. *Getting Started Guide_RAE_Prime_ENG_508* Explains that RMHP sends the *Getting Started Guide* to tell RAE and Prime members how to access material on the website or how to request paper copies.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The RAE gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 1: Exhibit B1—None	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 2 indicates that RMHP will provide enrollees at least a 30-day notice of any change in the information that the State defines as significant. *Member Newsletter_Spring 2018* Page 2, *Important Information for RMHP Prime Members*, informs Members of a copay change for outpatient hospital visits to be effective July 1, 2018. Page 2, *Coming Soon*, informs Members that beginning July 1, 2018, Prime members will	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	participate in the Regional Accountable Entity (RAE). Examples of written notices of significant changes are listed above.	
11. For any RAE member handbook or supplement to the member handbook provided to members, the RAE ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The RAE ensures that its member handbook or supplement references a link to the Health First Colorado member handbook. *42 CFR 438.10* Contract Amendment 1: Exhibit B1—7.3.8.1	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Pages 1-2 indicate how RMHP prepares member materials so that all information is consistent with federal requirements. *Getting Started Guide_RAE_Prime_ENG_508* Section 4, *Understand Your Resources*, informs Members that they can find their Health First Colorado Member handbook at healthfirstcolorado.com or co.gov/peak. *V_Screen Shot_#11_Link to HFC Member Handbook* This screen shot shows the link to the Health First Colorado Handbook that is on the RMHP website. RMHP also sends the *Health First Colorado Handbook* to Members upon request.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The RAE makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 1: Exhibit B1—7.3.10.1	*V_CM_Prov Term Cross Dept_PP* It is the policy of RMHP to ensure that all members assigned to a Primary Care Physician (PCP) or who have had at least one visit within the previous twelve months, are notified when the PCP is no longer contracted with RMHP. It is the intent of RMHP to give Member notice of PCP terminations as soon as possible but no less than within 15 days of issuance of the notice of termination. This document outlines, at a high level, the cross departmental workflow of the PCP termination process. *V_CS_PCP Term Ltr* Letter to Member advising them that their Primary Care Physician is no longer contracted with RMHP.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The RAE develops and maintains a customized and comprehensive website which includes: • RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 1: Exhibit B1—7.3.9.1.1–5; 7.3.9.1.9–11; 7.3.9.2	*V_Screen Shot_#13_Customized Website* This document shows the location on the website of each of these requirements.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* Contract Amendment 1: Exhibit B1—7.3.9.1.6	*V_Prime Directory_ 1118 ENG_ 508* *V_RAE Directory_ENG_508* The Prime and RAE Provider Directories are available on the RMHP website in both electronic and paper form. The paper directory includes the provider's name, group affiliation, street address, and specialty. In addition, the paper provider directory indicates: • Languages offered • Icons/symbols by the provider's name if they are accepting new patients, or if they accept established patients only. • Handicap accessibility through use of a wheelchair icon/symbol. • Providers who have completed RMHP's Disability Competent Care Training Program are listed directly before Page 1. *V_Screen Shot_# 14_Updating Electronic Provider Directory* Under *Demographic Information*, it indicates that practitioners and hospitals may self-report, or update upon RMHP's request, the demographic information displayed in the directory, including name, address, phone number, gender, languages spoken, medical group affiliation, hospital affiliation, and accepting current patients. The electronic provider directory is updated at least weekly. RMHP has recently changed our procedure	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	to update the electronic directory three times a week to maintain accuracy. *V_PNM_Provider Directory Update Tool_RAE1 PCMP* *V_PNM_Provider Directory Update Tool_Prime Specialists* *V_PNM_Provider Directory Update Tool_BH Providers* *V_PNM_Provider Directory Update Letter 111518* RMHP has implemented a quarterly Provider Attributes Survey process. Primary care, behavioral health, and specialist providers are asked to provide demographic information, including: • Accommodations for people with physical disabilities, including equipment • Appointment availability – e.g. after hours, weekends • Language capabilities • Populations served – e.g. pediatric only, adult only, both pediatric and adult • Safe Space provider for LGBTQ clients • Specialization / areas of expertise for behavioral health providers – e.g. eating disorders, sexual assault, substance use disorders • Staff trainings on cultural competency or disability competency care	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_PNM_Directory Procedures_2018 Page 2 indicates that for Prime, RMHP Regional Organization and CHP Directories: Information included in a paper provider directory is updated at least monthly, and electronic provider directories are updated no later than 30 calendar days after the RMHP receives updated provider information. As stated above, our electronic directory is currently updated 3 times a week.	
Findings: HSAG reviewed RMHP's provider directory in paper and in electronic form. HSAG found that the directories did not include information pertaining to whether or not the provider had completed cultural competency training and whether the provider's office offered accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.		
Required Actions: RMHP must update its provider directories to include whether or not the provider has completed cultural competency training and whether the provider's office has accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.		
15. Provider directories are made available on the RAE website in machine-readable files and formats. *42 CFR 438.10(h)(4)* Contract Amendment 1: Exhibit B1—7.3.9.1.8	*V_Prime Directory_ 1118 ENG_ 508* *V_Accessibility Report_Prime Directory* *V_RAE Directory_ENG_508* *V_Accessibility Report_RAE Directory* *V_Screen Shot_#15_Link to Provider Directories* The screen shot indicates that the RAE and MCO (Prime) provider directories are available on the rmhp.org website. The Accessibility reports above show that these documents have passed 508 remediation.	**RAE:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: HSAG evaluated RMHP's website, RMHP.org, for machine-readability using the WAVE Web accessibility evaluation tool and found that sections of the provider directory contained accessibility and contrast errors.		
Required Actions: RMHP must ensure that its electronic provider directory is fully machine-readable and readily accessible.		
16. The RAE shall develop electronic and written materials for distribution to newly enrolled and existing members that includes all of the following: • RAE's single toll-free customer service phone number. • RAE's email address. • RAE's website address. • State relay information. • The basic features of the RAE's managed care functions as a primary care case management (PCCM) entity and prepaid inpatient health plan (PIHP). • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the RAE. • Medicaid benefits, including State Plan benefits and those in the Capitated Behavioral Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • The requirement for the RAE to provide adequate access to behavioral health services included in the Capitated Behavioral Health Benefit, including the network adequacy standards. • The RAE's responsibilities for coordination of member care.	*V_#16_Crosswalk to Documents* This document provides a crosswalk for each requirement, and the document source and page number. This information is available in electronic and written form. The documents include: *Getting Started Guide_RAE_Prime_ENG_508* *Prime Member Handbook_ENG_508* *V_Screen Shot _# 16_Electronic Member Material* *Health First Colorado_Member Handbook_1018* *Health First Colorado_Member Handbook RMHP Insert_508* *V_Prime Directory_118 ENG_508*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Information about where and how to obtain counseling and referral services that the RAE does not cover because of moral or religious objections. • To the extent possible, quality and performance indicators for the RAE, including member satisfaction. Contract Amendment 1: Exhibit B1—7.3.6.1		
17. The RAE annually mails each member a notice that specifies how to request a new copy of the handbook. Contract Amendment 1: Exhibit B1—7.3.8.1	*Member Newsletter_Fall 2018* Page 2, *RMHP Helpful Resources*, advises Members how to find documents online, and how to request a paper copy of the Handbook at no cost. This notice is sent annually.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The RAE provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the RAE and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 2 states that RMHP will make materials available to a member in paper form via U.S. mail and without charge within 5 days of request. Page 3 describes the process for sending member materials upon request by mail or by e-mail, including the timeframe for response to the request. Customer Service Reps will document if the member agrees to receive the information by e-mail.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 1: Exhibit B1—None	*Prime Member Handbook_ENG_508* Page iv advises members that the Handbook and the Provider Directory are at rmhp.org where they can view or print these documents. They can also ask Rocky Mountain Health Plans to mail a copy at any time at no cost. Page 18 tells members that they can see the prescription drugs covered by RMHP and learn about RMHP medication management by going to RMHP's website, rmhp.org, and look for formularies. Page ii lists the RMHP website URL under *Important Websites*, and informs members that they can go to the website for information about providers, benefits and services, and more. Page iv and 6 tells members that the Provider Directory is at rmhp.org where they can view or print this document. They can also ask Rocky Mountain Health Plans Customer Service to mail a copy at any time at no cost. *Member Newsletter Fall 2018* Page 3, *RMHP Helpful Resources*, informs members that Member information, such as the Handbook and Provider Directory, are available on	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	the Internet and includes the applicable Internet address.	
19. The RAE makes available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 1: Exhibit B1—None	*Prime Member Handbook_ENG_508* See page 44, *How RMHP Works,* for statement that Member can get more information about how RMHP works, including how RMHP is arranged, and information on RMHP's physician incentive plans.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

RAE Results for Standard V—Member Information							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	83%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The RAE provides information to members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and how to obtain additional information. Contract Amendment 1: Exhibit B1—7.3.12.1	*XI_CM_EPSDT Policy & Procedure* This document describes the measures, process, and interventions (oral and written) RMHP uses to provide information to members and their families about the services EPSDT covers. Page 5, Section I, #6, *Preventive Care and Screening* States that RMHP provides clinical practice guidelines and resources on age-specific screening schedules (Bright Futures/American Academy of Pediatrics) and immunization schedules (CDC). This document is used by RMHP care management to inform the services they provide to members. Page 8, Section III, #2B *Treatment* Sets forth that RMHP care coordination offers assistance with transportation and scheduling appointments. *XI_QI_Annual EPSDT Member Notification Process* This document describes RMHP's annual process for notifying eligible members and their caregivers, in clear and nontechnical language, of EPSDT benefits. At this time this is Prime only.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_QI_Prime EPSDT_0-17 ENG SP This annual letter was sent in 2018 to members with children under the age of 18 to inform them about the EPSDT program, including the services available to them without cost. The letter is sent in both English and Spanish. *XI_QI_Prime_EPSDT_18-20 ENG SP* This annual letter was sent in 2018 to members between the ages of 18-20 to inform them about the EPSDT program, including the services available to them without cost. This letter is sent in both English and Spanish. *Getting Started Guide_RAE_Prime_Eng_508* This document provides information to members and their families regarding the services provided by EPSDT and how to obtain additional information. *Member Newsletter_Winter 2018* Page 3 provides information to members and their families regarding the services provided by EPSDT and how to obtain additional information. *Prime Member Handbook_ENG_508* Page i provides phone numbers for Healthy Communities EPSDT Family Health Coordinators	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and county Human Services and Social Services Departments. Pages 28-30, *Keeping Your Child Healthy*, explains the EPSDT program in clear non-technical language informing members about the benefits of preventive healthcare. It describes the services that are available and how to obtain additional information (including that additional assistance is available by contacting Family Health Coordinators/Healthy Communities). Page 6 (*Getting Care – The Basics*), page 23 (*Transportation)* and page 32 (*Human Services Department in Your Area*). These sections address how to obtain transportation. Pages 24-25 describe the wrap-around services that are covered by Health First Colorado. EPSDT wrap-around services are also found within the *Covered Benefits and Services* section beginning on page 14. *Child Well-Care Reminders:* • *XI_QI_192C_Immunizations Education* • *XI_QI_95 Congrats on Newborn* • *XI_QI_196C_Happy First Birthday Education*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *XI_QI_108C 16 Month Immunizations Incentive* • *XI_QI_ 112C Well Child Visit Schedule* • *XI_QI_126C Teen Wellness Incentive 14-17* • *XI_QI_133C Preteen Wellness Incentive 10-13* Educational flyers are sent to Prime members throughout the year. Examples of these brochures and Member materials are included and referenced above. *XI_Screen Shot_#1_Glossary* This website page provides a glossary of terms that includes EPSDT, with a link to learn more about EPSDT. *XI_Screen Shot_#1_ Learn About* This screenshot includes information about the EPSDT program and provides another method (electronic) to inform members about the program. This section reviews screening, diagnostic and treatment services that are part of the comprehensive EPSDT benefit. In addition, this includes links to Health First Colorado, Healthy Communities, and Family Health Coordinator contacts.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Health_First_Colorado_Member_Handbook _1018 Pages 23-27 describe the EPSDT benefit offered to member's age 20 years and under. The member handbook is available for Health First Colorado members. RMHP distributes this handbook to members upon request. A link to this handbook is also posted on the RMHP website.	
2. The RAE makes network providers aware of the Colorado Medicaid EPSDT program information, including: • Employing Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. • Advising network providers of EPSDT support services available through other entities including, but not limited to, local public health departments and Healthy Communities. Contract Amendment 1: Exhibit B1—7.6.2.3, 12.8.3.4; 12.9.3.4	*XI_CM_EPSDT Policy & Procedure* Pages 5-6, Section I, #6, *Preventive Care and Screening* States that RMHP provides clinical practice guidelines and resources that guide providers on age-specific screening schedules (Bright Futures/American Academy of Pediatrics), immunization schedules (CDC), and contact information for counties that have Healthy Communities programs. The Provider Manual informs providers about EPSDT benefits, and accessing wrap-around benefits as well as support services of Healthy Communities. *XI_EPSDT Webinar_Addressing Best Practices 0918* *XI_EPSDT Webinar_Coding & Billing 1018* *XI_EPSDT Webinar_ Comprehensive Benefit and PARs 1118*	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_Announcing Lunch Learn Webinar EPSDT Addressing Best Practices *XI_Announcing Lunch Learn Webinar EPSDT Coding & Billing* *XI_Announcing Lunch Learn Webinar EPSDT Comp Overview & PARs* The above training and education webinars and announcements demonstrate that RMHP provides trainings and updates on EPSDT to network providers at least every six months. These examples are for webinars that took place in September, October, and November 2018. These webinars will continue to be offered and updated at least every 6 months. Each webinar has a slide on the services provided by Healthy Communities and the goals of the partnership between RMHP and Healthy Communities. *Provider Newsletter_Fall 2018* Page 8 makes providers aware of the Colorado Medicaid EPSDT program and informs network providers about the benefits of well-child care and EPSDT. The Fall training schedule is announced.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_Screen Shot_#2_ Trainings and Info This section of the website provides links to the aforementioned training webinars on key EPSDT topics requested by providers. *2018-19 Provider Manual.* Pages 66-68 describe the Colorado Medicaid EPSDT program, and includes references to the Health First Colorado website and how to access EPSDT materials. The manual also includes Healthy Communities contact information. For assistance with additional diagnosis and treatment needs, a referral should be made to a different practitioner or to Healthy Communities, specifically their Outreach and Case Management Office. The manual also provides information on public health programs such as the Vaccines for Children Program. *XI_PNM_Annual EPSDT Provider Letter* This letter is sent to providers annually to make network providers aware of the Colorado Medicaid EPSDT program information.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The RAE creates an annual onboarding plan in partnership with Healthy Communities contractors describing how the organizations will collaborate for the onboarding of children and families. • The RAE trains Healthy Communities contractors about the Accountable Care Collaborative and the Contractor's unique interventions and processes. • The RAE refers child members and their families to Healthy Communities for assistance with finding community resources and navigating child and family services. Contract Amendment 1: Exhibit B1—7.6.2.2–4	*XI_CI_RMHP MOU_Healthy Communities 120418* The MOU describes how RMHP and Healthy Communities (HC) will work together to ensure members have access to RMHP and HC resources and services. The entities are meeting quarterly to review the plan, identify progress made and provide relevant policy and programmatic updates. The MOU describes how the organizations will work together to perform outreach and onboarding activities (pages 1-2), and processes for referrals from RMHP care coordination to Healthy Communities, and from Healthy Communities to RMHP care coordination (pages 3-4). It provides that RMHP will train Health Communities contractors about the ACC and RMHP (page 1). *XI_CM_EPSDT Policy & Procedure* Page 6, Section I, #8 *Preventive Care and Screening provides* information consistent with the MOU, which describes the referral process between RMHP and Healthy Communities as well as what resources Heathy Communities provides specific to EPSDT. *XI_Screen Shot_#7_Healthy Communities Info* Explains how children and families can receive assistance through the Healthy Communities program, and provides a link to information on the Health First Colorado website.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The RAE assists providers in resolving barriers or problems related to EPSDT benefits. Contract Amendment 1: Exhibit B1—12.8.7.6	*XI_CM_EPSDT Policy & Procedure* Page 8, Section III, #2 *Treatment* General policy sets forth that for children who are Medicaid members, medically necessary EPSDT services not covered by RMHP (wraparound services) are referred to Healthy Communities and Health Care Policy and Financing (HCPF) for action as needed. *XI_PNM_Provider Relations Rep Duties* This job description demonstrates that the provider relations rep is available to resolve barriers in general for providers (see paragraphs 4-6), which can include EPSDT if this is an identified need. The position is responsible for addressing and resolving a variety of complex, escalated, or specialized inquiries related to health plan benefits, contracts and policies, or other provider related issues. *2018-19 Provider Manual* Pages 66-68 provide information on the EPSDT program, including what is covered and proper billing and coding. In addition, contact information is provided for situations where services may not be covered or additional resources are needed. *XI_EPSDT Webinar_ Coding & Billing 1018* The webinar includes details on the comprehensive benefits as well as details on best practices for	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	coding and billing, which can be helpful in navigating the benefit as a provider.	
5. For children under the age of 21, the RAE provides or arranges for the provision of all medically necessary *Capitated Behavioral Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280. (EPSDT program*). For the Capitated Behavioral Health Benefit*, the RAE*:* • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all appropriate mental/behavioral health developmental screening to EPSDT beneficiaries who request it. • Ensures screenings are performed by a provider qualified to furnish mental health services. • Ensures screenings are performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record. • Provides diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3)(d), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	*XI_CM_EPSDT Policy & Procedure* This written Policy and Procedure describes RMHP's process for providing EPSDT services to members ages 20 and under. Pages 3-7, Section I *Preventive Care and Screening* Describe the myriad of methods (e.g., EPSDT Benefit Notification Letters, Welcome Calls, Member Handbook, Preventive Care Reminders, Healthy Communities, Care Management) RMHP employs to assure that appropriate mental/behavioral health developmental screenings are provided to members who request them. Pages 8-9, Section III, #3 *Treatment* States that care coordination at RMHP is committed to promoting culturally competent care that is delivered in a linguistically sensitive manner. Page 8, Section II, #4 *Assessment and Needs Identification* Provides that RMHP Care Management will arrange or refer members to access diagnostic and treatment services for all physical or mental illnesses or conditions discovered by any screening or diagnostic procedure – even if the service is not covered by the health plan.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_QI Credentialing Criteria and Process RMHP ensures providers rendering mental health screenings are qualified to do so through its credentialing process. *2018-19 Provider Manual.* Page 67 states that providers qualified to furnish primary medical and/or mental health services should perform screenings. Page 67 (last paragraph) instructs providers that screenings should be performed in a culturally and linguistically sensitive manner. Page 67 (last paragraph) instructs providers to record the results of screenings and examinations in the child's medical record. Page 67 (last paragraph) states that diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure are covered. Pages 105-106, *Cultural Competence* section communicates to providers RMHP's expectation that services are provided in a culturally competent manner. RMHP advocates for continued education and diversity training.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_EPSDT Webinar_ Comprehensive Benefit and PARs 1118 Slides 6-7 emphasize that the benefit includes any medically necessary services needed to diagnose and treat potential physical, intellectual or emotional delays and covers treatments necessary to address them.	
6. *For the Capitated Behavioral Health Benefits,* the RAE: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family. • Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61-62* Contract Amendment 1: Exhibit B1—14.5.3	*XI_CM_EPSDT Policy & Procedure* Page 8, Section III, #2 *Treatment* Sets forth how RMHP provides referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. Page 8, Section III, #2B *Treatment* Sets forth that RMHP care coordination offers assistance with transportation and scheduling appointments. Page 8, Section III, #2A *Treatment* Sets forth that RMHP care coordination will coordinate with outside agencies. *XI_CI_RMHP MOU_Healthy Communities 120418.* Sets forth that RMHP will coordinate with Healthy Communities and provide bi-directional referrals.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Healthy Communities provides coordination with WIC, Nurse Family Partnership, Head Start, DHS and other Agencies. *Prime Member Handbook_ENG_508* Pages 29-30 provide information to members about when and how to contact Healthy Communities EPSDT Family Health Coordinator. Pages 6, 23-24 and 32 explain how to get help to arrange transportation. *2018-19 Provider Manual* Pages 66-68 state that medically necessary treatments for conditions discovered by any screening or diagnostic procedure — even if they are not covered by First Health Colorado — may be covered by RMHP under the EPSDT program. The manual goes on to explain how a request for an EPSDT exception may be submitted. Contact information for the RMHP Care Management department is also provided. *XI_Screen Shot_#7_Healthy Communities Info* Explains how individuals can receive help through the Healthy Communities program, and provides a link to information on the Health First Colorado	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	website. Under *Getting Help*, the Healthy Communities program is described as helping by: • Arranging (through referral) for corrective treatment as determined by child health screenings • Referring for transportation assistance *XI_CM_List of Referral Entities* This screen shot from the Essette system is a list of entities where care management can make referrals. Senior staff on the care management team updates this list. The list includes medical and social resources such as state agencies and WIC.	
7. *For the Capitated Behavioral Health Benefits*, the RAE defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration.	*XI_CM_EPSDT Policy & Procedure* Page 2 presents RMHP's definition of medical necessity for EPSDT services, which comports with the definition set forth in regulation and in the contract.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. Contract Amendment 1: Exhibit B1—14.5.3 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E		
8. *For the Capitated Behavioral Health Benefit*, the RAE provides or arranges for the following for children/youth from ages 0 to 21: vocational services, intensive case management, prevention/early intervention activities; clubhouse and drop-in centers, residential care, assertive community treatment (ACT), recovery services, respite services. *Note: All EPSDT services are included in the State Plan or in Non-State Plan 1915(b)(3) Waiver Services (respite and vocational rehabilitation).* Contract Amendment 1: Exhibit B1—14.5.8.1	*XI_CI_1915(b)(3) Services by CMHCs* CMHCs within RAE Region 1 provide or arrange 1915(b)(3) services for children from ages 0 to 21. The crosswalk includes these 1915(b)(3) services. The CMHCs in RAE Region 1 are Axis, Center for Mental Health, Summit Stone and Mind Springs.	**RAE:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

RAE Results for Standard XI—EPSDT Services							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	8	**Total Score**		=	8
				Total Score ÷ Total Applicable		=	100%

Appendix B. Record Review Tools

Based on the sensitive nature of the coordination of care record reviews, they have been omitted from this version of the report. Please contact the Colorado Department of Health Care Policy and Financing's Office of Cost Control & Quality Improvement for more information.

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2018–2019 site review of **RMHP**.

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

HSAG Review Team	Title
Katherine Bartilotta	Associate Director
Gina Stepuncik	Senior Project Manager
RMHP Participants	**Title**
Alex Hulst	Integrated Behavioral Health Advisor
Amber Davis	Claims Supervisor
Amy Rowan	Outreach Coordinator, Tri County Health
Angela Nottingham	QI Intervention Developer
Anne Wilburn	RN Mountain Family Health Center
Ashley Painter	Communications Specialist
Audrey Oldright	Care Management Outreach Coordinator
Brett Teuscher	Senior Manager, Internal Audit
Carrie Calabro	Projects and Compliance Specialist
Carol Ann Hendrikse	Manager, RN Accountable Care Collaborative Clinical Programs
Cheryl Koch	Compliance Assistant
Christian Perez	Case Manager, Plan de Salud
Christy Hunt	Claims Production Manager
Cynthia Mattingley	QI Practice Transformation
Dale Renzi	Director, Provider Network Management
David Mok-Lamme	Senior Community Research Analyst
Debbie Breitkreuz	QI Intervention Developer
Erin Nipper	Credentialing Coordinator
Eve Presler	Special Populations and Training Manager
Greg Coren	Western Slope Provider Relations Manager and Provider Network Manager
Griffin Day	Community Health Worker, Mountain Family Health Center
Heather Cochrane	Supervisor, Claims Financial Reconciliation
Jay Puhler	Medicaid/Medicare Claims Reconciliation Specialist
Jerry Spomer	Director—Internal Audit, Member Benefit Administration, and Member Enrollment and Billing

RMHP Participants	Title
Jill Bystol	Quality Assurance Compliance Coordinator
Judy Narenkivicius	Supervisor, Credentialing and Quality Improvement
Karen Ramirez	CAC II Social Worker—UC Health, Ft. Collins
Kendra Peters	RAE Program Operation Support and Provider Training Administrator
Laurel Walters	Chief Operating Officer
Leanne Hart	Director, Marketing and Communications
Liz Bullock	West Region, Clinical Program Manager
Lori Stephenson	Director, Clinical Program Development and Evaluation
Marci O'Gara	Director, Customer Service
Matthew Cook	Director, Claims
Maura Cameron	Director, Quality Improvement
Meg Taylor	RAE Program Officer, Region 1
Mike Huotari	Vice President, Legal and Government Affairs
Molly Siegel	RAE Clinical Services Director
Nancy Soltero	RN, Mountain Family Health Center
Nicole Konkoly	RAE Network Relations Manager
Patrick Gordon	Vice President, RMHP
Paul Jackson	Director, Business Operations and Colorado Sales and Service
Pauline Casey	Senior Program Operations Leader
Rhonda Michaelson	Supervisor, Customer Service
Sandy Dowd	Director, Utilization Management
Sarah Weltzer	Behavioral Health Outreach Coordinator
Sheila Worth	Medical Strategic Initiatives Administrator
Sienna Hunter	Care Coordinator, La Plata Integrated Health, Axis Health Systems
Stephen Thompson	Manager of Care Team, UC Health, Fort Collins
Steven Robinson	Behavioral Health Compliance
Tim Sherman	Director, Regulatory Affairs
Department Observers	**Title**
Emily Berry	RAE 1 Program Specialist
Troy Peck	Prime Program Specialist
Murielle Romine	RAE 1 Program Administrator
Russ Kennedy	Quality and Compliance Specialist
Teresa Craig	Contract and Program Manager, CHP+ MCO and SMCN
Gina Robinson	EPSDT Program Administrator

Appendix D. Corrective Action Plan Template for FY 2018–2019

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

Table D-1—Corrective Action Plan Process

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

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

The CAP template follows.

Table D-2—FY 2018–2019 Corrective Action Plan for RMHP

Standard IV—Member Rights and Protections: RAE and Prime		
Requirement	**Findings**	**Required Action**
7. The RAE maintains written policies and procedures and provide written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the RAE. Advance directives policies and procedures address [numerous provisions], including: • Provisions for community education regarding advance directives that include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 1: Exhibit B1—7.3.11.3–7	RMHP did not have provisions for community education regarding advance directives. RMHP did provide an education session for healthcare providers; however, no education was provided to the community at large.	RMHP must develop provisions for community education regarding advance directives—including what constitutes an advance directive, emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and description of applicable State law concerning advance directives.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Standard IV—Member Rights and Protections: RAE and Prime		
Requirement	**Findings**	**Required Action**
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information: RAE and Prime		
Requirement	**Findings**	**Required Action**
5. *If the RAE makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR 438.10(c)(6)* Contract Amendment 1: Exhibit B1—7.3.14.1	HSAG evaluated RMHP's website, RMHP.org, using the WAVE Web accessibility tool and found that a sample of webpages pertaining to the RAE contained significant contrast errors (seventy or more) per page.	RMHP must ensure that its website is fully readily accessible per Section 508 guidelines.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		

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

Standard V—Member Information: RAE and Prime		
Requirement	**Findings**	**Required Action**
14. The RAE makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.*	HSAG reviewed RMHP's provider directory in paper and in electronic form. HSAG found that the directories did not include information pertaining to whether or not the provider had completed cultural competency training and whether the provider's office offered accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.	RMHP must update its provider directories to include whether or not the provider has completed cultural competency training and whether the provider's office has accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.

Standard V—Member Information: RAE and Prime		
Requirement	**Findings**	**Required Action**
42 CFR 438.10(h)(1-3) Contract Amendment 1: Exhibit B1—7.3.9.1.6		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-Up Planned:		
Documents to be Submitted as Evidence of Completion:		

Standard V—Member Information: RAE and Prime		
Requirement	**Findings**	**Required Action**
15. Provider directories are made available on the RAE website in machine-readable files and formats. *42 CFR 438.10(h)(4)* Contract Amendment 1: Exhibit B1—7.3.9.1.8	HSAG evaluated RMHP's website, RMHP.org, for machine-readability using the WAVE Web accessibility evaluation tool and found that sections of the provider directory contained accessibility and contrast errors.	RMHP must ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 guidelines.
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 E. Compliance Monitoring Review Protocol Activities

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal managed care regulations and contract requirements: • HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. • HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. • HSAG submitted all materials to the Department for review and approval. • HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	• HSAG attended the Department's Integrated Quality Improvement Committee (IQuIC) meetings and provided group technical assistance and training, as needed. • Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the RAE in writing of the request for desk review documents via email delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site activities. Thirty days prior to the review, the RAE provided documentation for the desk review, as requested. • Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the RAE's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The RAEs also submitted a list of care coordination cases that occurred between July 1, 2018, and December 31, 2018 (to the extent available at the time of the site visit). HSAG used a random sampling technique to select records for review during the site visit. • The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

For this step,	HSAG completed the following activities:
Activity 3:	**Conduct Site Visit**
	• During the on-site portion of the review, HSAG met with the RAE's key staff members to obtain a complete picture of the RAE's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the RAE's performance. • HSAG reviewed a sample of administrative records to evaluate care coordination activities and outcomes. • While on-site, HSAG collected and reviewed additional documents as needed. • At the close of the on-site portion of the site review, HSAG met with RAE staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the FY 2018–2019 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**
	• HSAG populated the report template. • HSAG submitted the draft site review report to the RAE and the Department for review and comment. • HSAG incorporated the RAE's and Department's comments, as applicable, and finalized the report. • HSAG distributed the final report to the RAE and the Department.

Appendix F. Focus Topic Discussion

Overview of FY 2018–2019 Focus Topic Discussion

For the FY 2018–2019 site review process, the Department requested that HSAG conduct open-ended on-site interviews with RAE staff members to gather information on each RAE's experience regarding *Transitioning and Integrating the Capitated Behavioral Health Benefit Into the RAE*. Focus topic interviews were designed to emphasize the member-related and provider-related components of transition and integration, including successes and challenges experienced in this inaugural year of RAE operations. HSAG collaborated with the Department to develop an interview guide to facilitate discussions and gather similar information from each RAE. Information gathered during the interviews will be analyzed in the 2018–2019 RAE Aggregate Report to determine and document statewide trends related to the ACC objective of integrating behavioral and physical healthcare for members. This section of the report contains the interview guide and a summary of the focus topic discussion for **RMHP**.

Members

Transitioning Members Into the RAE and Continuity of Care

In anticipation of the new structure for the Regional Accountable Entities, all Community Mental Health Centers (CMHCs) and Federally Qualified Health Centers (FQHCs) in Region 1 had previously created an organization—Reunion Health—to work in partnership with **RMHP** to deliver integrated behavioral health (BH) services to Medicaid members. **RMHP** met regularly with Reunion Health and the CMHCs in the Region to discuss transition processes and issues. This ongoing working relationship between **RMHP** and the Reunion Health CMHCs provided the foundation for identifying many of the members engaged in behavioral healthcare at the time of RAE contract initiation. While most RAE members received BH services through the four CMHCs in Region 1, RMHC also met with all behavioral health organizations (BHOs) across the State to identify members receiving BH specialty care outside the Region. All previously authorized services for members in treatment were carried forward by **RMHP**, thereby preventing any disruption in care. In addition, for members receiving behavioral health services in independent practices, **RMHP** identified members through any claims received and committed to payment for all BH services for a period of time pending completion of contracting with a provider. **RMHP** prioritized independent provider network (IPN) contracting or single case agreements with BH providers who were actively treating RAE members. In order to avoid member confusion and to promote transparency for members involved in BH care at the time of the RAE implementation, **RMHP** worked with providers behind the scene to modify processes for initiation of the RAE system. Through the transition period, all providers were allowed to continue to serve members in treatment and thereby ensure continuity of care. In addition, **RMHP** care coordination staff met with care coordinators from all BHOs and the four regional CMHCs to identify members who were high-risk or required complex care coordination services.

Care Coordination

All information regarding members identified by the BHOs or CMHCs as high-risk or having complex needs was entered into **RMHP**'s Essette care management system for tracking and collaborative care coordination between CMHCs and **RMHP**. **RMHP** followed up with all providers involved with these members to discuss care coordination activities. In addition, care coordinators met with each member to introduce themselves and to explain the RAE and care coordination processes. **RMHP** notified providers of outreach to the member. In meetings with the CMHCs, additional members with less intensive care coordination needs were also identified and remained the responsibility of the CMHCs' case managers in order to maintain transparency for members transitioning to the RAE. Each CMHC in the region has access to **RMHP**s Essette system, enabling secure sharing of member care coordination information. Implementation of BH services into the RAE has enabled **RMHP** to progressively build a BH claims data base for identifying members receiving services and to incorporate member data into the tiered stratification methodology used to identify high-risk and complex needs members for care coordination. **RMHP** considers BH needs as one component of its stratification methodology. In addition, **RMHP**'s "Hot-spotter" program identifies high-risk behavioral health members.

RAE members requiring specialty BH services, residential, or acute care seek services from providers located in the Denver metropolitan area. To ensure continuity during transitions of care from Children's Hospital and other acute care environments, **RMHP** arranged transition of care agreements and workflows between these facilities and the Fort Collins-based SummitStone Health Partners care coordination team. At the time of on-site review, **RMHP** was arranging transition of care workflows with the new and recently opened West Springs (i.e., Mind Springs) Hospital in Grand Junction for members being discharged from acute care.

Providers

Transitioning BH Providers Into the RAE and Provider Network Contracting

RAEs were required to complete contracting and credentialing of providers within 60 days of RAE contract implementation. **RMHP** committed to paying all providers for services received by Medicaid members pending completion of credentialing and contracting. **RMHP** initiated BH provider network contracting activities with regional CMHCs, which were providing services to most Medicaid members in the region. **RMHP**'s relationship with Reunion Health facilitated the fast-tracking of contracting with CMHCs, although staff members noted that the BHOs contracted differently than the RAE. Contracting with CMHCs required negotiating payment rates for the broad array of services and programs provided by the CMHCs. Staff members reported increased difficulty in contracting with BH providers and facilities on the "front range"—i.e., Larimer County and specialty facilities in the Denver area—due to the different financing structure and higher levels of payments in these facilities. Region 1 had very few residential or acute BH facilities, and RAE members were often required to travel to the front range to access these services. Many of those facilities had previously been associated with commercial insurers. Providers oriented to commercial rather than Medicaid populations and which had not previously had a Medicaid contract found Medicaid payment rates a challenge. **RMHP** had an exiting IPN of

approximately 350 BH providers to serve its other lines of business, which served as the base of providers targeted for contracting with the RAE. **RMHP** met with each individual practice to discuss the RAE integrated care model, offer a contract, and assist with provider applications for the RAE network. However, some IPN providers were not full-time practices, making contacting and executing a contract with them difficult. Staff members stated that **RMHP**'s long-term relationship with individual practices enhanced ability to transition providers into the RAE network. **RMHP** fast-tracked credentialing of RAE IPN applicants and extended a temporary letter of agreement to each practice pending completion of credentialing and contracting. When providers could be validated as Medicaid providers with the State, **RMHP** added a Medicaid amendment to the existing provider contract. Approximately 100 existing IPNs were not validated Medicaid providers and received assistance from **RMHP**'s provider relations staff to become Medicaid providers with the State. Staff members estimated that 80 to 90 percent of its BH IPN providers were retained in the RAE provider network.

Among the first practices to be contacted after initiation of the RAE contract were the integrated PCMP practices in which behavioral health providers were either employed or co-located. Provider relations explained the RAE reimbursement for short-term BH services delivered in the PCMP office and instructed practices on where and how to bill for various behavioral health services. Region 1 has numerous integrated PCMP practices, although the models of integration vary according to the size and diversity of each practice. Staff members stated that may members appreciate the benefits of being able to receive behavioral health visits within the PCMP, and reimbursement for behavioral health delivered in primary care settings has been positively received by PCMPs.

Opportunities/Challenges

Historically, RAE Region 1 had only one BH acute care facility available for members, requiring many Medicaid members to travel to the Denver area to receive acute care services. Mind Springs recently built and opened a second acute care facility—West Springs Hospital—in the Region, which has doubled the number of acute care beds available on the Western Slope. West Springs Hospital is also developing specialized programs and services. **RMHP** financially partnered with Mind Springs to develop the facility. All IPN network and primary care providers have direct referral access to the hospital. Staff members stated that this new environment has created an improved dynamic among providers and allows members to remain in the community to obtain needed mental healthcare.

While **RMHP** has encouraged development of integrated PCMP practices throughout the region, this model of care is not appropriate for all members or providers. Integrated practices must also continue to refer some members to specialists or specialty programs, as necessary. Whereas all integrated practices participate in **RMHP**'s Practice Transformation Program (PTP), PTP staff work with providers to identify and build referral relationships with other BH services in the area. In addition, the PHP program offers practice coaching regarding how to integrate BH providers into a primary care practice and offers tiered incentive payments to providers who commit to the highest levels of practice integration. **RMHP** has also encouraged care compacts between individual (non-integrated) primary care providers and individual BH providers and has implemented a key performance indicator (KPI) to measure the number of practices that have implemented at least two care compacts, one of which must be with a behavioral

health provider. **RMHP** is working on a mechanism to include BH practices in the PTP and tiered incentive payment structure.

Staff members stated that changing the formal structure for delivering behavioral health services from the BHOs to the RAEs has enhanced relationships throughout the region. Staff members described that more discussion occurs about mental health in general within communities and among providers. Within five community-based subregions of the RAE, **RMHP** and integrated practice providers meet with community leaders to obtain community perspectives on mental health, generating peer support and promoting interaction. All CMHCs are working to improve release of information and enhance two-way communications with referring providers and other members of the care team. Care coordinators from ICCTs and BH providers work more collaboratively, resulting in RAE involvement with members with the highest need for BH services and a smoother, more coordinated process overall. Reunion Health has formalized a mechanism for working on regionwide goals for mental health that will be member-focused and impact program-level development.

Staff members stated that the BH capitated payment to the RAE offers some flexibility for the RAE to finance needed care in the Region and to incent providers to meet value-based objectives of the RAE. **RMHP** outlined several initiatives related to services for special populations that have been facilitated by the integration of BH services into the RAE:

- Many rural areas of the Region have no IPN BH provider and no access to CMHCs. **RMHP** is engaged in an active development process with Heart Health Counseling to offer telehealth behavioral health services to every member throughout the region. Heart Health Counseling is a large and diverse BH practice capable of providing telehealth consultations and therapy. This initiative requires establishing a communication hub in various communities. The Quality Health Network health information exchange provides the infrastructure for communications. **RMHP** will provide the hardware and software and promote services to eligible members.
- **RMHP** care coordinators, Mind Springs Health CMHC, and the Department of Corrections collaborated on a process to engage pending parolees and to establish a post-release BH appointment for members prior to their release from prison.
- **RMHP** and county DHS agencies are working collaboratively to improve access to services for parents and children in the child welfare system who demonstrate many complex needs and require expanded access to services, including home-based services. Within the rural areas, delivery of home-based services is costly; therefore, **RMHP** and DHS are exploring reimbursement options.
- **RMHP** is working with substance use and medication-assisted treatment (MAT) providers to financially sustain these practices and to integrate these therapies into primary care practices.
- **RMHP** is committing financial and other resources to regional initiatives related to development of supportive housing for chronically homeless youth.
- **RMHP** has been working with the Department ongoing to explore payment options for improving the quality of services offered to BH members—e.g., expanding the BH covered services benefit (i.e., autism) and advocating for practice-specific tier-based payments for providers.

COLORADO
Department of Health Care Policy & Financing

Appendix G:
Fiscal Year 2018–2019 Site Review Report
for
Rocky Mountain Health Plans
Region 1 Managed Care Initiative

April 2019

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

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix G: Table of Contents

1. Executive Summary

Introduction

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

This report documents results of the fiscal year (FY) 2018–2019 site review activities for the **RMHP** Region 1 limited managed care initiative—**RMHP Prime**. For each of the four standard areas reviewed this year, this section contains summaries of strengths and findings as evidence of compliance, findings resulting in opportunities for improvement, and required actions. Section 2 describes the background and methodology used for the 2018–2019 compliance monitoring site review. Section 3 describes follow-up on the corrective actions required as a result of the 2017–2018 MCO site review activities. Appendix G-1 contains the compliance monitoring tool for the review of the MCO standards.

Summary of Compliance Results

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

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

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

Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
III. Coordination and Continuity of Care	11	11	11	0	0	0	100%
IV. Member Rights and Protections	7	7	6	1	0	0	86%
V. Member Information	19	18	15	3	0	1	83%
XI. Early and Periodic Screening, Diagnostic, and Treatment Services	7	7	7	0	0	0	100%
Totals	**44**	**43**	**39**	**4**	**0**	**1**	**91%**

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

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

RMHP's Prime MCO included select members and providers in a six-county subregion of RAE Region 1 located on the Western Slope. Prime providers administered capitated physical health benefits to members; Prime members received BH benefits through the RAE. As such, most of **RMHP**'s policies, procedures, and processes applicable to the RAE were also applicable to Prime.

RMHP's *Care Coordination Policy and Procedure* defined a comprehensive care management program meeting all Department requirements to assist members with access to needed services. The care management program outlined procedures addressing:

- Access to care coordination 24 hours a day/7 days a week.
- Initial outreach screening and referral to care coordination for comprehensive assessment when indicated.
- Comprehensive assessment of: medical, social, behavioral, developmental, educational, support system, and financial needs.
- Development of a care plan addressing member needs, identified gaps in care, and cultural sensitivity.
- Establishing member goals, and maintaining involvement with member until goals are achieved.
- Establishing a lead coordinator.
- Providing care coordination at the point of care whenever possible—e.g., home, provider office, hospital, care facility.
- Communicating care plan to providers and facilitating provider communications.
- Documentation of assessment, care plan, interventions, and member progress in the Essette care management software (Essette).

RMHP used available claims data and information from intake screenings and comprehensive needs assessments to categorize all members into four levels of potential care coordination interventions as follows: Tier 1—Healthy members/health promotion and prevention; Tier 2—Mitigating emerging risks; Tier 3—Managing outcomes across multiple care settings; Tier 4—Managing multiple chronic illnesses. Stratification methodologies considered medical, behavioral, and social support needs of members. The *Care Coordination Policy and Procedure* defined specific populations targeted for care coordination to include: members stratified in high-risk tiers; inpatient and emergency department transitions; behavioral health (BH) crisis follow-up; pregnancy, diabetes, or pediatric asthma medical conditions; members with SHCN; members identified by the Colorado Overutilization Program (COUP), **RMHP** Drug Safety program, or **RMHP** "Hot-Spotter" program; criminal justice-involved (CJI); foster children; social determinants of health needs.

The Department assigned each member to a Prime PCMP on enrollment, using specified Prime eligibility criteria—e.g., geographic location and member demographics applicable to Prime enrollment. However, **RMHP** actively monitored Prime provider attribution reports received from the Department and worked ongoing with Prime providers to confirm and correct inaccurate provider attribution. **RMHP** matched existing provider claims information and electronic medical records data to the attribution list, requested each practice to review its assigned panel of attributed members and correct inaccuracies, and worked with the Department to correct identified inaccuracies. **RMHP**'s Prime member handbook informed members of the 90-day time frame for opting out of the MCO.

RMHP's customer service staff conducted an outreach welcome call to all newly enrolled members within 30 to 45 days of enrollment to explain the benefits of the plan, assist members with identifying and changing their assigned PCMP, conduct an initial intake screening of member needs, and identify any continuity-of-care needs for members. **RMHP** received daily files of member health needs surveys conducted by the Department and transferred results into the **RMHP** individual member intake assessment maintained in Essette to prevent duplication of intake screening performed by **RMHP** customer service staff; however, staff reported that the volume of health needs surveys received from the Department had been minimal. **RMHP**'s customer service staff remained available to serve members and providers through the "One-Call Center" and provided ongoing care coordination for Tier 1 members.

RMHP's utilization management (UM), care coordination, and customer service staff operations were well integrated within the organizational structure. In addition, 10 integrated care coordination teams (ICCTs) were distributed regionwide to provide care coordination to members in local communities; most Prime members received care coordination through the teams located within the Prime service area. All documentation of member-specific care management information, including health needs assessments and service plans, was entered and maintained in Essette, which included all Department-required components. Essette enabled secure sharing of care coordination files among care coordination teams involved with the member. **RMHP** had a business associate agreement with each participating care coordination partner to protect confidentiality of member information. For providers and organizations unable to directly access Essette, **RMHP** conducted verbal outreach to share assessment and care plan information and provided the information in writing upon request through secure communication channels. Documents and on-site interviews described UM discharge planning, assisting members with transitions of care, and care coordination interaction with other managed care plans, FFS providers, and community organizations. Staff members stated that **RMHP**'s improved access to BH claims data and to BH providers through the RAE has made care coordination seamless for Prime members. **RMHP**'s Prime provider network also included integrated care practices with embedded BH providers and care coordinators.

Prime PCMP provider agreements outlined provider responsibilities for ongoing coordination of services for members, including conducting assessments and developing care plans based on assessments. **RMHP**'s provider agreements and provider manual outlined requirements for maintaining and sharing medical records in a confidential manner in compliance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations. PCMP deliberate provider interventions to coordinate services for members were enhanced through information available to providers through

the Quality Health Network health information exchange and **RMHP**'s practice transformation program (PTP). The PTP educated providers regarding essential elements of care coordination in transitions of care and in coordination with specialist referrals, and promoted care compacts between providers. Staff stated **RMHP** had implemented a key performance indicator (KPI) to measure care compacts between providers, including at least one BH entity, and further incented providers to increase levels of care coordination in their practices through PTP tiered payments to providers.

Summary of Findings Resulting in Opportunities for Improvement

HSAG observed during on-site care coordination presentations that PCMPs do not always respond to medical record requests from other providers in a timely manner, thereby risking gaps in continuity of care. HSAG recommended that **RMHP** enhance Prime provider requirements to include responding to medical records requests "in a timely manner."

Summary of Required Actions

HSAG identified no required actions related to this standard.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

RMHP maintained written policies on member rights. Within its policies, **RMHP** delineated the rights and responsibilities for its members and included methods for the distribution of these rights to members and providers. Members received information about their rights, including a list of rights and responsibilities, in the Prime member handbook. Providers received information on member rights and responsibilities within the provider manual**.** Within its member newsletter, **RMHP** periodically included instructions for accessing a list of member rights and responsibilities, located on the website.

RMHP ensured, primarily through a review of its customer service interactions, that employees and providers afford members their rights. Staff members described the process for monitoring calls received via the customer service phone line. Member calls that described any issue of dissatisfaction that could possibly be related to a rights issue were flagged for further review. During onsite review, **RMHP** staff provided HSAG with documentation of a summary of member calls categorized as potential rights issues. **RMHP** reviewed these summaries periodically to evaluate and determine whether the issues were actually related to member rights and then responded as needed.

RMHP delineated advance directive information within its policies, the Prime member handbook, and the provider manual.

RMHP addressed compliance with federal and State laws that pertain to member rights through its policies. **RMHP** evidenced compliance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E— HIPAA, through its policies, staff procedures, and mandatory in-service trainings. During on-site interviews, staff members described methods, including secured printers and secured emails, used to safeguard protected health information (PHI).

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

HSAG found that **RMHP** did not have provisions for community education regarding advance directives. In the past, **RMHP** had relied on the **RMHP** Foundation to provide advance directive education to the community; however, the Foundation did not conduct this activity during the review period and would not likely be providing this function going forward. **RMHP** did provide an education session to healthcare providers; however, no education was provided to the community at large. **RMHP** must develop provisions for community education regarding advance directives, including what constitutes an advance directive; emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment; and description of applicable State law concerning advance directives.

Standard V—Member Information

Summary of Strengths and Findings as Evidence of Compliance

RMHP provided information to members in various formats, including on its website, via the *Getting Started Guide*, and within the Prime member handbook. After a member was enrolled with **RMHP**, the member was mailed his or her member ID; the Prime member handbook; and a copy of the *Getting Started Guide*, a supplement to the member handbook. The handbook and the guide included accurate information as defined in 42 CFR 438.10 (g). The *Getting Started Guide* provided members with a well-illustrated pathway to navigating the **RMHP** healthcare system. Prior to its release, the *Getting Started Guide* and other important member documents were reviewed by the Member Advisory Council (MAC) for feedback. HSAG reviewed email strings between MAC members with suggested changes and revisions. Subsequent to the mailing of the *Getting Started Guide*, **RMHP** contacted members via telephone to establish contact and screen for needs. **RMHP** also mailed a quarterly newsletter to members that reminded members what resources are available and how to access services.

HSAG reviewed a sample of written member information and found that **RMHP** used easily-understood language; employed a font size that met the requirement; and made available various formats, if requested. In addition, **RMHP** included a notice with all important member communications that

directed members to assistance, interpretive services, and auxiliary aids in 18-point font and written in 18 prevalent languages.

RMHP maintained a website that housed information about healthcare services available and how to access them—including a searchable provider directory, drug formulary, a link to the member handbook, community resources, covered benefits, and contact information. **RMHP**'s searchable provider directory included information about individual providers and provider groups. **RMHP** described a newly launched Provider Attributes Survey, through which **RMHP** aims to gather additional information from providers about their facilities and practices. **RMHP** intends to publish information gathered from the survey in the provider directory. This will further enhance the provider information made available to members to potentially increase access to care for members with disabilities; members self-referring for BH specialists who specialize in key areas (e.g., eating disorders and sexual assault); and members who identify as lesbian, gay, bisexual, transgendered, or queer (LGBTQ).

Summary of Findings Resulting in Opportunities for Improvement

RMHP is required to inform the member that information provided electronically is available in paper form without charge upon request and is provided within five business days. While this is noted in the Prime member handbook, HSAG suggests that **RMHP** also inform the member in a prominent place on the website.

Summary of Required Actions

HSAG evaluated **RMHP**'s website—rmhp.org—using the WAVE Web accessibility tool and found that a sample of webpages pertaining to the MCO had significant contrast errors—eighty or more—per page. **RMHP** must ensure that its website is fully readily accessible per Section 508 standards.

HSAG evaluated the searchable provider directory on **RMHP**'s website—rmhp.org—for machine-readability using the WAVE Web accessibility evaluation tool and found accessibility and contrast errors. **RMHP** must ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 standards.

HSAG reviewed **RMHP**'s provider directory in paper and in electronic form. HSAG found that the directories did not include information pertaining to whether or not the provider had completed cultural competency training and whether the provider's office has accommodations (including offices, exam rooms, and equipment) for people with physical disabilities. **RMHP** must update its provider directories to include whether or not the provider has completed cultural competency training and whether the provider's office has accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Summary of Strengths and Findings as Evidence of Compliance

RMHP's *EPSDT Policy and Procedure* (applicable to RAE and Prime) described a comprehensive program for managing and providing EPSDT services for members under 21 years of age, including:

- Definition of "medical necessity" applicable to EPSDT.
- Procedures for coordinating care for: obtaining EPSDT screenings; finding specialists; obtaining wraparound services; coordinating with other agencies; assessing members identified through developmental screenings as having SHCN; and assisting members with finding a primary care provider (PCP), making appointments, and arranging for transportation as needed.
- Definition of "comprehensive EPSDT benefits."
- Adoption of the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule as a guide to screenings and immunizations.
- Provision of member notifications regarding EPSDT benefits.
- Mechanisms for informing providers regarding EPSDT services, including provider manuals and newsletters as well as clinical practice guidelines regarding age-appropriate screenings, Centers for Disease Control and Prevention (CDC) immunization schedules, and contacting Healthy Communities.
- Partnering with Healthy Communities, including **RMHP** referral guidelines.

RMHP notified members of EPSDT benefits through new member welcome calls, the new member *Getting Started Guide*, the Prime member handbook, an annual notification letter to members informing of EPSDT benefits available to them, and various well-child care reminders sent to applicable members throughout the year. The **RMHP** website provided members detailed information on types of screenings available at no cost; frequency of screening services; diagnostic and treatment services; age-specific immunizations; and services available through Healthy Communities; and provided links to the Department, Healthy Communities, and the AAP periodicity schedule. **RMHP** care coordinators were available to assist providers and members with referrals for services not covered by the plan, to out-of-network providers, to appropriate State agencies and programs, to CMHCs, and for members with special healthcare needs.

RMHP educated providers regarding EPSDT benefits through the **RMHP** provider manual, an annual EPSDT provider letter, and provider webinars. **RMHP** provided evidence of three provider webinars—presented September through November 2018—to address specific issues related to EPSDT services. The provider manual informed providers of the EPSDT benefit, Healthy Communities, and wraparound services available to EPSDT-eligible members. The provider manual informed providers that **RMHP** had adopted the AAP Bright Futures periodicity schedule and listed all components and requirements of periodic health screenings. **RMHP** provided evidence that it conducts an annual audit of a small sample

of Prime provider medical records to verify that EPSDT screenings and examinations are documented in the medical record.

RMHP submitted materials developed for 110 practices enrolled in the **RMHP** PTP to improve skills, processes, and infrastructure related to provision of periodic health screens within practices. Materials addressed six distinct categories of EPSDT benefits. **RMHP** demonstrated that it assisted providers with resolving barriers related to EPSDT benefits; staff members stated that providers had identified barriers or concerns related to the pediatric periodicity schedule, appropriate CPT coding, genetic testing, lead toxicity screening, understanding what services are provided by whom, and authorization procedures. Staff members stated that UM medical reviewers had been specifically trained in the expanded EPSDT medical necessity authorization criteria.

RMHP provided evidence of a memorandum of understanding (MOU between **RMHP** and each of the 10 county Health Communities programs across Region 1. The MOU outlined agreement to collaborate to conduct onboarding of new RAE and Prime members as well as addressing roles and responsibilities of **RMHP** and the Healthy Communities entity to educate members regarding benefits and coordinate needed EPSDT services for members. Each agreement stated that referrals between **RMHP** and Healthy Communities would be "determined by local care coordination teams and county Healthy Communities staff." **RMHP** staff members stated that **RMHP** maintained both a regional-level relationship with Healthy Communities partners to facilitate inter-agency education, and local-level relationships to define referral processes applicable to each individual community. Staff members stated that within six months **RMHP** planned to share the Essette care coordination documentation platform with each Healthy Communities partner.

RMHP demonstrated significant attention to administering EPSDT benefits to Prime members through a comprehensive targeted approach involving member communications, provider education and assistance, care coordination activities, integrated operations, and cooperation with Healthy Communities and other EPSDT-related service agencies.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to this standard.

Summary of Required Actions

HSAG identified no required actions related to this standard.

2. Overview and Background

Overview of FY 2018–2019 Compliance Monitoring Activities

For the FY 2018–2019 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care; Standard IV—Member Rights and Protections; Standard V—Member Information; and Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services. Compliance with applicable federal managed care regulations and managed care contract requirements was evaluated for the limited managed care initiative (MCO) through review of all four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the RAE contract requirements and regulations specified by the federal Medicaid managed care regulations published May 6, 2016. HSAG assigned each requirement in the compliance monitoring tool a score of *Met, Partially Met, Not Met, or Not Applicable* for the MCO. Due to the July 1, 2018, effectiveness date of the RAE contract, the Department determined that the review period was July 1, 2018, through December 31, 2018. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key RAE and MCO personnel to determine compliance with applicable federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, and member and provider informational materials. While the RAE and MCO managed care requirements were reviewed simultaneously on-site, HSAG delineated results for each product line into individual separate reports. However, required corrective actions for the MCO are the responsibility of the RAE and are incorporated into Appendix D of the RAE Region 1 report.

The four standards chosen for the FY 2018–2019 site reviews represent a portion of the managed care requirements. The following standards will be reviewed in subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard VI—Grievances and Appeals, 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 RAE regarding:

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

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

FY 2017–2018 Corrective Action Methodology

As a follow-up to the FY 2017–2018 site review, each health plan that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the health plan was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the health plan and determined whether it successfully completed each of the required actions. HSAG and the Department continued to work with **RMHP Prime** until it completed each of the required actions from the FY 2017–2018 compliance monitoring site review.

Summary of FY 2017–2018 Required Actions

For FY 2017–2018, HSAG reviewed Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

For the Grievance System standard, **RMHP Prime** was required to:

- Ensure that members receive written acknowledgement of each grievance within two working days of the health plan's receipt of the grievance.
- Ensure that written acknowledgement of each appeal is sent to members within two working days of receipt, unless the member or designated client representative requests an expedited resolution.
- Ensure that the written notice of appeal resolution letter includes the date that the resolution process was completed and accurate State fair hearing time frame requirements.
- Ensure that all documentation, including notice of resolution template letters, support that, for adverse benefit determinations, members may request State fair hearings within 120 calendar days from the dates of the notices of resolution.

For the Member Information standard, **RMHP Prime** had no required actions.

For the Provider Participation and Program Integrity standard, **RMHP Prime** was required to have a method to verify regularly, by sampling or other methods, whether services represented to have been delivered by network providers were received by members.

For the Subcontracts and Delegation standard, **RMHP Prime** had no required actions.

Summary of Corrective Action/Document Review

RMHP Prime submitted a proposed CAP in April 2018. HSAG and the Department reviewed and approved the proposed plan and responded to **RMHP Prime**. **RMHP Prime** submitted documents as evidence of completion of its proposed interventions in October 2018. HSAG and the Department reviewed and approved **RMHP Prime**'s evidence of completion of the required actions and responded to **RMHP Prime** in January 2019.

Summary of Continued Required Actions

RMHP Prime successfully completed the 2017–2018 CAP, resulting in no continued corrective actions.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. A. *For the Capitated Physical Health Benefits,* the MCO implements procedures to deliver care to and coordinate services for all members. B. The MCO's care coordination activities place emphasis on acute, complex, and high-risk patients and ensure active management of high-cost and high-need patients. The RAE ensures that care coordination: • Is accessible to members. • Is provided at the point of care whenever possible. • Addresses both short- and long-term health needs. • Is culturally responsive. • Respects member preferences. • Supports regular communication between care coordinators and the practitioners delivering services to members. • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems. • Is documented, for both medical and non-medical activities. • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs. *42 CFR 438.208(b)* Contract Amendment 1: Exhibit M1—11.3.1, 11.3.7	*III_CM_Care Coordination Policy and Procedure* This policy and procedure describes the Rocky Mountain Health Plans (RMHP) comprehensive, client and family centered integrated care coordination program. • Is accessible to members: *Access to Care Coordination* on pages 13-14 • Is provided at the point of care whenever possible: *Active Care Plan Maintenance* on page 19 • Addresses both short- and long-term health needs: *Care Plan Development* on page 16 • Is culturally responsive: Found throughout the P&P, e.g., pages14 -16, 19 • Respects member preferences: Found throughout the P&P, e.g., pages 14 -16 • Supports regular communication between care coordinators and the practitioners delivering services to members: *Care Plan Development* on page 16; *Active Care Plan Maintenance and Follow-up* on pages 19-20 • Reduces duplication and promotes continuity by collaborating with the member and the member's care team to identify a lead care coordinator for members receiving care coordination from multiple systems: *Initial Care Coordination Outreach and Screening* on page 14; *Care Plan Development* on page 18	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• Is documented, for both medical and non-medical activities: *Care Plan Development* on page 17 • Addresses potential gaps in meeting the member's interrelated medical, social, developmental, behavioral, educational, informal support system, financial, and spiritual needs: *Care Plan Development* on page 16 *III_CM_Comprehensive Needs Assessment* RMHP assesses the Member's health and health behavior risks, medical and nonmedical needs, and social determinants of health needs, including determining if a care plan exists. RMHP uses a comprehensive, client/family centered, integrated approach to assessment of members for care coordination needs. *III_CM_Sample Care Plan Redacted* RMHP care coordination works collaboratively with the Member and caregivers (if applicable) to create an individualized care plan that includes documentation of the Member's desired health outcomes and identifies other providers of that member's care coordination team. *III_CM_RAE Care Coordination Activity & ICCT's* This workflow describes Outreach Populations and how they are placed in a campaign. It illustrates the	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	coverage area of the RAE 1 Care Teams and how they and the Dedicated Outreach Teams feed into the Care Coordination Process. It identifies Regional or Project Based Populations that feed into the Dedicated Outreach Teams. *III_CM_Health Needs Survey Process* *III_CM_Health Needs Survey Workflow* *III_CM_ Health Needs Survey Example* *III_CM_ Health Needs Survey File 071718 Redacted* The Health Needs Survey is a voluntary survey completed by Members enrolling in a Medicaid program such as RAE or Prime. Members indicate when they need help managing their health conditions, are pregnant, would like help with resources or to receive an outreach call from a care coordinator. Survey data is transferred from HCPF to the RAE and helps prioritize Members who could benefit from care coordination. *III_CM_Care Plan Workflow v3* *III_CM_Essette Documentation Screen Shot* *III_CM_Essette Care Plan Example* These documents illustrate how RMHP care coordination works collaboratively with the Member and caregivers (if applicable) to create an individualized care plan that includes documentation of the Member's desired health outcomes and identifies other providers of that Member's care coordination team.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
2. The MCO ensures that each member receiving *capitated physical health services* has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services accessed by the member. • The member must be provided information on how to contact his or her designated person or entity. *42 CFR 438.208(b)(1)* Contract Amendment 1: Exhibit M1—None	*III_CM_Care Coordination Policy and Procedure* Pages 13-14 describe Member *Access to Care Coordination.* Page 14 describes *Initial Care Coordination Outreach and Screening.* *CS_RAE_PRIME_Welcome Call Script* *CM_Welcome Call Intake Screener* RMHP Customer Service representatives make outbound Welcome calls to all new members. Whether the Member call is outgoing or incoming, the initial Member conversation introduces care coordination and screens the Member for social, medical and behavioral health needs. When a Member is reached and a Screener is completed, the information is housed in Essette. *CS_RAE_Prime Sorry We Missed You_ENG SP* This letter is sent to all members who are not reached through the Welcome Call. Members are urged to call Customer Service if they need assistance to access appropriate care and/or to connect with community resources. *Getting Started Guide_RAE_Prime_ENG_508* This is mailed to all new Members upon enrollment. In the section *Get Help with Your Care*, Members are advised how to contact a Care Coordinator.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime Member Handbook_ENG_508 Page 11 explains *How to Contact an RMHP Care Coordinator.* *III_CS_Medicaid One Call Flow* This shows the simple process Members can follow to reach a Care Coordinator.	
3. The MCO receives and processes the Department's attribution and assignment list to ensure accurate member attribution and assignment. Members enrolled in the MCO have 90 days in which to opt out. Any member who does not opt out remains enrolled until the member's next open enrollment period, at which time the member shall receive an open enrollment notice. Subsequent enrollment will be for 12 months, and a member may not disenroll from the RAE's *Managed Care Capitation Initiative*. Contract Amendment 1: Exhibit M1—6.7	*III_CI_Attribution Validation Description* This document describes the quarterly activity taken by RMHP to ensure accurate member attribution and assignment. *III_CM_RAE PCMP Change Process* This document describes the process for helping RAE Member's identify and change their Primary Care Medical Provider (PCMP). Care Coordinators (CC) offer a three way call with Member, the CC and the Department's enrollment broker to assist the Member in choosing a different PCMP. *Prime Member Handbook_ENG-508* On pages 9-10, Members are advised of the circumstances and timeframe for leaving RMHP. They must call the number for Health First Colorado Enrollment to request disenrollment or to change plans. *Note regarding MCO opt out activity*: all MCO enrollment/disenrollment activity is performed by	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	First Health Colorado Enrollment (the enrollment broker).	
4. The MCO ensures that care coordination includes deliberate provider interventions to coordinate with other aspects of the health system or interventions over an extended period of time by an individual designated to coordinate a member's health and social needs. Contract Amendment 1: Exhibit M1—11.3.3.2	*III_CM_Care Coordination Policy and Procedure* This requirement is addressed throughout this P&P mainly in the *Care Plan Development* section at pages16 and 18-20. *III_CM_People with SHCN Policy* Addresses this requirement for people with special health care needs. On page 1, item 2 provides that RMHP coordinates health care services for children with Special Health Care Needs with other agencies or entities. *III_PT_Med Nghbrhd Initiative Summary* This document describes RMHP's work at developing a medical neighborhood, including work to improve communication and coordination between providers and care team members via Practice Transformation Programs described in the document. *III_PT_Care Compact Presentation* This is a PPT presentation that was delivered to providers at the RMHP Summit Learning Collaborative that explains how a care compact supports communication and safe transitions between primary care and specialty providers. *III_PT_ Care Compact Element Planner* Tool developed by the Practice Transformation Team and distributed during Learning Collaboratives for	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	provider use so that they understand the elements necessary for developing effective care compacts supporting care coordination, *III_PT_ Care Compact Key Components* Tool developed by the Practice Transformation Team and distributed during Learning Collaboratives that describes the key elements of a care compact and includes a care compact template. *III_PT_ Foresight–GV Neurology* *III_PT_ Western Valley FP–Atlas Arch Neurosurgery* Examples of care compacts between primary care and specialty practices.	
5. The MCO implements procedures to coordinate services furnished to the member: • Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays. • With the services the member receives from any other managed care plan. • With the services the member receives in fee-for-service (FFS) Medicaid. • With the services the member receives from community and social support providers. *42 CFR 438.208(b)(2)* Contract Amendment 1: Exhibit M1—11.3.10, 11.3.5, 10.3.2,10.3.4, 14.5.1.3	*III_CM_Care Coordination Policy and Procedure* The 4th and 6th paragraphs under *Care Plan Development* on page 16 describe the procedures to coordinate services to the Member under the circumstances listed. *III_CM_RAE Communication to Effectively Coordinate Care* This policy and procedure describes how communication is facilitated among PCMPs, ICCTs, CMHCs, and other RAEs, including through the use of Essette, between settings of care and with other services the Member is receiving	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The MCO uses the results of the health needs survey, provided by the Department, to inform member outreach and care coordination activities. The MCO: • Processes a daily data transfer from the Department containing responses to member health needs surveys. • Reviews the member responses to the health needs survey on a regular basis to identify members who may benefit from timely contact and support from the member's PCMP, RAE, or MCO. *42 CFR 438.208(b)(3)* Contract Amendment 1: Exhibit M1—7.5.2–3	*III_CM_ Health Needs Survey Process* *III_CM_Health Needs Survey Workflow* *III_CM_ Health Needs Survey Example* *III_CM_ Health Needs Survey File 071718 Redacted* The Health Needs Survey is a voluntary survey completed by Members enrolling in a Medicaid program such as RAE or Prime. Members indicate when they need help managing their health conditions, are pregnant, would like help with resources or to receive an outreach call from a care coordinator. The policy describes how RMHP processes and stratifies the survey. The Workflow illustrates how RMHP receives, processes and reviews the data to inform member outreach and care coordination activities.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. *For the Capitated Physical Health Benefits:* The MCO ensures: • That each member receives an individual intake and assessment appropriate for the level of care needed. • Use of the information gathered in the member's intake and assessment to build a service plan. • Provision of continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems. *42 CFR 438.208(c)(2-3)* Contract Amendment 1: Exhibit M1—14.5.1.1–3	*CS_RAE_PRIME_Welcome Call Script* *CM_Welcome Call Intake Screener* RMHP Customer Service representatives make outbound Welcome calls to all new members. Whether the Member call is outgoing or incoming, the initial Member conversation introduces care coordination and screens the member for social, medical and behavioral health needs. When a Member is reached and a Screener is completed, the information is housed in Essette. *III_CS_RAE & Prime Welcome Call_Stats* These statistics illustrate the attempts to reach and complete an initial intake Screener for RAE and Prime Members during the months of July-	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	November, 2018. During that time, intake Screeners were completed on 69.12% of Members reached. *III_CM_Care Coordination Policy and Procedure* • That each member receives an individual intake and assessment appropriate for the level of care needed: Pages 1-2 indicate that "All members identified by these activities receive outreach to attempt screening, assessment, coordination and care planning as needed." • Use of the information gathered in the member's intake and assessment to build a service plan: *CarePlan Development* on page 16, first paragraph. • Provision of continuity of care for members who are involved in multiple systems and experience service transitions from other Medicaid programs and delivery systems: *Special Populations* on pages 5-10 describes continuity of care activities for Members in transition and involved in multiple systems. *III_CM_Continuity & Coordination of Care 2018 Intent/Policy* on page 1 indicates RMHP facilitates continuity and coordination of medical care across its delivery system.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	III_CI_Care Coordination Report_Q1_FY18-19 v2 This is a report of the care coordination activity in Quarter 1 of 2018-19, submitted to HCPF as a deliverable. Tab 4 describes the type, nature, and relative outcomes of the activities provided to members transitioning across care settings.	
8. *For the Capitated Physical Health Benefits:* The MCO shares with other entities serving the member the results of identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR 438.208(b)(4)* Contract Amendment 1: Exhibit M1—None	*III_CM_Care Coordination Policy and Procedure* Page 2 explains that RMHP utilizes a care management system platform, Essette, to achieve distribution of all of the Members identified by stratification, ADT alerts, Special Populations and Referrals to RMHP or ICCT staff. Screening, assessment, care planning, and follow up are all managed through Essette. Community Mental Health Centers use the same system for referral and care coordination. This sharing and integration of Essette allows coordination of the many entities that may be providing care/services to a member resulting in better member outcomes and less duplication of care and services.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
9. *For the Capitated Physical Health Benefits:* The MCO ensures that each provider furnishing services to members maintains and shares, as appropriate, member health records, in accordance with professional standards. *42 CFR 438.208(b)(5)* Contract Amendment 1: Exhibit M1—None	*2018-19 Provider Manual* Pages 101-102 describe PCP responsibilities for maintaining and sharing records with specialty physicians and Consultants. Member confidentiality is described at the bottom of page 102. Pages 103-105 details all aspects of *Medical Records* maintenance, including *Release of Information and Transfer of Records.* Detailed information about what	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	office records should include is provided. Providers are responsible for the maintenance of adequate medical records, which are to be secure, complete, legible, accurate, accessible, organized, and maintained in a format that facilitates retrieval of information. *III_PNM_Physician Medical Services Agreement* Section 2.N.(7), page 11 requires physicians to share medical records with other treating providers to facilitate continuity of care consistent with state and federal law.	
10. The MCO possesses and maintains an electronic care coordination tool to support communication and coordination among members of the provider network and health neighborhood. The care coordination tool collects and aggregates, at a minimum: • Name and Medicaid ID of member for whom care coordination interventions were provided. • Age. • Gender identity. • Race/ethnicity. • Name of entity or entities providing care coordination, including the member's choice of lead care coordinator if there are multiple coordinators. • Care coordination notes, activities, and member needs. • Stratification level. • Information that can aid in the creation and monitoring of a care plan for the member—such as clinical history,	*III_CM_Care Coordination Policy and Procedure* Page 2 explains that RMHP utilizes a care management system platform, Essette, to support communication and coordination among the many entities (members of the provider network and health neighborhood) providing care/services to members. *III_CM_Essette Screen Shot 1* (Name, Age, Gender, Care Coordinator, Stratification Level [Acuity]*)* *III_CM_Essette Screen Shot 2 (*Medicaid ID) *III_CM_Essette Screen Shot* 3 (Lead Care Coordinator) *III_CM_Essette Screen Shot 4* (Assessment, Care Plan, Notes) *III_CM_Essette Documentation Screen Shot* (Care Coordination Notes, activities and member needs; information that can aid in the creation and monitoring of a care plan for the Member; Claims	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
medications, social supports, community resources, and member goals. Contract Amendment 1: Exhibit M1—15.2.1.1, 15.2.1.3, 15.2.1.4	Admissions, ER Visits, Medications, Social Supports*)* These documents illustrate the data that is collected and aggregated in Essette, including the items listed in the requirement.	
11. The MCO ensures that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR 438.208(b)(6)* Contract: 20.B Contract Amendment 1: Exhibit M1—11.3.7.11, 15.2.1.2.2	*III_CM_Care Coordination Policy and Procedure* Page 19 of *Care Plan Development* provides that "[a]ny communication with a non-member representative will require the appropriate Appointment of Representative/HIPAA paperwork to be filled out." *CM_HIPAA Consent Form 0918* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR requirements to assure member privacy is protected. RMHP uses this *Authorization to Use or Disclose Specific Information* (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *CM_Confidentiality and Retention of Member Records* Section I, page 1 states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our members. All information obtained in an official capacity is confidential and staff will comply with HIPAA Privacy Regulations.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

MCO Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	11	**Total Score**		=	11
				Total Score ÷ Total Applicable		=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO has written policies regarding the member rights specified in this standard. *42 CFR 438.100(a)(1)* Contract Amendment 1: Exhibit M1—7.3.7.1–2	*IV_CS_Prime RAE CHP+ Member Rights & Responsibilities* This *Policy and Procedure* documents RMHP's written policy regarding a Prime, RAE, or CHP+ Member's Rights and Responsibilities.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
2. The MCO complies with any applicable federal and State laws that pertain to member rights and ensure that employees and contracted providers observe and protect those rights. *42 CFR 438.100(a)(2)* Contract Amendment 1: Exhibit M1—None	*2018-19 Provider Manual* Page 107-108 of the Provider Manual describes Member rights to network providers. (Note: *RAE 1 Behavioral Health Provider Manual* will be available onsite). *IV_PNM_LawExhibit to Provider Agreements* See Page 7-8, Section 5 for *Medicaid Recipient Rights*. Page 8, Section 6 lists the federal and State laws with which RMHP, providers and subcontractor shall comply. *IV_Compliance Plan_Corp_Mission and Values* Page 2 of the *Compliance Plan* illustrates RMHP's Mission and Values. RMHP's value statement confirms that "We honor the rights of physicians and patients in medical decision-making."	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The MCO's policies and procedures ensure that each member is guaranteed the right to: • Receive information in accordance with information requirements (42 CFR 438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. • Request and receive a copy of his or her medical records and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR 438.206 through 42 CFR 438.210). *42 CFR 438.100(b)(2) and (3)* Contract Amendment 1: Exhibit M1—7.3.7.2.1–6; 7.3.7.4	*IV_CS_Prime RAE CHP+ Member Rights & Responsibilities* Page 2, Section 6 Member rights as specified in state and federal regulation. *Member Newsletter_Fall 2018* Page 3, *RMHP Helpful Resources* advises Members how to find information online to learn more about their Member rights and responsibilities.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The MCO ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the health plan, its network providers, or the State Medicaid agency treats the member. *42 CFR 438.100(c)* Contract Amendment 1: Exhibit M1—7.3.7.2.7	*IV_CS_Prime RAE CHP+ Member Rights & Responsibilities* Page 2, bullet #8 indicates that the Member is able to exercise their rights without being treated differently. *2018-19 Provider Manual* Page 107 indicates that Members are able to freely exercise their rights without being treated differently. *Prime Member Handbook_ENG_508* Page 38, bullet #8 indicates to Members that they are able to exercise their rights without being treated differently. *IV_PNM_LawExhibit to Provider Agreements* Page 7-8, Section 5, *Medicaid Recipient Rights,* which states that "Contractor shall ensure that Medicaid Recipients have the rights set forth in 42 C.F.R. section 438.100(b)(2), including but not limited to the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, consistent with 42 C.F.R., section 438.100.(b)(2)(v)."	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
5. The MCO complies with any other federal and State laws that pertain to member rights including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and Section 1557 of the Patient Protection and Affordable Care Act. *42 CFR 438.100(d)* Contract Amendment 1: 21.U	*IV_Screen Shot_#5_Federal and State Laws* Information about federal and State laws that pertain to Member rights is posted on the RMHP.org website. It is also posted in prominent locations in RMHP physical office locations. *2018-19 Provider Manual* Page 106 informs providers of the RMHP Equal Opportunity Policy Statement. *Prime Member Handbook_ENG_508* Page 44 informs Members of the RMHP Equal Opportunity Policy. *IV_HR_ Law Exhibit_Non-Prov_Ind Contractor_1018* This Law Exhibit is attached to all non-provider contracts that are executed with RMHP. See pages 3-4, #11 for a list of statutes and regulations that RMHP requires the Contractor and any subcontractor to comply. *IV_PNM_LawExhibit to Provider Agreements* Law Exhibit, page 1, Sections I.1. and I.2. present the *Non-Discrimination* and *Equal Opportunity* language found in provider contracts. Page 8, Section III.6 references other federal and state laws that pertain to Member rights.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. For medical records and any other health and enrollment information that identifies a particular member, the MCO use and disclose individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42 CFR 438.224* Contract: 20.A Exhibit A—2.c and 3.a	*CM_HIPAA Consent Form 0918* In the process of coordinating care, RMHP follows all HIPAA and 45 CFR guidelines to assure member privacy is protected. RMHP uses this *Authorization to Use or Disclose Specific Information* (Consent Form) for RMHP to use/obtain or disclose specific personal health information. *CM_Confidentiality and Retention of Member Records* Page 1, Section I states that employees of Rocky Mountain have a moral and legal obligation and responsibility to protect the privacy of our Members. All information obtained in an official capacity is confidential and will comply with HIPAA Privacy Regulations. Section II describes how RMHP protects the confidentiality of all Member records.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The MCO maintains written policies and procedures and provide written information to individuals concerning advance directives with respect to all adult individuals receiving care by or through the MCO. Advance directives policies and procedures include: • A clear statement of limitation if the MCO cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians.	*Prime Member Handbook_ENG_508* Pages 42-52 provides written information to Members about advance directives. *2018-19 Provider Manual* Pages 93-94 provides written information to providers about advance directives.	**MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. • Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. • Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. • Provisions for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. • Provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and provision that members are not discriminated against based on whether they have executed an advance directive. • Provisions for ensuring compliance with State laws regarding advance directives. • Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. • Provisions for the education of staff concerning its policies and procedures on advance directives.	1st bullet RMHP does not impose any limitations with respect to implementing advance directives as a matter of conscience, therefore no statement to this effect is included in written information to individuals. 2nd, 3rd and 4th bullets *IV_RMHMO Medicare Medicaid Advance Directives _PP* This policy implements advance directives. Page 2, item 3, specifies that the provider's obligations with respect to advance directions must comply with 42 CFR 489, Subpart I and, at a minimum, do the following. • Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians. • Identify the state legal authority permitting such objection. • Describe the range of medical conditions or procedures affected by the conscientious objection. *2018-19 Provider Manual* Page 94 explains practitioner responsibilities around advance directives, including the policies they must have in place to provide information to Members about their rights under state law to	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Provisions for community education regarding advance directives that include: – What constitutes an advance directive. – Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. – Description of applicable State law concerning advance directives. *42 CFR 438.3(j)* *42 CFR 422.128* Contract Amendment 1: Exhibit M1—7.3.11.3–7	create an advance directive, and the policies of their organization to respect implementation of those rights (including any limitations because of conscientious objections). 5th and 6th bullets *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 1 under "Process," paragraphs 1.c. and d. provide that Members rights include that advance directive information is given to the Member's family if he or she is incapacitated at the time of enrollment. Once the Member is no longer incapacitated, the information is given to the individual directly. Page 1, under "Procedure," paragraph 1 requires providers to have and comply with written policies and procedures for advance directives, including requirements in 42 CFR 489.102. Subsection (e) of this regulation sets forth the timing of the provision of advance directive information when the Member is incapacitated. *IV_PR_ Advance Directives_PP* Page 2, third bullet, practitioners must provide advance directive information to incapacitated Members once they are no longer incapacitated.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	7th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 1. Item 4, and page 2, item 2.b sets forth the Member's right to have an advance directive recorded in the medical record. Page 2, item 4 provides that when chart audits occur they will include a review for the presence or absence of advance directives in the medical record. *V_PR_ Advance Directives_PP* Page 1, under "Key Components," a practitioner is required to include a Member's advance directive in the medical record. *2018-19 Provider Manual* Page 94 provides that a practitioner must include a Member's advance directive in the medical record. 8th bullet *Prime Member Handbook_ENG_508* Page 50, *Know the Law*, informs Members that they will not be denied services, treatment or admission to a health care facility if the Member does not sign an advance directive. *IV_PR_ Advance Directives_PP* Under "Purpose" on page 1 of the policy, providers are prohibited from discriminating against Members based on whether the Member has executed an advance directive. Under "Key	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Components" a practitioner may not condition the provision health or medical care based on whether the Member has signed an advance directive. *2018-19 Provider Manual* Page 94 provides that a practitioner may not condition the provision of health or medical care based on whether or not the Member has signed an advance directive. 9th bullet *Prime Member Handbook_ENG_508* To ensure compliance with state laws regarding advance directives, page 52 provides information to Members about how to complain if an advance directive is not followed. 10th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 2, item 2.a. provides that Members will be informed of changes in state law concerning advance directives no later than 90 days following the change in law. 11th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP*	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 2, item 5.c. provides that RMHP will train staff on policies and procedures on advance directives. 12th bullet *IV_RMHMO Medicare Medicaid Advance Directives _PP* Page 2, item 5.d. provides that RMHP will provide community education on advance directives, including issues that the education will address.	
Findings: RMHP did not have provisions for community education regarding advance directives. In the past, RMHP had relied on the RMHP Foundation to provide advance directive education to the community; however, the Foundation did not conduct this activity during the review period and would not likely be providing this function going forward. RMHP did provide an education session to healthcare providers; however, no education was provided to the community at large.		
Required Actions: RMHP must develop provisions for community education regarding advance directives—including what constitutes an advance directive, emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and description of applicable State law concerning advance directives.		

MCO Results for Standard IV—Member Rights and Protections							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	6
				Total Score ÷ Total Applicable		=	86%

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO provides all required member information to members in a manner and format that may be easily understood and is readily accessible by enrollees. • The MCO ensures that all member materials (for large-scale member communications) have been member tested. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR 438.10(b)(1)* Contract Amendment 1: Exhibit M1—7.2.5, 7.2.7.9	*See also Element #5 for evidence that information is readily accessible by members.* *V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* This Policy and Procedure describes the process to assure that all materials intended for distribution to RMHP RAE and Prime members are reviewed and edited to promote ease of use for RMHP enrollees, and to assure that they are readily accessible. Pages 1-2 also explain the process that RMHP follows to ensure that materials are member tested. *Getting Started Guide_RAE_Prime_ENG_508* *Prime Member Handbook_ENG_508* *V_Prime Directory_ 1118 ENG_ 508* *V_RAE Directory_ENG_508* *Health First Colorado_Member Handbook RMHP Insert_508* *V_Prime-CHP Formulary_ENG_508* The documents listed **above** are examples of materials demonstrating that member information is provided in a manner and format that is easily understood. *V_Accessibility Report_RAE-Prime_Getting Started Guide*	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_Accessibility Report_Health First Colorado Handbook_RMHP Insert *V_Accessibility Report_Prime Member Handbook* *V_Accessibility Report_Prime Directory* *V_Accessibility Report_RAE Directory* *V_Accessibility Report_Prime-CHP Formulary* The Accessibility Reports listed **above** show that these required member documents have passed 508 remediation.	
2. The MCO has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR 438.10(c)(7)* Contract Amendment 1: Exhibit M1—7.3.6.1.7	*Health First Colorado_Member Handbook_1018* *Health First Colorado_Member Handbook RMHP Insert_508* The Department distributes the *Health First Colorado Member Handbook.* RMHP sends the *Health First Colorado Handbook* and the *RMHP Insert* to Members upon request. *Prime Member Handbook_ENG_508* The *Prime Member Handbook* includes information to help members understand the requirements and benefits of the plan. The RMHP Customer service number is listed on the cover and in the footer of each page of the handbook. *Getting Started Guide_RAE_Prime_ENG_508* This document includes important information to help Member understand the requirements and benefits of the RAE and Prime plans. It also includes information about how to access valuable	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	information on the RMHP website. It is mailed to new Members upon enrollment. *CS_RAE_Prime_ Welcome Call Script* *CM_Welcome Call Intake Screener* *CS_RAE_Prime_ Sorry we Missed You_ENG SP* The documents listed **above** illustrate other mechanisms (e.g., telephone calls, follow-up letter) we use to assist members to understand the requirements and benefits of the plan. *V_Screen Shot_# 2_Understanding Plan* This screen shot provides information about *Understanding the Regional Organization*.	
3. For consistency in the information provided to members, the MCO uses the following as developed by the State, when applicable and when available: • Definitions for managed care terminology, including: appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 2, second bullet, indicates that for consistency in the information provided to members, RMHP will use the definitions for managed care terminology developed by the Department as soon as they are made available to RMHP. *Health First Colorado_Member Handbook_1018* The Department distributes this handbook. *V_Screen Shot_#11_Link to HFC Member Handbook*	**MCO:** ☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. • Model member handbooks and member notices. *42 CFR 438.10(c)(4)* Contract Amendment 1: Exhibit M1—3.6	RMHP provides a link to the *Health First Colorado Member Handbook* located on the Health First Colorado website. *V_CM_RAE-Prime Medicaid Denial Ltr_Model Adverse Ben Det Template* This is a sample letter that uses the Model Adverse Determination template provided by the Department.	
Findings: The Department has not provided a list of these definitions to the health plans, excepting a few that may appear in the contract. HSAG is unable to review all documents for use of these terms. HSAG alerted the health plans to be aware of this requirement and to consistently use definitions from the Department when available.		
4. The MCO makes written information available in prevalent non-English languages in their service areas and in alternative formats upon member request at no cost. • Written materials that are critical to obtaining services include provider directories, member handbooks, appeal and grievance notices, and denial and termination notices. • All written materials for members must: – Use easily understood language and format. – Use a font size no smaller than 12-point. – Be available in alternative formats and through provision of auxiliary aids and service that take into consideration the special needs of members with disabilities or limited English proficiency. – Include taglines in large print (18-point) and prevalent non-English languages describing how to	*V_CI_ Getting Started Guide_RAE_Prime _SP_508* *V_Prime Member Handbook_SP_508* *V_Prime Directory_1118 SP_508* *V_RAE Directory_SP* *CS_RAE_Prime Sorry We Missed You_ENG SP* *V_ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination_ SP_061418* *V_Prime-CHP Formulary_100118 SP* *V_CM_Grievance Resolution Template_SP* *V_CM_Appeals Resolution Template_SP* The documents listed **above** are examples of member materials that are available to Members in Spanish. Spanish is the prevalent non-English language in the RMHP Prime and RAE service-area.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
request auxiliary aids and services, including written translation or oral interpretation and the toll-free and TTY/TDY customer service numbers and availability of materials in alternative formats. – Be member tested. *42 CFR 438.10(d)(3) and (d)(6)* Contract Amendment 1: Exhibit M1—7.2.7.3–9, 7.3.13.3	*Prime Member Handbook_ENG_508* Cover Page (large print) and page iii-iv of the Prime Member Handbook explains how members can access materials in other languages and formats. *V_ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 061418* This document indicates in 18 different languages that language assistance services are available to members free of charge. It includes taglines in large print (18-point) and prevalent non-English languages. The Notice of Nondiscrimination describes how to request free auxiliary aids and services to assist people with disabilities to communicate effectively with us. This notice is inserted in all written materials that are critical to obtaining services. *V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 1-2 states that RMHP will create member material that is easy to use and understand, that RMHP will make materials available in non-English languages and alternative formats without charge, that taglines will be included and that documents will be member tested.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_CS_Process for Large Print Document Request *V_CS_Process for Alternate Language Document Request* These Customer Service processes explain RMHP's process for making written information available in other formats and alternate languages.	
5. *If the MCO makes information available electronically:* Information provided electronically must meet the following requirements: • The format is readily accessible (see definition of "readily accessible" above). • The information is placed in a website location that is prominent and readily accessible. • The information can be electronically retained and printed. • The information complies with content and language requirements. • The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR 438.10(c)(6)* Contract Amendment 1: Exhibit M1—7.3.14.1	*V_IT_Section 508 Compliance Testing Report CUS-100 HealthSparq One* The searchable, online provider directory is accessible. HealthSparq (online directory vendor) provided this *Compliance Testing Report* with affirmation that the web pages meet 508 compliance mandates. *V_Accessibility Report_RAE-Prime Getting Started Guide* *V_Accessibility Report_Prime Member Handbook* *V_Accessibility Report_Prime Directory* *V_Accessibility Report_RAE Directory* *V_Accessibility Report_Prime-CHP Formulary* *V_Accessibility Report_Health First Colorado Handbook_RMHP Insert* The Accessibility Reports listed above show that these required member documents posted on rmhp.org have passed 508 remediation.	**MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP Page 3 indicates that required member materials that are accessible electronically to Members online (e.g., member handbooks, provider directory, formulary) will meet the stated requirements. Page 2 indicates that RMHP will make Member materials available to an enrollee in paper form via U.S. mail and without charge within five (5) business days of a request. *Prime Member Handbook_ENG_508* Page iv indicates that the Member Handbook and the Provider Directory are at rmhp.org where the member can view or print these documents. Members are informed that they can also ask RMHP to mail a copy at any time at no cost. *V_Screen Shot_#13_Customized Website* These sample screen shots illustrate examples of content available on the website.	
Findings: HSAG evaluated RMHP's website, RMHP.org, using the WAVE Web accessibility evaluation tool and found that a sample of pages on the website pertaining to RMHP Prime contained significant contrast errors (eighty or more) per page.		
Required Actions: RMHP must ensure that its website is fully readily accessible per Section 508 standards.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
6. The MCO makes available to members in electronic or paper form information about its formulary. *42 CFR 438.10(i)* Contract Amendment 1: R1 Exhibit M1—14.2.1.6.2.1–2 R5 Exhibit M1—14.2.1.7.2.1–2	*Getting Started Guide_RAE_Prime_ENG_508* Page 4 explains how to access the formulary online and how to request a paper copy at no charge. *Prime Member Handbook_ENG_508* Page 18 explains how to access the formulary online. *V_Screen Shot_#6_Drug Formularies* This screen shot shows that RMHP makes information about its formulary available to Members on the website in electronic and paper form.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
7. The MCO makes interpretation services (for all non-English languages) available free of charge, notify members that oral interpretation is available for any language and written translation is available in prevalent languages, and inform about how to access those services. • This includes oral interpretation and use of auxiliary aids such as TTY/TDY and American Sign Language. • The MCO notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities and inform how to access such services. *42 CFR 438.10 (d)(4) and (d)(5)* Contract Amendment 1: Exhibit M1—7.2.6.2-4	*V_CS_Accommodations for Mem w Disabilities_PP* This P&P describes how RMHP accommodates Members with communication barriers. Customer Service provides the following services: • Members who are hearing impaired can access TTY; 711 or use Live Chat or email. • For non-English speaking Members, CS utilizes LanguageLine Solutions interpreters. • Auxiliary aids and services (e.g., large print, braille, non-English written materials are available. • These services are provided at no cost to the Member.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Prime Member Handbook_ENG_508 Pages 3 & 14 explain that for callers who do not speak English, RMHP uses Certified interpreters. RMHP provides interpretation services at no cost to members, and advises members to tell Customer Service if they need interpreter services or help in other languages. *V_ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 061418* This document indicates in 17 different languages that language assistance services are available to members free of charge. The *Notice of Nondiscrimination* informs Members that RMHP provides free auxiliary aids and services to people with disabilities to communicate effectively with us. This notice is inserted in all written materials that are critical to obtaining services. *V_CS_Handle Language Line Calls* *V_CS_Handle Relay Colorado Calls* These documents describe the process that Customer Service Representatives follow to handle Language Line and Relay Colorado phone calls with Members.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
8. The MCO ensures that: • Language assistance is provided at all points of contact, in a timely manner and during all hours of operation. • Customer service telephone functions easily access interpreter or bilingual services. Contract Amendment 1: Exhibit M1—7.2.6.1, 7.2.6.5	*Prime Member Handbook_ENG_508* Cover Page (large print) and page iii-iv of the Prime Member Handbook explains how members can access materials in other languages and formats. Hours of operation for customer service are specified. *V_ACC_Prime_CHP+ Multi Language Insert Tagline and Nondiscrimination 061418* This document indicates in 17 different languages that language assistance services are available to members free of charge. The *Notice of Nondiscrimination* informs Members that RMHP provides free auxiliary aids and services to people with disabilities to communicate effectively with us. This notice is inserted in all written materials that are critical to obtaining services. *V_CS_Handle Language Line Calls* *V_CS_Handle Relay Colorado Calls* These documents describe the process that Customer Service Representatives follow to handle Language Line and Relay Colorado phone calls with Members.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
9. The MCO provides each member with a member handbook within a reasonable time after receiving notification of the member's enrollment. *42 CFR 438.10 (g)(1)* Contract Amendment 1: Exhibit M1—None	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 2-3 state that the *Getting Started Guide* is mailed to all new RAE members within a reasonable timeframe after notification of a member's enrollment. The *Getting Started Guide* advises members how to access the Member Handbook on the website or request a paper copy. *Getting Started Guide_RAE_Prime_ENG_508* Explains that RMHP sends the *Getting Started Guide* to tell RAE and Prime members how to access material on the website or how to request paper copies.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
10. The MCO gives members written notice of any significant change (as defined by the State) in the information required at 438.10(g) at least 30 days before the intended effective date of the change. *42 CFR 438.10(g)(4)* Contract Amendment 1: Exhibit M1—None	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 2 indicates that RMHP will provide enrollees at least a 30-day notice of any change in the information that the State defines as significant. *Member Newsletter_Spring 2018* Page 2, *Important Information for RMHP Prime Members*, informs Members of a copay change for outpatient hospital visits to be effective July 1, 2018. Page 2, *Coming Soon*, informs Members that beginning July 1, 2018, Prime members will	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	participate in the Regional Accountable Entity (RAE). Examples of written notices of significant changes are listed above.	
11. For any MCO member handbook or supplement to the member handbook provided to members, the MCO ensures that information is consistent with federal requirements in 42 CFR 438.10(g). • The MCO ensures that its member handbook or supplement references a link to the Prime member handbook. *42 CFR 438.10* Contract Amendment 1: Exhibit M1—7.3.8.1	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Pages 1-2 indicate how RMHP prepares member materials so that all information is consistent with federal requirements. *Getting Started Guide_RAE_Prime_ENG_508* Section 4, *Understand Your Resources,* informs Members that they can find their Health First Colorado Member handbook at healthfirstcolorado.com or co.gov/peak. *V_Screen Shot_#11_Link to HFC Member Handbook* This screen shot shows the link to the Health First Colorado Handbook that is on the RMHP website. RMHP also sends the *Health First Colorado Handbook* to Members upon request.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
12. The MCO makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR 438.10(f)(1)* Contract Amendment 1: Exhibit M1—7.3.10.1	*V_CM_Prov Term Cross Dept_PP* It is the policy of RMHP to ensure that all members assigned to a Primary Care Physician (PCP) or who have had at least one visit within the previous twelve months, are notified when the PCP is no longer contracted with RMHP. It is the intent of RMHP to give Member notice of PCP terminations as soon as possible but no less than within 15 days of issuance of the notice of termination. This document outlines, at a high level, the cross departmental workflow of the PCP termination process. *V_CS_PCP Term Ltr* Letter to Member advising them that their Primary Care Physician is no longer contracted with RMHP.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
13. The MCO develops and maintains a customized and comprehensive website which includes: • RAE's contact information. • Member rights and handbooks. • Grievance and appeal procedures and rights. • General functions of the RAE. • Trainings. • Provider directory • Access to care standards. • Health First Colorado Nurse Advice Line. • Colorado Crisis Services information. • A link to the Department's website for standardized information such as member rights and handbooks. Contract Amendment 1: Exhibit M1—7.3.9.1.1-5; 7.3.9.1.9-11; 7.3.9.2	*V_Screen Shot_#13_Customized Website* This document shows the location on the website of each of these requirements.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
14. The MCO makes available to members in paper or electronic form the following information about contracted network physicians (including specialists), hospitals, pharmacies, behavioral health providers, and long-term services and supports (LTSS) providers: • The provider's name and group affiliation, street address(es), telephone number(s), website URL, specialty (as appropriate), and whether the provider will accept new enrollees. • The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or provider's office, and whether the provider has completed cultural competency training. • Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. *Note: Information included in a paper provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 calendar days after the contractor receives updated provider information.* *42 CFR 438.10(h)(1-3)* Contract Amendment 1: Exhibit B1—7.3.9.1.6 Exhibit M1—7.3.9.1.6	*V_Prime Directory_ 1118 ENG_ 508* *V_RAE Directory_ENG_508* The Prime and RAE Provider Directories are available on the RMHP website in both electronic and paper form. The paper directory includes the provider's name, group affiliation, street address, and specialty. In addition, the paper provider directory indicates: • Languages offered • Icons/symbols by the provider's name if they are accepting new patients, or if they accept established patients only. • Handicap accessibility through use of a wheelchair icon/symbol. • Providers who have completed RMHP's Disability Competent Care Training Program are listed directly before Page 1. *V_Screen Shot_# 14_Updating Electronic Provider Directory* Under *Demographic Information*, it indicates that practitioners and hospitals may self-report, or update upon RMHP's request, the demographic information displayed in the directory, including name, address, phone number, gender, languages spoken, medical group affiliation, hospital affiliation, and accepting current patients. The electronic provider directory is updated at least weekly. RMHP has recently changed our procedure	**MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	to update the electronic directory three times a week to maintain accuracy. *V_PNM_Provider Directory Update Tool_RAE1 PCMP* *V_PNM_Provider Directory Update Tool_Prime Specialists* *V_PNM_Provider Directory Update Tool_BH Providers* *V_PNM_Provider Directory Update Letter 111518* RMHP has implemented a quarterly Provider Attributes Survey process. Primary care, behavioral health, and specialist providers are asked to provide demographic information, including: • Accommodations for people with physical disabilities, including equipment • Appointment availability – e.g. after hours, weekends • Language capabilities • Populations served – e.g. pediatric only, adult only, both pediatric and adult • Safe Space provider for LGBTQ clients • Specialization / areas of expertise for behavioral health providers – e.g. eating disorders, sexual assault, substance use disorders • Staff trainings on cultural competency or disability competency care	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	V_PNM_Directory Procedures_2018 Page 2 indicates that for Prime, RMHP Regional Organization and CHP Directories: Information included in a paper provider directory is updated at least monthly, and electronic provider directories are updated no later than 30 calendar days after the RMHP receives updated provider information. As stated above, our electronic directory is currently updated 3 times a week.	
Findings: HSAG reviewed RMHP's provider directory in paper and in electronic form. HSAG found that the directories did not include information pertaining to whether or not the provider had completed cultural competency training and whether the provider's office offered accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.		
Required Actions: RMHP must update its provider directories to include whether or not the provider has completed cultural competency training and whether the provider's office has accommodations (including offices, exam rooms, and equipment) for people with physical disabilities.		
15. Provider directories are made available on the MCO website in machine-readable files and formats. *42 CFR 438.10(h)(4)* Contract Amendment 1: Exhibit M1—7.3.9.1.8	*V_Prime Directory_ 1118 ENG_ 508* *V_Accessibility Report_Prime Directory* *V_RAE Directory_ENG_508* *V_Accessibility Report_RAE Directory* *V_Screen Shot_#15_Link to Provider Directories* The screen shot indicates that the RAE and MCO (Prime) provider directories are available on the rmhp.org website. The Accessibility reports above show that these documents have passed 508 remediation.	**MCO:** ☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
Findings: HSAG evaluated RMHP's website, RMHP.org, for machine-readability using the WAVE Web accessibility evaluation tool and found that sections of the provider directory contained accessibility and contrast errors.		
Required Actions: RMHP must ensure that its electronic provider directory is fully machine-readable and readily accessible per Section 508 standards.		
16. The MCO shall develop electronic and written materials for distribution to newly enrolled and existing members that includes all of the following: • MCO's single toll-free customer service phone number. • MCO's email address. • MCO's website address. • State relay information. • The basic features of the MCO's managed care functions. • Which populations are subject to mandatory enrollment into the Accountable Care Collaborative. • The service area covered by the MCO. • Medicaid benefits, including State Plan benefits and those in the Capitated Physical Health Benefit. • Any restrictions on the member's freedom of choice among network providers. • The requirement for the MCO to provide adequate access to health services included in the Capitated Physical Health Benefit, including the network adequacy standards. • The MCO's responsibilities for coordination of member care. • Information about where and how to obtain counseling and referral services that the MCO does not cover because of moral or religious objections.	*V_#16_Crosswalk to Documents* This document provides a crosswalk for each requirement, and the document source and page number. This information is available in electronic and written form. The documents include: *Getting Started Guide_RAE_Prime_ENG_508* *Prime Member Handbook_ENG_508* *V_Screen Shot _# 16_Electronic Member Material* *Health First Colorado_Member Handbook_1018* *Health First Colorado_Member Handbook RMHP Insert_508* *V_Prime Directory_118 ENG_508*	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• To the extent possible, quality and performance indicators for the MCO, including member satisfaction. Contract Amendment 1: Exhibit M1—7.3.6.1		
17. The MCO annually mails each member a notice that specifies how to request a new copy of the handbook. Contract Amendment 1: Exhibit M1—7.3.8.1	*Member Newsletter_Fall 2018* Page 2, *RMHP Helpful Resources*, advises Members how to find documents online, and how to request a paper copy of the Handbook at no cost. This notice is sent annually.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
18. The MCO provides member information by either: • Mailing a printed copy of the information to the member's mailing address. • Providing the information by email after obtaining the member's agreement to receive the information by email. • Posting the information on the website of the MCO and advising the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. • Providing the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR 438.10(g)(3)* Contract Amendment 1: Exhibit M1—None	*V_CI_Prep_Maintain_ Distribute_ Medicaid_CHP+ _Member Materials_PP* Page 2 states that RMHP will make materials available to a member in paper form via U.S. mail and without charge within 5 days of request. Page 3 describes the process for sending member materials upon request by mail or by e-mail, including the timeframe for response to the request. Customer Service Reps will document if the member agrees to receive the information by e-mail. *Prime Member Handbook_ENG_508* Page iv advises members that the Handbook and the Provider Directory are at rmhp.org where they can view or print these documents. They can also ask Rocky Mountain Health Plans to mail a copy at any time at no cost.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 18 tells members that they can see the prescription drugs covered by RMHP and learn about RMHP medication management by going to RMHP's website, rmhp.org, and look for formularies. Page ii lists the RMHP website URL under *Important Websites*, and informs members that they can go to the website for information about providers, benefits and services, and more. Page iv and 6 tells members that the Provider Directory is at rmhp.org where they can view or print this document. They can also ask Rocky Mountain Health Plans Customer Service to mail a copy at any time at no cost. *Member Newsletter Fall 2018* Page 3, *RMHP Helpful Resources*, informs members that Member information, such as the Handbook and Provider Directory, are available on the Internet and includes the applicable Internet address.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
19. The MCO makes available to members, upon request, any physician incentive plans in place. *42 CFR 438.10(f)(3)* Contract Amendment 1: Exhibit M1—None	*Prime Member Handbook_ENG_508* See page 44, *How RMHP Works*, for statement that Member can get more information about how RMHP works, including how RMHP is arranged, and information on RMHP's physician incentive plans.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

MCO Results for Standard V—Member Information							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	18	**Total Score**		=	15
				Total Score ÷ Total Applicable		=	83%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
1. The MCO provides information to members and their families regarding the services provided by Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) and how to obtain additional information. • The MCO provides information to members and parents about: – The periodicity table. – Scheduling and transportation to EPSDT appointments. – The full range of EPSDT wraparound benefits and mental health treatment services available through State Medicaid. Contract Amendment 1: Exhibit M1—Scope of Work—7.3.12.1 Exhibit M1—Covered Services—1.1.14.1	*XI_CM_EPSDT Policy & Procedure* This document describes the measures, process, and interventions (oral and written) RMHP uses to provide information to members and their families about the services EPSDT covers. Page 5, Section I, #6, *Preventive Care and Screening* States that RMHP provides clinical practice guidelines and resources on age-specific screening schedules (Bright Futures/American Academy of Pediatrics) and immunization schedules (CDC). This document is used by RMHP care management to inform the services they provide to members. Page 8, Section III, #2B *Treatment* Sets forth that RMHP care coordination offers assistance with transportation and scheduling appointments. *XI_QI_Annual EPSDT Member Notification Process* This document describes RMHP's annual process for notifying eligible members and their caregivers, in clear and nontechnical language, of EPSDT benefits. At this time this is Prime only.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_QI_Prime EPSDT_0-17 ENG SP This annual letter was sent in 2018 to members with children under the age of 18 to inform them about the EPSDT program, including the services available to them without cost. The letter is sent in both English and Spanish. *XI_QI_Prime_EPSDT_18-20 ENG SP* This annual letter was sent in 2018 to members between the ages of 18-20 to inform them about the EPSDT program, including the services available to them without cost. This letter is sent in both English and Spanish. *Getting Started Guide_RAE_Prime_Eng_508* This document provides information to members and their families regarding the services provided by EPSDT and how to obtain additional information. *Member Newsletter_Winter 2018* Page 3 provides information to members and their families regarding the services provided by EPSDT and how to obtain additional information. *Prime Member Handbook_ENG_508* Page i provides phone numbers for Healthy Communities EPSDT Family Health Coordinators	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	and county Human Services and Social Services Departments. Pages 28-30, *Keeping Your Child Healthy*, explains the EPSDT program in clear non-technical language informing members about the benefits of preventive healthcare. It describes the services that are available and how to obtain additional information (including that additional assistance is available by contacting Family Health Coordinators/Healthy Communities). Page 6 (*Getting Care – The Basics*), page 23 (*Transportation)* and page 32 (*Human Services Department in Your Area*). These sections address how to obtain transportation. Pages 24-25 describe the wrap-around services that are covered by Health First Colorado. EPSDT wrap-around services are also found within the *Covered Benefits and Services* section beginning on page 14. *Child Well-Care Reminders:* • *XI_QI_192C_Immunizations Education* • *XI_QI_95 Congrats on Newborn*	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	• *XI_QI_196C_Happy First Birthday Education* • *XI_QI_108C 16 Month Immunizations Incentive* • *XI_QI_ 112C Well Child Visit Schedule* • *XI_QI_126C Teen Wellness Incentive 14-17* • *XI_QI_133C Preteen Wellness Incentive 10-13* Educational flyers are sent to Prime members throughout the year. Examples of these brochures and Member materials are included and referenced above. *XI_Screen Shot_#1_Glossary* This website page provides a glossary of terms that includes EPSDT, with a link to learn more about EPSDT. *XI_Screen Shot_#1_ Learn About* This screenshot includes information about the EPSDT program and provides another method (electronic) to inform members about the program. This section reviews screening, diagnostic and treatment services that are part of the comprehensive EPSDT benefit. In addition, this includes links to Health First Colorado, Healthy Communities, and Family Health Coordinator contacts.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Health_First_Colorado_Member_Handbook _1018 Pages 23-27 describe the EPSDT benefit offered to member's age 20 years and under. The member handbook is available for Health First Colorado members. RMHP distributes this handbook to members upon request. A link to this handbook is also posted on the RMHP website.	
2. The MCO makes network providers aware of the Colorado Medicaid EPSDT program information, including: • Employing Department materials to inform network providers about the benefits of well-child care and EPSDT. • Ensuring that trainings and updates on EPSDT are made available to network providers every six months. • Advising network providers of EPSDT support services available through other entities including, but not limited to, local public health departments and Healthy Communities. Contract Amendment 1: R1 Exhibit M1—12.8.3.4, 12.9.3.4, 14.2.2.4.2	*XI_CM_EPSDT Policy & Procedure* Pages 5-6, Section I, #6, *Preventive Care and Screening* States that RMHP provides clinical practice guidelines and resources that guide providers on age-specific screening schedules (Bright Futures/American Academy of Pediatrics), immunization schedules (CDC), and contact information for counties that have Healthy Communities programs. The Provider Manual informs providers about EPSDT benefits, and accessing wrap-around benefits as well as support services of Healthy Communities. *XI_EPSDT Webinar_Addressing Best Practices 0918* *XI_EPSDT Webinar_Coding & Billing 1018* *XI_EPSDT Webinar_ Comprehensive Benefit and PARs 1118*	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_Announcing Lunch Learn Webinar EPSDT Addressing Best Practices *XI_Announcing Lunch Learn Webinar EPSDT Coding & Billing* *XI_Announcing Lunch Learn Webinar EPSDT Comp Overview & PARs* The above training and education webinars and announcements demonstrate that RMHP provides trainings and updates on EPSDT to network providers at least every six months. These examples are for webinars that took place in September, October, and November 2018. These webinars will continue to be offered and updated at least every 6 months. Each webinar has a slide on the services provided by Healthy Communities and the goals of the partnership between RMHP and Healthy Communities. *Provider Newsletter_Fall 2018* Page 8 makes providers aware of the Colorado Medicaid EPSDT program and informs network providers about the benefits of well-child care and EPSDT. The Fall training schedule is announced.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_Screen Shot_#2_ Trainings and Info This section of the website provides links to the aforementioned training webinars on key EPSDT topics requested by providers. *2018-19 Provider Manual.* Pages 66-68 describe the Colorado Medicaid EPSDT program, and includes references to the Health First Colorado website and how to access EPSDT materials. The manual also includes Healthy Communities contact information. For assistance with additional diagnosis and treatment needs, a referral should be made to a different practitioner or to Healthy Communities, specifically their Outreach and Case Management Office. The manual also provides information on public health programs such as the Vaccines for Children Program. *XI_PNM_Annual EPSDT Provider Letter* This letter is sent to providers annually to make network providers aware of the Colorado Medicaid EPSDT program information.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
3. The MCO creates an annual onboarding plan in partnership with Healthy Communities contractors describing how the organizations will collaborate for the onboarding of children and families. • The MCO trains Healthy Communities contractors about the Accountable Care Collaborative and the Contractor's unique interventions and processes. • The MCO refers child members and their families to Healthy Communities for assistance with finding community resources and navigating child and family services. Contract Amendment 1: Exhibit M1—7.6.2.2–4	*XI_CI_RMHP MOU_Healthy Communities 120418* The MOU describes how RMHP and Healthy Communities (HC) will work together to ensure members have access to RMHP and HC resources and services. The entities are meeting quarterly to review the plan, identify progress made and provide relevant policy and programmatic updates. The MOU describes how the organizations will work together to perform outreach and onboarding activities (pages 1-2), and processes for referrals from RMHP care coordination to Healthy Communities, and from Healthy Communities to RMHP care coordination (pages 3-4). It provides that RMHP will train Health Communities contractors about the ACC and RMHP (page 1). *XI_CM_EPSDT Policy & Procedure* Page 6, Section I, #8 *Preventive Care and Screening provides* information consistent with the MOU, which describes the referral process between RMHP and Healthy Communities as well as what resources Heathy Communities provides specific to EPSDT. *XI_Screen Shot_#7_Healthy Communities Info* Explains how children and families can receive assistance through the Healthy Communities program, and provides a link to information on the Health First Colorado website.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
4. The MCO assists providers in resolving barriers or problems related to EPSDT benefits. Contract Amendment 1: Exhibit M1—12.8.6.3	*XI_CM_EPSDT Policy & Procedure* Page 8, Section III, #2 *Treatment* General policy sets forth that for children who are Medicaid members, medically necessary EPSDT services not covered by RMHP (wraparound services) are referred to Healthy Communities and Health Care Policy and Financing (HCPF) for action as needed. *XI_PNM_Provider Relations Rep Duties* This job description demonstrates that the provider relations rep is available to resolve barriers in general for providers (see paragraphs 4-6), which can include EPSDT if this is an identified need. The position is responsible for addressing and resolving a variety of complex, escalated, or specialized inquiries related to health plan benefits, contracts and policies, or other provider related issues. *2018-19 Provider Manual* Pages 66-68 provide information on the EPSDT program, including what is covered and proper billing and coding. In addition, contact information is provided for situations where services may not be covered or additional resources are needed.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	XI_EPSDT Webinar_ Coding & Billing 1018 The webinar includes details on the comprehensive benefits as well as details on best practices for coding and billing, which can be helpful in navigating the benefit as a provider.	
5. For children under the age of 21, the MCO provides or arranges for the provision of all medically necessary *Capitated Physical Health Benefit* covered services in accordance with 42 CFR Sections 441.50 to 441.62 and 10 CCR 2505-10 8.280 (EPSDT program). *For the Capitated Physical Health Benefit*, the MCO: • Has written policies and procedures for providing EPSDT services to members ages 20 and under. • Ensures provision of all required components of periodic health screens as set forth by the American Academy of Pediatrics Bright Futures periodicity schedule. Screenings include: – Comprehensive unclothed physical exam. – Detailed health and developmental history. – Assessment of vision, hearing, mouth, oral cavity, and teeth (with referral to a dentist beginning at age 1). – Developmental screening. – Appropriate immunizations. – Lead toxicity screening. – Age-specific screenings and laboratory tests. – Health education and anticipatory guidance.	*XI_CM_EPSDT Policy & Procedure* This written Policy and Procedure describes RMHP's process for providing EPSDT services to members ages 20 and under. Page 8, Section II, #4 *Assessment and Needs Identification* Provides that RMHP Care Management will arrange or refer members to access diagnostic and treatment services for all physical or mental illnesses or conditions discovered by any screening or diagnostic procedure – even if the service is not covered by the health plan. Page 5, Section I, #6 *Preventive Care and Screening* States that RMHP has implemented the AAP Bright Futures periodicity schedule. Pages 8-9, Section III, #3 *Treatment* States that care coordination at RMHP is committed to promoting culturally competent care that is delivered in a linguistically sensitive manner.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Ensures screenings are performed by a provider qualified to furnish primary medical services. • Ensures screenings are performed in a culturally and linguistically sensitive manner. • Ensures results of screenings and examinations are recorded in the child's medical record. • Provides diagnostic services in addition to treatment of physical illnesses or conditions discovered by any screening or diagnostic procedure. *42 CFR 441.55; 441.56(c)* Contract Amendment 1: Exhibit M1—Statement of Work—7.7.5.2 Exhibit M1—Covered Services—1.1.14.1 10 CCR 2505-10 8.280.8.A, 8.280.4.A (3), 8.280.4.A (4), 8.280.4.A (5), 8.280.4.C (1–3)	*XI_EPSDT Webinar_ Comprehensive Benefit and PARs 1118* Slide 4 of this provider webinar describes the content of a comprehensive screening. Slides 6-7 emphasizes that the benefit includes any medically necessary services needed to diagnose and treat potential physical, intellectual or emotional delays and covers treatments necessary to address them. *Provider Newsletter_Fall 2018* Page 8 instructs providers regarding the screening, diagnosis and treatment components of the EPSDT program, and announces the Fall EPSDT training schedule. *VIII QI Credentialing Criteria and Process* RMHP ensures providers rendering screenings are qualified to do so through its credentialing process. *2018-19 Provider Manual.* *Pages 66-67 d*escribe the EPSDT program and states that the AAP Bright Futures schedule has been adopted by Colorado. This section goes on to describe the contents of screenings and lists all of the elements set forth in this requirement.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	Page 67 states that providers qualified to furnish primary medical and/or mental health services should perform screenings. Page 67 (last paragraph) instructs providers that screenings should be performed in a culturally and linguistically sensitive manner. Page 67 (last paragraph) instructs providers to record the results of screenings and examinations in the child's medical record. Page 67 (last paragraph) states that diagnostic services in addition to treatment of mental illnesses or conditions discovered by any screening or diagnostic procedure are covered. Pages 105-106, *Cultural Competence* section communicates to providers RMHP's expectation that services are provided in a culturally competent manner. RMHP advocates for continued education and diversity training. *XI_QI_2018 EPSDT Audit Summary Report* RMHP conducts an annual audit of a small sample of provider medical records in QHN to verify EPSDT screenings and examinations are documented in the medical record. This report	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	summarizes the results of this longitudinal audit of QHN records. *XI_PT_CMS_117_Childhood Immunization Status* *XI_PT_Toolkit NQF 1448 Developmental Screening in the First Three Years of Life* *XI_PT_Toolkit NQF 1516 Well-Child Visit in 3-6 Years of Life* *XI_PT_Toolkit NQF 1392 Well-Child Visits in the First 15 Months of Life* *XI_PT_Population Health and Care Mgmt in Pediatric Pops* *XI_PT_Care Mgmt in Pediatric Subpop* *XI_PT_Patient & Family Engagement in Pediatric Pops* RMHP developed these materials for its Practice Transformation program to help providers with resources and tools to help provide or arrange care for children ages 0 to 21. These are used to improve skills, processes and infrastructure within the practice particularly as it relates to periodic health screens.	
6. *For the Capitated Physical Health Benefits,* the MCO: • Provides referral assistance for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening and diagnosis. • Provides assistance with transportation and assistance scheduling appointments for services if requested by the member/family.	*XI_CM_EPSDT Policy & Procedure* Page 8, Section III, #2 *Treatment* Sets forth how RMHP provides referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
• Makes use of appropriate State health agencies and programs including: vocational rehabilitation; maternal and child health; public health, mental health, and education programs; Head Start; social services programs; and Women, Infants and Children (WIC) supplemental food program. *42 CFR 441.61-62* Contract Amendment 1: Exhibit M1—7.7.5.2	Page 8, Section III, #2B *Treatment* Sets forth that RMHP care coordination offers assistance with transportation and scheduling appointments. Page 8, Section III, #2A *Treatment* Sets forth that RMHP care coordination will coordinate with outside agencies. *XI_CI_RMHP MOU_Healthy Communities 120418.* Sets forth that RMHP will coordinate with Healthy Communities and provide bi-directional referrals. Healthy Communities provides coordination with WIC, Nurse Family Partnership, Head Start, DHS and other Agencies. *Prime Member Handbook_ENG_508* Pages 29-30 provide information to members about when and how to contact Healthy Communities EPSDT Family Health Coordinator. Pages 6, 23-24 and 32 explain how to get help to arrange transportation.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
	2018-19 Provider Manual Pages 66-68 state that medically necessary treatments for conditions discovered by any screening or diagnostic procedure — even if they are not covered by First Health Colorado — may be covered by RMHP under the EPSDT program. The manual goes on to explain how a request for an EPSDT exception may be submitted. Contact information for the RMHP Care Management department is also provided. *XI_Screen Shot_#7_Healthy Communities Info* Explains how individuals can receive help through the Healthy Communities program, and provides a link to information on the Health First Colorado website. Under *Getting Help*, the Healthy Communities program is described as helping by: • Arranging (through referral) for corrective treatment as determined by child health screenings • Referring for transportation assistance *XI_CM_List of Referral Entities* This screen shot from the Essette system is a list of entities where care management can make referrals. Senior staff on the care management team updates this list. The list includes medical and social resources such as state agencies and WIC.	

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the Health Plan**	**Score**
7. *For the Capitated Physical Health Benefits*, the MCO defines medical necessity for EPSDT services as a program, good, or service that: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all. • Is provided in accordance with generally accepted professional standards for health care in the United States. • Is clinically appropriate in terms of type, frequency, extent, site, and duration. • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider. • Is delivered in the most appropriate setting(s) required by the client's condition. • Provides a safe environment or situation for the child. • Is not experimental or investigational. • Is not more costly than other equally effective treatment options. Contract Amendment 1: Exhibit M1—7.7.5.3.7 10 CCR 2505-10 8.076.8; 8.076.8.1; 8.280.4.E	*XI_CM_EPSDT Policy & Procedure* Page 2 presents RMHP's definition of medical necessity for EPSDT services, which comports with the definition set forth in regulation and in the contract.	**MCO:** ☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

MCO Results for Standard XI—EPSDT Services							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	7
				Total Score ÷ Total Applicable		=	100%