Colorado Medicaid
Community Mental Health Services Program

FY 2009–2010 Site Review Report

for

Access Behavioral Care

May 2010

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

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Overview of FY 2009–2010 Compliance Monitoring Activities

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

This is the sixth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2009–2010 site review process, the Department requested a review of seven areas of performance. For its review of **Access Behavioral Care** (**ABC**), HSAG developed a review strategy consisting of seven standards that it had not reviewed within the previous two fiscal years. The areas chosen for review were Standard I—Emergency and Poststabilization Services (a subset of Standard I—Coverage and Authorization of Services); Standard IV—Member Rights and Protections; Standard VI—The Grievance System (Grievances Only); 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. Compliance with federal regulations was evaluated through review of the seven standards. This report documents results of the FY 2009–2010 site review activities for the review period—July 1, 2009, through February 18–19, 2010 (the date of the on-site review). Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Appendices A and B contain details of the findings.

Methodology

In developing the data collection tools and in reviewing the seven standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions that were issued June 14, 2002, and were effective August 13, 2002. To determine compliance, HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key BHO personnel. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. Details of the review of the seven standards are in Appendix A. Details of the on-site grievance record review are in Appendix B.

The seven standards chosen for the FY 2009–2010 site reviews represent a portion of the requirements based on Medicaid managed care requirements. The remainder of Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination of Care, Standard V—Member Information, and the remainder of Standard VI—the Grievance System, will be reviewed in subsequent years.

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

Objective of the Site Review

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

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

Summary of Results

Based on the results from the Compliance Monitoring Tool and conclusions drawn from the review activities, HSAG assigned each element within the standards in the Compliance Monitoring Tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual element within the Compliance Monitoring Tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations to enhance some elements, regardless of the score. While HSAG provided recommendations for enhancement of BHO processes based on these identified opportunities for improvement, for requirements that may have been scored *Met*, these recommendations do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **ABC** for each of the standards. Details of the findings for each standard are in Appendix A.

Table 1-1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I	Emergency and Poststabilization Services	9	9	9	0	0	0	100%
IV	Member Rights and Protections	6	6	6	0	0	0	100%

Table 1-1—Summary of Scores for the Standards								
Standard #	Description of Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
VI	The Grievance System (Grievances Only)	13	13	11	2	0	0	85%
VII	Provider Participation and Program Integrity	8	8	8	0	0	0	100%
VIII	Credentialing and Recredentialing	39	39	39	0	0	0	100%
IX	Subcontracts and Delegation	6	5	5	0	0	1	100%
X	Quality Assessment and Performance Improvement	12	12	12	0	0	0	100%
	Totals	**93**	**92**	**90**	**2**	**0**	**1**	**98%**

2. Summary of Performance Strengths and Required Actions for Access Behavioral Care

Overall Summary of Performance

For six of the seven standards HSAG reviewed, **ABC** received overall percentage-of-compliance scores of 100 percent, which indicates a comprehensive understanding of the managed care requirements in the BBA and a clear strength for **ABC**. The BHO received a score of 85 percent for Standard VI—The Grievance System, indicating an area for improvement. **ABC**'s policies and procedures were comprehensive, easy to understand, and presented in an organized manner. During the on-site interviews, **ABC** staff members were able to clearly articulate procedures followed, which corroborated the written policies and procedures.

Standard I—Emergency and Poststabilization Services

Summary of Findings and Opportunities for Improvement

ABC had the Emergency and Poststabilization Care policy, which included prudent layperson language and stipulated that the BHO did not limit what constituted an emergency medical condition based on a list of diagnoses or symptoms as required by the BBA. The BHO also had effective practices in place to ensure that behavioral health providers deferred to emergency room physicians regarding decisions about member readiness for transfer or discharge.

Summary of Strengths

ABC clearly communicated information to its members regarding how to access crisis care and the ability to receive emergency services through noncontracted providers. The BHO's Provider Manual also included language regarding **ABC**'s policy to pay emergency claims to out-of-network providers. **ABC** auto-adjudicated its emergency claims and demonstrated that it actively monitored denied emergency room claims to ensure that denials were warranted.

Summary of Required Actions

There were no required actions for this standard.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

ABC had several polices in place that addressed member rights and protections in accordance with BBA requirements. **ABC**'s Member Rights and Responsibilities policy required that the BHO maintain written policies and procedures related to member rights and mandated that rights be clearly communicated to both members and providers. **ABC** also had a nondiscrimination policy that defined the BHO's responsibility to protect member rights and to take necessary action to address any allegations of discrimination. A list of member rights was posted on the **ABC** Web site and was included in the BHO's Member and Family Handbook and Provider Manual. **ABC** also required staff to attend training regarding member rights on an annual basis.

Summary of Strengths

ABC widely communicated information regarding member rights and protections through various print documents, including its Member and Family Handbook, Provider Manual, flyers, and newsletters. Information related to member rights was also frequently shared with members attending Member and Family Advisory Board (MFAB) meetings. **ABC** used data from multiple sources, including member satisfaction surveys, feedback from peer specialists, and grievances data to help identify member concerns related to rights violations.

Summary of Required Actions

There were no required actions for this standard.

Standard VI—The Grievance System (Grievances Only)

Summary of Findings and Opportunities for Improvement

ABC received an overall score of 85 percent compliance with grievance standards. The **ABC** grievance policies and procedures clearly defined the BHO's process by which a member or his or her designated representative may file grievances orally and in writing. The **ABC** Member and Family Handbook and the Provider Manual demonstrated the BHO's communication of the grievance process, required time frames for filing grievances, methods by which members may file grievances, and members' rights as they pertain to grievances and State fair hearings to members and providers.

The grievance file review provided evidence that: **ABC** provided written acknowledgment of a grievance to the member within two working days of receipt of the grievance for 8 of the 10 files reviewed, **ABC** staff members who processed grievances were not involved in any previous level of the review, **ABC** provided written disposition of a grievance to the member within 15 working days from the date the grievance was received for 8 of the 10 files reviewed, and when staff required additional time to collect information for a grievance, which was in the member's best interest, **ABC** staff notified the member in writing to extend the timeline to resolve the grievance. The notice of extension also contained the reason for the delay. For grievances that involved a clinical issue, **ABC** staff involved staff with the appropriate level of clinical expertise in treating the member's condition to make a decision on the grievance. In 6 of the 10 files reviewed, the resolution letter contained the required content.

Summary of Strengths

ABC documentation of clinical involvement was very clear and well documented in each of the grievance files reviewed that involved a clinical issue.

Summary of Required Actions

ABC must ensure that when processing grievances, all grievances are acknowledged and resolved within the required time frames. Letters of disposition must contain the resolution of the disposition process and the correct date on which the grievance was resolved.

Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

ABC received an overall score of 100 percent compliance with provider participation and program integrity standards. Since **ABC** is a product line of Colorado Access, provider networking and corporate compliance activities, which are described below, are part of the administrative functions of Colorado Access. The provider agreements, contract amendments, and policies contained the required provisions that the BHO would not prohibit or otherwise restrict a health care professional acting within the scope of his or her practice from advising or advocating on behalf members, that members may not be held liable for payments to providers, and that Colorado Access did not contract with providers excluded from participation in federal health care programs.

The Colorado Access Corporate Compliance Program demonstrated Colorado Access' administrative procedures, which were designed to guard against fraud and abuse. The Corporate Compliance Plan and policies contained all of the required provisions for designating a compliance officer, training the compliance officer, training staff for compliance, and conducting internal monitoring and reporting. The plan and policies included procedures for responding to detected offenses.

Summary of Strengths

The Colorado Access Corporate Compliance Program was very well organized and comprehensive. The Corporate Compliance Plan and related policies clearly described the Corporate Compliance Program. The corporate compliance training program and related presentations were comprehensive and included quizzes and refresher courses for existing staff.

Summary of Required Actions

There were no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

ABC received an overall score of 100 percent compliance with credentialing and recredentialing standards. Since **ABC** is a product line of Colorado Access, provider credentialing and recredentialing activities, which are described below, are part of the administrative functions of Colorado Access. The Colorado Access policies contained the necessary provisions for a comprehensive credentialing and recredentialing program.

The BHO's credentialing and recredentialing policies described the process for evaluating and selecting providers to participate in the network and for notifying providers of credentialing decisions within the required time frames. The credentialing and recredentialing process included the use of an online or paper application completed by the practitioner, attestation from the practitioner, primary source verification, and recommendations to the medical director to approve credentialing or recredentialing of practitioners who completed the credentialing or recredentialing process and whose files met the credentialing or recredentialing criteria and did not contain any information that would deny credentialing or recredentialing of the practitioner. The Practitioner Credentialing and Recredentialing policy described the processes for primary source verification.

The time limits specified in the policy for application and verifying licensure, clinical privileges, work history, malpractice history, and licensure sanctions was 180 calendar days, which was consistent with National Committee for Quality Assurance (NCQA) requirements. The policy stated that no time limit was required for the U.S. Drug Enforcement Administration (DEA) certificate and the work history, which was also NCQA-compliant. For board certification verification, however, the policy stated the time limit was within one year of the committee's decision. This time frame was not compliant with the NCQA requirement of 180 days. However, the credentialing file review provided evidence that practitioner information was verified at the primary source within 180 days of the committee's decision. Although the NCQA time limits for board certification changed to 365 days in 2009, the managed behavioral healthcare organization (MBHO) standard of 180 days for board certification verification supersedes the NCQA standard of 365 days. The Colorado Access policy would be strengthened by clarifying that the time limit for verifying board certification for the BHO line of business is 180 days.

The BHO's credentialing and recredentialing policies listed providers' rights as they pertained to the credentialing and recredentialing process. The Provider Manual also provided evidence that providers were notified of their rights and the appeal process related to credentialing or recredentialing. Colorado Access' Credentialing and Recredentialing policy detailed the process for delegating credentialing, which occurred only after the satisfactory completion of a predelegation audit and Colorado Access' approval of the delegated entity's credentialing policies and procedures. The predelegation audit reports provided evidence that Colorado Access conducted a predelegation audit of each of the delegates. The delegation oversight review reports, which were reviewed on-site, provided evidence that Colorado Access conducted ongoing monitoring of delegates.

Summary of Strengths

The evidence provided by Colorado Access to demonstrate its monitoring of delegated entities' credentialing programs was comprehensive and included credentialing and recredentialing file audits. The delegated credentialing and recredentialing audit tools used by Colorado Access were consistent with NCQA standards. Additionally, the ongoing delegated credentialing monitoring reports provided evidence of a comprehensive, ongoing monitoring structure.

The Credentials Committee minutes were well organized and provided clear evidence of the committee's review of credentialing files that did not meet credentialing or recredentialing standards.

Summary of Required Actions

There were no required actions for this standard.

Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

ABC's Delegation policy described the delegation process, including the development of a written agreement with each delegate and the BHO's responsibilities for ongoing monitoring. The policy also stated that **ABC** retained ultimate accountability for delegated activities. **ABC** delegated managed care functions, including credentialing, claims, grievances, and the after-hours handling of telephone intake, assessment, and crisis counseling. **ABC** had delegation agreements in place that met all applicable requirements of the Code of Federal Regulations (CFR) and NCQA. All of the delegation agreements identified the scope of delegated activities, included a listing of reporting requirements, and described the process for handling any concerns related to problem performance.

Summary of Strengths

ABC conducted ongoing monitoring and oversight of its delegates through the review of reports submitted as deliverables. The BHO also completed annual audits to evaluate each delegate's compliance with requirements in the delegation agreement. **ABC** demonstrated through meeting minutes, e-mails, and other documentation that it closely monitored delegate performance in addressing areas of deficiency and that any ongoing issues related to problem performance were addressed by the Delegation Oversight and Quality Improvement committees.

Summary of Required Actions

There were no required actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

ABC published a quality assessment and performance improvement (QAPI) program description that described its quality program, included a list of goals and objectives related to performance improvement, defined the QAPI program governance structure, and described the role and responsibilities of the various committees that were part of the program. **ABC** also produced an annual work plan that detailed quality improvement activities to be addressed in the upcoming fiscal year. The BHO convened both a Quality Improvement Committee (QIC) and Medical/Behavioral Quality Improvement Committee (MBQIC) to address issues related to performance improvement. **ABC** had two performance improvement projects (PIPs) in place, as required, and maintained a health information system that had the capability to collect, analyze, integrate, and report quality data.

Summary of Strengths

ABC had a health information system that produced a wide variety of reports related to utilization of services, accessibility of care, coordination of care, member satisfaction, and other quality measures described in the BHO's QAPI program description and QAPI program work plan. **ABC** published an annual QAPI program evaluation that included a summary of key metric trending, a review of study findings for each measure included in the QAPI program work plan, and intervention strategies to further improve performance in the upcoming fiscal year. **ABC** also evaluated the QAPI program throughout the year through the sharing of quality data at QIC and MBQIC meetings.

Summary of Required Actions

There were no required actions for this standard.

3. Follow-up on FY 2008–2009 Corrective Action Plan *for* Access Behavioral Care

Methodology

As a follow-up to the FY 2008–2009 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all components for which the BHO received a score of *In Partial Compliance* or *Not In Compliance*. The plan was to include interventions to achieve compliance and the timeline associated with those activities. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with the BHO until HSAG and the Department determined that the BHO completed each of the required actions from the FY 2008–2009 compliance monitoring site review, or until the time of the on-site portion of the BHO's FY 2009–2010 site review.

Summary of 2008–2009 Required Actions

As a result of the 2008–2009 site review, **ABC** was required to revise all applicable policies and related documents to include a definition of an action that was consistent with the BBA definition and was consistent across types of actions. **ABC** was required to ensure that notices of action and appeal resolution letters were easy to understand from a member perspective. **ABC** was also required to revise its applicable policies and related documents to accurately reflect the requirements and time frames for continuation of benefits during the appeal and State fair hearing processes.

Summary of Corrective Action/Document Review

ABC submitted a CAP to address all requirements in July 2009. After careful review, HSAG and the Department determined that, if implemented as written, **ABC**'s CAP would adequately address all required actions. **ABC** submitted documents to HSAG and the Department that demonstrated implementation of its CAP in August 2009. After requiring **ABC** to make minor edits, HSAG and the Department determined that **ABC** had successfully implemented its plan to address all required actions.

Summary of Continued Required Actions

ABC successfully completed all FY 2008–2009 required actions. There were no required actions continued from FY 2008–2009.

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(a)	1. The Contractor defines Emergency Medical Condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ◆ Serious impairment to bodily functions ◆ Serious dysfunction of any bodily organ or part	**Documents Submitted/Location Within Documents:** 1. CCS309: Emergency and Post-Stabilization Care, Definitions (pg 2) 2. Member Handbook (pg 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Emergency and Poststabilization Care policy contained a definition of emergency medical condition that was taken verbatim from 42 CFR 438.114(a). A definition for the term was also included in a section of ABC's Member and Family Handbook that described how to access emergency mental health services.		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(a)	2. The Contractor defines Emergency Services as follows: ◆ Services furnished by a provider that is qualified to furnish these services under this title ◆ Needed to evaluate or stabilize an emergency medical condition	**Documents Submitted/Location Within Documents:** 1. CCS309: Emergency and Post-Stabilization Care, Definitions (pg 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Emergency and Poststabilization Care policy included a definition for emergency services that was consistent with 42 CFR 438.114(a). The policy defined an emergency service as a covered inpatient or outpatient service furnished by a qualified provider to evaluate or stabilize a member's emergency medical condition.		
	Required Actions: None		
42CFR438.114(a)	3. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition.	**Documents Submitted/Location Within Documents:** 1. CCS309: Emergency and Post-Stabilization Care, Definitions (pg 2) 2. Provider Manual (pg 30) 3. Member Handbook (pgs 9, 10)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Emergency and Poststabilization Care policy defined poststabilization care as a covered service related to an emergency medical condition that is provided after a member is stabilized to maintain the stabilized condition or to improve or resolve the member's medical status. A definition of postabilization services as well as a listing of the types of providers offering the service was also included in ABC's Member and Family Handbook and Provider Manual.		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(c)(1)	4. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.	**Documents Submitted/Location Within Documents:** 1. CCS309: Emergency and Post-Stabilization Care, Section V (pg 3) 2. Provider Manual (pg 49) 3. Member Handbook (pgs 8-10)I	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Emergency and Poststabilization Care policy stated that the BHO was responsible for paying claims for emergency and urgently needed care in accordance with federal laws. The policy also specified that ABC was fiscally responsible for any needed emergency services for its members, even in cases in which care and treatment were provided by a nonparticipating provider. The ABC Member and Family Handbook instructed members to use the closest hospital to seek emergency care. The BHO's Provider Manual also included language regarding ABC's policy to pay emergency claims to out-of-network providers.		
	Required Actions: None		
42CFR438.114(c)(1)	5. The Contractor may not deny payment for treatment obtained under either of the following circumstances: ◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have had the following outcomes ▪ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ▪ Serious impairment to bodily functions ▪ Serious dysfunction of any bodily organ or part ◆ A representative of the Contractor's organization instructed the member to seek emergency services	**Documents Submitted/Location Within Documents:** 1. CCS309: Emergency and Post-Stabilization Care, Section V (pg 3) 2. Provider Manual (pg 49) 3. Member Handbook (pg 3, 4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Findings: ABC's Emergency and Poststabilization Care policy included prudent layperson language and contained a general statement regarding the BHO's fiscal responsibility to pay claims for emergency services in accordance with federal laws. The policy also addressed ABC's responsibility for payment of emergency claims in cases in which an ABC staff person or representative instructed the member to seek emergency services. During the interview, staff stated that emergency claims were auto-adjudicated and were paid in all cases involving enrolled ABC members with a behavioral health diagnosis who received a covered behavioral health service. Staff also reported that ABC actively monitored denied emergency room claims to ensure that denials were warranted.		
	Required Actions: None		
42CFR438.114(d)(1)	6. The Contractor does not: ◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services	**Documents Submitted/Location Within Documents:** 1. CCS309: Emergency and Post-Stabilization Care, Section IV (pg 3) 2. Member Handbook (pg 4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Emergency and Poststabilization Care policy included prudent layperson language and stipulated that the BHO did not limit what constituted an emergency medical condition based on a list of diagnoses or symptoms. The policy also prohibited denying payment for emergency claims in cases in which the emergency room or other provider failed to notify the member's primary care provider, ABC, or the applicable State agency of the member's screening and treatment.		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.114(d)(2)	7. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	**Documents Submitted/Location Within Documents:** 1. CCS309: Emergency and Post-Stabilization Care, Section VII (pg 4) 2. Member Handbook (pg 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Emergency and Poststabilization Care policy stated that members who presented with an emergency medical condition were not to be held liable for payment of any subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member. The ABC Member and Family Handbook also stated that members were not financially responsible for emergency care. At the interview, staff clarified that ABC did not charge copays for any Medicaid-covered behavioral health services.		
	Required Actions: None		
42CFR438.114(d)(3)	8. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.	**Documents Submitted/Location Within Documents:** 1. CCS309: Emergency and Post-Stabilization Care, Section VIII (pg 4) 2. Member Handbook (pg 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Emergency and Poststabilization Care policy required that the BHO allow the attending emergency physician or the provider actually treating the member to determine when the member was sufficiently stabilized for transfer or discharge. The policy also stated that the treating provider's determination was binding on ABC, which was responsible for payment. The ABC Member and Family Handbook included information regarding the treating provider's responsibility to make decisions regarding each member's need to receive continuing care in an inpatient setting or acute treatment unit (ATU).		
	Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.10(f)(6)(viii)(B)	9. The Contractor does not require prior authorization for emergency services.	**Documents Submitted/Location Within Documents:** 1. CCS309: Emergency and Post-Stabilization Care, Section II (pg 3) 2. Provider Manual (pg 30) 3. Member Handbook (pg 9)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The ABC Emergency and Poststabilization Care policy clarified that emergency services did not require prior authorization. The BHO's Member and Family Handbook contained a definition of service authorization and indicated that there was no requirement for prior authorization for emergency services. The handbook instructed members to seek care directly from the closest hospital. The ABC Provider Manual also included language regarding the lack of need for prior authorization for emergency care.		
	Required Actions: None		

Results for Standard I—Emergency and Poststabilization Services							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	9	**Total Score**		=	9

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.100(a)(1)	1. The Contractor has written policies regarding member rights.	**Documents Submitted/Location Within Documents:** 1. CS212-Member Rights and Responsibilities, Section I (pg 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC had several polices in place that addressed member rights and protections in accordance BBA requirements. ABC's Member Rights and Responsibilities policy required that the BHO maintain written policies and procedures related to member rights as required by federal and State statute. The policy also required that rights be clearly communicated to members and providers. ABC's Nondiscrimination policy defined the BHO's responsibility to protect member rights and to take necessary action to address any allegations of discrimination. In addition, the ABC Protection of Health Information policy described the BHO's role in protecting member confidentiality, including safeguarding members' protected health information (PHI).		
	Required Actions: None		
42CFR 438.100(a)(2)	2. The Contractor ensures that its staff and affiliated providers take member rights into account when furnishing services to members.	**Documents Submitted/Location Within Documents:** 1. CS212 (2-23-09), Sections III-V (pg 2 2. Provider Manual, Section IV (pgs 18-19, 55) 3. FY09 Q 4 ABC Grievance and Appeals report.zip 4. FY10 Q1 ABC Grievance and Appeals report.zip	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: A list of member rights was posted on the ABC Web site and included in the BHO's Member and Family Handbook. The ABC Provider Manual referred contracted providers to the Web site and to the Member and Family Handbook for a list of rights. The Provider Manual also contained telephone numbers for the State ombudsman for Medicaid managed care and for the ABC Office of Member and Family Affairs (OMFA). Information provided at the time of the desk review was that internal staff members were required to attend a training regarding member rights at the time of hire and participate in refresher training on an annual basis thereafter. ABC provided grievances and appeals reports for the fourth quarter of 2009 and the first quarter of 2010 that illustrated that the BHO had the capability to track and trend grievances related to member rights and protections. There were no grievances filed in the area of member rights for the period under review.		
	Required Actions: None		

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.100(b)(2) & (3)	3. The Contractor ensures that members have the right to: ◆ Receive information in accordance with information requirements (42CFR438.10) ◆ Be treated with respect and with due consideration for his or her dignity and privacy **(Member Handbook, bullet #1, pg 19-20)** ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand **(Member Handbook, bullet #19, pg 19-20)** ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment **(Member Handbook, bullet #22, pg 19-20)** ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation **(Member Handbook, bullet #26, pg 19-20)** ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45CFR164.524 and 164.526 **(Member Handbook, bullet #27, pg 19-20)** ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210) **(Member Handbook, bullet #11-14, pg 19-20)**	**Documents Submitted/Location Within Documents:** 1. Member Handbook, Member Rights and Responsibilities (pgs 18-22) 2. 1st Qtr 2009 (Jan) Part Newsletter 3. 3rd Qtr 2009 (July) Part Newsletter 4. 1st Qtr 2010 (Jan) Part Newsletter 5. FY09 Qtr 4 ABC Grievance and Appeal report.zip 6. FY10 Qtr 1 ABC Grievance and Appeal report.zip 7. Provider Manual	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Findings: ABC included a listing of member rights, including all those required in 42 CFR 438.100(b)(2)&(3), in its Member and Family Handbook distributed to each member at the time of enrollment. Member rights were also posted on the ABC Web site. The BHO provided a copy of a provider newsletter published in January 2010 that contained information regarding the ombudsman for Medicaid managed care. ABC also monitored grievance data on a quarterly basis to help ensure that member rights were upheld. At the interview, staff indicated that personnel from OMFA were responsible for distributing member materials related to member rights, facilitating MFAB meetings, and advocating on behalf of members as needed. ABC staff also stated that the Experience of Care and Outcomes (ECHO) survey was used to evaluate member satisfaction, including whether members felt they were treated with respect and dignity.		
	Required Actions: None		
42CFR438.100(c)	4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor treats the member.	**Documents Submitted/Location Within Documents:** 1. Member Handbook, Member Rights and Responsibilities (pgs 19-20, bullets 32 and 33) 2. Provider Manual, Section X (pg 55) 3. FY09 Qtr 4 ABC Grievance and Appeal report.zip 4. FY10 Qtr 1 ABC Grievance and Appeal report.zip	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: A list of member rights included in the Member and Family Handbook and posted on the ABC Web site identified the member's right to express an opinion about care received without the member's services being affected. The handbook and Web site also stated that members could exercise their rights without fear of retaliation. The ABC Provider Manual required providers to ensure that members felt free to express their concerns without fear of adverse consequences. In addition, ABC's Problem Reporting and Non-Retaliation policy described steps to be taken by the BHO to protect members, employees, providers, and others who report problems and concerns in good faith. ABC monitored grievances data to help ensure that members felt free to exercise their rights.		
	Required Actions: None		

Standard IV—Member Rights and Protections			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.100(d)	5. Contractor complies with any other federal and State laws (such as Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and Titles II and III of the Americans with Disabilities Act and other laws regarding privacy and confidentiality).	**Documents Submitted/Location Within Documents:** 1. ADM205-Nondiscrimnination	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The ABC Nondiscrimination policy mandated compliance with all State and federal Laws and prohibited discrimination based on race, color, national origin, sex, religion, creed, sexual orientation, age, or mental or physical disability. The ABC Protection of Health Information policy addressed the protection of member privacy and confidentiality, including safeguarding member PHI. In addition, the requirement to comply with federal and State laws was included in both the ABC Provider Manual and in provider contracts. At the interview, staff stated that network providers were offered ongoing training in the areas of cultural competency and diversity.		
	Required Actions: None		
42CFR438.224	6. The Contractor 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.	**Documents Submitted/Location Within Documents:** 1. HIP201-Protection of Health Information	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC had a comprehensive Protection of Health Information policy that addressed the use and disclosure of member information, the processing of requests from members to access information, and the handling of member complaints regarding Health Insurance Portability and Accountability Act (HIPAA)-related issues. Staff reported that all employees were required to complete HIPAA training as part of their new hire orientation and to attend a HIPAA general awareness training each year. ABC employees were also required to sign an annual confidentiality statement stating that they would protect member PHI.		
	Required Actions: None		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	6	**Total Score**		=	6
			Total Score ÷ Total Applicable			=	100%

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.402(a) Volume 8 8.209.1	1. The Contractor has a system in place that includes a **grievance** process.	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process 2. QM201-Investigation of Potential Clinical Quality of Care Grievances and Referrals	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy described the BHO's member grievance system and the processes by which members may file a grievance and the procedures ABC used for processing and resolving member grievances within the required time frames. ABC staff stated that members filed grievances in writing or by calling the customer service call center, which transfers grievance calls to the Grievance and Appeals Unit. ABC staff explained that the mental health centers also received member grievances, but ABC staff members processed grievances and issued notification letters on behalf of the mental health centers.		
	Required Actions: None		
42CFR438.400(b) Volume 8 8.209.2	2. The Contract defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or an employee, or failure to respect the member's rights.	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process, Grievance definitions (pg 3) 2. Member Handbook, Grievances and Appeals (pg 23) 3. Provider Manual, Section X. Member and Family Affairs (pg 57)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy contained the definition of a grievance, which stated that a grievance was an oral or written expression of dissatisfaction communicated by a member or a designated client representative (DCR) about any matter other than an action, including quality of care or services provided, aspects of interpersonal relationships such as the rudeness of a provider or an employee, or the failure to respect a member's rights. The Member and Family Handbook and Provider Manual provided evidence that this definition of grievance was communicated to members and providers.		
	Required Actions: None		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.402(b)(1) Volume 8 8.209.1	3. The Contractor has provisions for who may file grievances: ◆ A member may file a grievance (or his or her authorized representative), ◆ A provider may file a grievance on behalf of a member (Colorado permits the provider to act as the member's authorized representative)	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process, Section I.A.1 (pg 3) 2. Member Handbook , Grievances and Appeals (pg 23) 3. Provider Manual, Section X. Member and Family Affairs (pg 57)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy contained the provisions that grievances may be filed by members or their DCR. The policy also contained the provision that providers may serve as the DCR and file a grievance on behalf of a member, as long as the member provided written authorization of the designation of third-party involvement. The Member and Provider Handbook and Provider Manual provided evidence that ABC communicated who may file a grievance and the use of a DCR to members and providers.		
	Required Actions: None		
42CFR438.402(b)(3) Volume 8 8.209.5.D	4. The Contractor accepts grievances orally or in writing.	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process, Section A (pg.3) 2. Member Handbook, Who to Contact to File a Grievance (pg 23) 3. Provider Manual, Section X. Member and Family Affairs (pg 57)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy provided evidence of ABC's provision for accepting grievances orally or in writing. The Member and Provider Handbook and Provider Manual provided evidence that this provision was communicated to members and providers.		
	Required Actions: None		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.402(b)(2) Volume 8 8.209.5.A	5. The member has 20 calendar days from the date of the incident to file a grievance.	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process, Section I.A.1 (pg 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy detailed the BHO's provision that members must file a grievance within 20 calendar days from the date of the incident. The Member and Family Handbook and Provider Manual provided evidence that ABC informed members and providers that a member or his or her DCR must file a grievance within 20 calendar days from the date of the incident.		
	Required Actions: None		
42CFR438.406(a) Volume 8 8.209.4.C	6. In handling grievances, the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process, Section A.7 (pg4) 2. Member Handbook , Welcome Page, Member and Family Affairs (pgs 16-17), Grievances and Appeals (pgs 23-24), Contact info on every page footer 3. Provider Manual , Section X. Member and Family Affairs (pg 57)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy stated that the BHO would provide reasonable assistance in completing forms and taking other procedural steps, including providing interpreter services and toll-free numbers that have adequate teletype/telecommunications device for the deaf (TTY/TDD) and interpreter capability for members who file a grievance. The Member and Family Handbook and Provider Manual included information to inform members and providers that assistance was available to members when filing a grievance.		
	Required Actions: None		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.406(a) Volume 8 8.209.5.B	7. The Contractor acknowledges each grievance in writing within two working days of receipt.	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process, Section I. A.2 (pg 3) 2. FY10 Q 1 ABC Grievance and Appeals Report.zip 3. CoAccess_2-Day Grievance Acknowledgement Letter	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy contained the provision that member grievances would be acknowledged within two working days of receipt of the grievance. The Colorado Access Grievance Acknowledgement Letter sample provided evidence of the type of communication sent to members when acknowledging receipt of a member grievance. Of the 10 grievance files reviewed, 8 grievance files provided evidence that the BHO acknowledged the grievance within two working days.		
	Required Actions: ABC must ensure that all grievances are acknowledged in writing within two working days of receipt of the grievance.		
42CFR438.406(a) Volume 8 8.209.5.C	8. The Contractor ensures that the individuals who make decisions on grievances are individuals who: ◆ Were not involved in any previous level of review or decision-making ◆ If deciding a grievance regarding the denial of expedited resolution of an appeal, or a grievance that involves clinical issues, has the appropriate clinical expertise in treating the member's condition or disease.	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process, Section I.A.3 (pg 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy contained the provision that grievance resolution decisions were made by a designated employee who was not involved in any previous level of review or decision making regarding the grievance, and who had appropriate clinical expertise in treating the member's condition when the grievance involved clinical issues or the denial of a request for expedited resolution of an appeal. Of the 10 grievance files reviewed, all 10 files provided evidence that the individuals who made decisions on grievances were not involved in any previous level of review or decision making. Three of the grievances reviewed involved a clinical issue, and in all instances, ABC staff involved clinicians with the appropriate clinical expertise in treating the member's condition when making a decision on the grievances.		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Required Actions: None		
42CFR438.408(b)&(d) Volume 8 8.209.5.D &F	9. The Contractor must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the Contractor receives the grievance. The notice includes: ◆ The results of the disposition/resolution process ◆ The date it was completed	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process, Section I.A.4 (pg 3) 2. FY10 Q1 ABC Grievance and Appeals Report.zip 3. CoAccess_Grievance Resolution Letter	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy contained the provision that grievances were resolved as expeditiously as the member's health condition requires and within 15 business days from receipt of the grievance if an extension was not required. The policy also stated that staff would provide a written resolution to members that explained the resolution of the grievance and the date it was completed. Of the 10 grievance files reviewed, 8 grievances were resolved within the required time frame, 9 grievance files provided evidence that the resolution letter contained the correct date of disposition, and 6 of the grievance files provided evidence that the resolution letter contained the results of the investigation and disposition process. ABC staff stated that one of the grievances was resolved outside of the required time frame because staff had to schedule a meeting between the member and the mental health center, and the grievance was not closed until the meeting occurred.		
	Required Actions: The BHO must ensure that all grievances are resolved within the required time frame and that resolution letters contain all of the required content, including the date on which the grievance was resolved and the results of the investigation and disposition process.		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.408(c) Volume 8 80209.5.E	10. The Contractor may extend the timeframes for resolution of grievances by up to 14 calendar days if: ◆ The member requests the extension, or ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest	**Documents Submitted/Location Within Documents:** 1. ADM203 6-26-09 (Section I.A.5, pg 3) 2. FY10 Qtr 1 ABC Grievance and Appeals Report.zip 3. CoAccess_14-Day Grievance Extension Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy contained the provision that the BHO may extend the resolution time frame of a grievance up to 14 calendar days if the member or DCR requests the extension, or if the BHO shows a need for additional information and that the delay is in the member's best interest. The policy further stated that the BHO would provide the member or DCR with prior written notice of the reason for the delay. The grievance file review provided evidence that staff sent letters of extension to members when there was a need to collect additional information and the extension was in the member's best interest.		
	Required Actions: None		
42CFR438.408(c)(2) Volume 8 80209.5.E	11. If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.	**Documents Submitted/Location Within Documents:** 1. ADM203 6-26-09 (Section I.A.5, pg 3) 2. Member Handbook, Grievances and Appeals (pg 24) 3. Provider Manual, Member Grievances and Appeals (pg 57) 4. FY10 Q1 ABC Grievance and Appeals Report.zip	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Member Grievance Process policy contained the provision that the BHO may extend the resolution time frame of a grievance up to 14 calendar days if the member or DCR requests the extension, or if the BHO shows a need for additional information and that the delay is in the member's best interest. The policy further stated that the BHO would provide the member or DCR with prior written notice of the reason for the delay. The grievance file review provided evidence that the BHO provided written notification to members, which included the reason for the extension, when the BHO extended the time frame to resolve the grievance.		
	Required Actions: None		

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.414 Volume 8 8.209.3.B	12. The Contractor must provide the information about the grievance system specified in 42CFR438.10 to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The right to file grievances ◆ The right to file appeals ◆ The right to a State fair hearing ◆ The requirements and timeframes for filing grievances and appeals ◆ The method for obtaining a State fair hearing ◆ The rules that govern representation at the State fair hearing ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing ◆ The toll free numbers the member may use to file a grievance or an appeal by phone ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service	**Documents Submitted/Location Within Documents:** 1. Member Handbook, Grievances and Appeals (pgs 23-29) 2. Provider Manual, Member Grievances and Appeals (pgs 57, 62-67)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—The Grievance System—Grievances Only			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Findings: The Provider Manual provided evidence that providers were informed of the following member rights: the right to file grievances; the toll-free numbers to file a grievance orally; the right to file appeals; the right to a State fair hearing; the requirements and time frames for filing grievances and appeals; the method for obtaining a State fair hearing; the rules that govern representation at a State fair hearing; the availability of assistance filing a grievance, an appeal, or requesting a State fair hearing; and the fact that, when requested by the member, benefits will continue if an appeal or request for a State fair hearing is filed within the time frames specified for filing. The Member and Family Handbook listed all of the avenues by which members may file a grievance and included the toll-free telephone numbers available to members to file a grievance orally with the plan. The Member and Family Handbook contained the provision that if benefits continued during the appeal or State fair hearing process, the member may be required to pay the cost of services provided while the appeal was pending if the final decision was adverse to the member. The Member and Family Handbook and Provider Manual contained the provision that providers may serve as the member's designated representative and file an appeal on the member's behalf with the written permission of the member.		
	Required Actions: None		
42CFR438.416 Volume 8 8.209.3.C	13. The Contractor maintains records of all grievances, and submits quarterly reports to the Department.	**Documents Submitted/Location Within Documents:** 1. ADM203-Member Grievance Process, Section I.A.8 (pg 3) 2. FY10 Q1 ABC Grievance and Appeals Report.zip	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The ABC Grievance and Appeals Report for Quarter 1 of FY 2010 provided evidence that the BHO had a mechanism to track and maintain grievances and submit quarterly reports to the Department. The quarterly report listed the type of grievance received, the type of individual filing the grievance (i.e., the member or his or her representative), whether or not the grievance involved a clinical issue, and the grievance investigation outcome.		
	Required Actions: None		

Results for Standard VI—The Grievance System							
Total	Met	=	11	X	1.00	=	11
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	13	**Total Score**		=	11
			Total Score ÷ Total Applicable			=	85%

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.102(a)	1. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient for the following: ◆ The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered ◆ Any information the member needs in order to decide among all relevant treatment options ◆ The risks, benefits, and consequences of treatment or non-treatment ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions	**Documents Submitted/Location Within Documents:** 1. Provider Manual, Section IV, Treatment Options (pg 22) 2. Member Handbook, Your Rights (pgs 19-20) 3. CS212-Member Rights and Responsibilities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Manual provided evidence that ABC maintained the provision and communicated its policy to providers that ABC did not prohibit or otherwise restrict health care professionals from advising or advocating on behalf of a member who is the provider's patient for the following: the member's health status; medical care or treatment options, including any alternative treatments that may be self-administered; any information the member needs to decide among all relevant treatment options; the risks, benefits, and consequences of treatment or nontreatment; and the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.102(b)	2. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: ◆ To the State ◆ To member before and during enrollment ◆ To members within 90 days after adopting the policy with respect to any particular service (consistent with the format provisions in 42CFR438.10) (The Contractor need not furnish information on how and where to access the service.)	**Documents Submitted/Location Within Documents:** 1. Provider Manual (Page 22)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Manual contained the provision that a provider must notify ABC if he or she objects to providing a service on moral or religious grounds. ABC staff stated that it did not object to any covered services based on religious or moral grounds.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.12(a)(1) 42CFR438.214(c)	3. The Contractor does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and does not discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	**Documents Submitted/Location Within Documents:** 1. PNS202-Selection and Retention of Providers, Policy Statement (pg 1) 2. Provider Manual, Non-Discrimination Policy (pg 18)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The nondiscrimination policy detailed in the Provider Manual included ABC's provision for not discriminating—in terms of participation, reimbursement, or indemnification—against any health care professional who is acting within the scope of his or her license under state law solely on the basis of the license. The Provider Manual also contained the provision that the BHO would not make credentialing and recredentialing decisions based solely on an applicant's type of practice or types of clients the practitioner may specialize in treating.		
	Required Actions: None		
42CFR438.12(a)(1)	4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.	**Documents Submitted/Location Within Documents:** 1. PNS202-Selection and Retention of Providers, Section I.D (pg 3) and I.G.2 (pg 4) 2. Provider Manual (pg 60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Manual contained the provision that if the BHO declines to include a provider in its provider network, the BHO would provide written notice of the reason for the decision to the provider. ABC staff stated that for providers who met the credentialing criteria and whose specialty was needed by the network, ABC had not denied participation of the provider. Staff stated that if ABC found during the recredentialing process that a provider no longer met the credentialing criteria, a notice would be sent to the provider denying his or her recredentialing and subsequent participation in the program.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.106	5. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor's debts in the event of the Contractor's or subcontractor's insolvency ◆ Covered services provided to the member for which the State does not pay the Contractor ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider that provides the services under a contractual, referral, or other arrangement ◆ Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly	**Documents Submitted/Location Within Documents:** Provider contract template (will be made available for review at the site review) 1. Provider Manual, Member Billing and Balance Billing (pg 15)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Manual provided evidence that providers were informed of ABC's provision that members may not be held liable for covered services, regardless of whether or not Medicaid paid the claim. Review of provider contracts provided evidence that ABC informed providers that they must agree that in no event—including nonpayment by Colorado Access, the insolvency of Colorado Access, or breach of the agreement—shall providers bill; charge; collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against members or persons other than Colorado Access.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.214(d)	6. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act.	**Documents Submitted/Location Within Documents:** 1. CMP206-Sanction, Exclusion, Prohibited Affiliations, and Opt-Out Screening, Section I (pgs 3-4) 2. CR318-Ongoing Monitoring of Practitioner Sanctions, Grievances, and Occurrences of Adverse Events, Section II.A.1 (pg 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Sanction, Exclusion, Prohibited Affiliations, and Opt-Out Screening policy contained the BHO's provisions that it maintained a process for screening employees, providers, and other individuals to ensure that they were not under sanction, debarment, or exclusion by an authorized federal or State law enforcement, regulatory or licensing agency. The process also included screening for individuals who had "opted-out" of providing services under the Medicare program (excluding emergency or urgently needed services), which would preclude Colorado Access from employing or contracting with them.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.608	7. The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: ◆ Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards ◆ The designation of a compliance officer and a compliance committee that are accountable to senior management ◆ Effective training and education for the compliance officer and the Contractor's employees ◆ Effective lines of communication between the compliance officer and the Contractor's employees ◆ Enforcement of Standards through well publicized disciplinary guidelines ◆ Provision for internal monitoring and auditing ◆ Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Medicaid managed care contract requirements	**Documents Submitted/Location Within Documents:** 1. Compliance Plan Rev1 Jan09 2. CMP201-Problem Reporting and Non-Retaliation 3. CMP202-Corporate Compliance Hotline Operation 4. CMP203-Standards of Business Conduct 5. CMP204-Corporate Compliance Program Education and Training 6. CMP205-Compliance Issue Resolution and Incident Records Management 7. CMP206-Sanction, Exclusion, Prohibited Affiliations, and Opt-Out Screening 8. CMP207-Unannounced Visits 9. CMP208-Subpoenas 10. CMP209-Search Warrants 11. CMP210-Record Retention and Destruction 12. CMP211-Fraud and Abuse 13. CMP212-False Claims Act 14. Executive Compliance Committee Minutes (available on site for review) 15. Compliance Reports 16. COAC Intranet Screen Print 1-14-10 17. DST QA Program 18. COA QA Client Summary Report Dec 2009 19. Claims Processing Update July 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's corporate compliance structure fell under the purview of Colorado Access, of which ABC was a product line. The Corporate Compliance Plan description detailed the BHO's commitment to comply with all applicable federal and State standards, which were designed to protect against fraud and abuse. The plan described the designation of a compliance officer, who reported directly to the president and chief operating officer and had direct communication with the executive committee of the Board of Directors. The Corporate Compliance Plan listed all of the compliance policies used to guide the operation of the BHO's compliance program. The		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Corporate Compliance Program Education and Training policy described the corporate compliance training program that Colorado Access employed to train and educate all employees and the corporate compliance officer. The corporate compliance program standards of business conduct training presentation for new hires provided evidence of Colorado Access' new hire training program for corporate compliance. The corporate compliance refresher training course and training quiz provided evidence of the ongoing training that occurred for Colorado Access staff. The Colorado Access fraud, waste and abuse training presentations provided evidence of additional trainings that Colorado Access employed for staff. The Problem Reporting and Non-retaliation policy described the lines of communication between the compliance officer and Colorado Access' employees. The policy stated that all employees were responsible for reporting misconduct, including actual or potential violations of applicable laws, rules, HIPAA privacy and security requirements, contract provisions, policies, procedures, the Colorado Access standards of business conduct, and regulations, including the False Claims Act, to the employee's supervisor, management, the corporate compliance officer, or the compliance hotline. The Corporate Compliance Hotline Operation policy described the operation of the hotline and the protection of employees who use the hotline to report suspected fraud or abuse. The Corporate Compliance Plan stated that employees were required to comply with the corporate compliance program. The Corporate Compliance Plan stated that the compliance requirements were incorporated into all employee job descriptions, and employees were subject to disciplinary action if they failed to comply with the provisions and requirements of the corporate compliance program. The Corporate Compliance Plan also listed the types of disciplinary actions the BHO would employ if employees did not comply with the program. The Sanction, Exclusion, Prohibited Affiliations, and Opt-Out Screening policy detailed the types of internal monitoring and auditing the BHO employed to detect potential fraud and abuse and noncompliance with the requirements of the compliance program. The Compliance Report for the second quarter of FY 2009 provided evidence of the BHO's ongoing compliance program monitoring. The Compliance Issue Resolution and Incident Records Management policy described the response and resolution process by the corporate compliance officer when compliance issues are raised through various communication channels. The Fraud and Abuse policy described disciplinary and enforcement action—such as corrective action plans, employment termination, or contract termination—against employees, providers, subcontractors, consultants, and agents found to have committed fraud and abuse. The Colorado Access Executive Compliance Committee meeting minutes from April 27, 2009, provided evidence that the compliance committee reviewed potential compliance issues and ongoing audits and discussed the methods by which compliance issues could be resolved.		
	Required Actions: None		

Standard VII—Provider Participation and Program Integrity			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.610	7. The Contractor may not knowingly have a director, partner officer, employee, subcontractor, or owner (owning 5 percent or more of the entity) who is debarred, suspended or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549.	**Documents Submitted/Location Within Documents:** 1. CMP206-Sanction, Exclusion, Prohibited Affiliations, and Opt-Out Screening , Section I 2. Employment and Affiliations Report 092109	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Sanction, Exclusion, Prohibited Affiliations, and Opt-Out Screening policy described ABC's provisions the ABC would not establish or knowingly have a relationship with an individual or entity who is disbarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No.12549. The policy further specified that the types of relationships included: a director, officer, or partner of Colorado Access; a person with beneficial ownership of 5 percent or more of Colorado Access' equity (this was not applicable due to Colorado Access being a nonprofit corporation); a person with an employment, consulting, or other arrangement with the contractor for the provision of items and services that are significant and material to Colorado Access' obligations under its contract with the Department.		
	Required Actions: None		

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	8

Total Score ÷ Total Applicable	=	100%

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA—CR1	1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, All 2. CR302-Office Site Visit for Practitioner Credentialing, All 3. CMP206-Sanction, Exclusion, Prohibited Affiliation, and Opt-Out Screening, All 4. CR306-Credentialing and Recredentialing Application: Notification and Follow-up Process, All 5. CR307- Credentialing and Recredentialing Practitioner Review Classification, All 6. CR312-Practitioner Rights, All 7. CR213-Adverse Actions and Hearing and Appeals Process for Practitioners, All 8. CR318-Ongoing Monitoring of Practitioner Sanctions, Grievances, and Occurrences of Adverse Events, All 9. PNS202-Selection and Retention of Providers, All 10. QM203-Delegation, All (note: all QM203 attachments can be found in the Standard IX folder) 11. Provider Manual (pgs 59-62) 12. Credentialing Committee Roster 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Colorado Access, a health plan with several product lines, performed the credentialing and recredentialing processes for ABC, its behavioral health product line. The Practitioner Credentialing and Recredentialing policy provided an overview of Colorado Access' credentialing and recredentialing processes, referring to other pertinent policies for specific details. Processes reviewed on-site were consistent with the policies and provided evidence of Colorado Access' well-defined credentialing and recredentialing processes.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR1— Element A Element B NCQA CR9— Element A NCQA CR10— Element A Element B Element C 42CFR438.214(a) NCQA CR1— Element A and B NCQA CR9 CR10-Element A and C	2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers, psychiatric nurse specialist, and or licensed professional counselors.	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section I (pg 3) Credentialing Committee Minutes (available on site for review)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy described each type of practitioner subject to Colorado Access's credentialing processes. Practitioners credentialed and recredentialed by Colorado Access included medical doctors, doctors of osteopathy, podiatrists, chiropractors, doctors of dental science, psychologists, psychiatrists, social workers, nurses, and counseling professionals (including family therapists and licensed professional counselors). The Colorado Access provider directory for behavioral health provided evidence that Colorado Access maintained a robust selection of providers, which included hospitals, residential treatment centers, mental health centers, licensed clinical social workers, licensed professional counselors, marriage and family therapists, psychologists, as well as other independent behavioral health practitioners.		
	Required Actions: None		
	2.B. The verification sources used	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section VIII (pgs 6-7) and Section XIV. A-J (pgs 9-13)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Colorado Access Practitioner Credentialing and Recredentialing policy described the acceptable primary sources used for verifying licensure, education and training, DEA or Controlled Dangerous Substance (CDS) certification, board certification, and malpractice coverage.		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Required Actions: None		
	2.C. The criteria for credentialing and recredentialing	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section VIII, pgs. 6-7 2. CR307-Credentialing and Recredentialing Practitioner Review Classification, All 3. Provider Manual (pgs 59-60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy described the criteria for network participation, which applied to all practitioners under the scope of Colorado Access' credentialing program. The Credentialing/Recredentialing Practitioner Review Classification and Credentials Committee Determination Process policy (Practitioner Review Classification policy) described the specific criteria for files meeting the standard for clean files and those that are submitted to the Colorado Access Credentials Committee. The ABC Provider Manual informed providers of the criteria for participation and continued participation in ABC's provider network.		
	Required Actions: None		
	2.D. The process for making credentialing and recredentialing decisions	**Documents Submitted/Location Within Documents:** 1. CR307-Credentialing and Recredentialing Practitioner Review Classification, All 2. CR301-Practitioner Credentialing and Recredentialing, Section IX (pgs 7-8), and Section XV (pg 14)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy described the Colorado Access Credentials Committee and its processes for reviewing practitioner applications and making credentialing and recredentialing decisions. The Practitioner Review Classification policy described the process and criteria for files that may go directly to the medical director for review.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section VII (pg 6)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy described the process for the credentialing program coordinator to review credentialing files for completeness and timeliness and for forwarding the file to the chief medical officer or the associate medical director physician designee for review. The Practitioner Review Classification policy described which files may be reviewed by the chief medical officer or the associate medical director physician designee, and which files are sent to the Credentials Committee for review. The policy stated that the Credentials Committee may also review any file designated as "meeting criteria." The Credentials Committee minutes provided evidence that the Credentials Committee reviewed credentialing and recredentialing files as well as the list of providers who were approved by the medical director when providers met, without exception, all of the credentialing criteria.		
	Required Actions: None		
	2.F. The process for delegating credentialing or recredentialing (if applicable)	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Sections II (pg 4), VI (pg 5), IX (pg 7), XIV.J (pg 13), XV (pg 14) 2. Provider Manual (pg 62)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC reported that it delegated credentialing to Denver Health and Hospital Authority, National Jewish Health, and University Physicians, Inc. Colorado Access staff stated that Colorado Access credentialed the hospitals of each of the delegates as organizational providers. However, each delegate also maintained a network of physicians and, therefore, Colorado Access delegated credentialing to Denver Health and Hospital Authority, National Jewish Health, and University Physicians so they may credential practitioners within their own respective networks. The Practitioner Credentialing and Recredentialing policy described the process for the delegation. The policy stated that initially, delegation occurs only after satisfactory completion of a predelegation audit and Colorado Access' approval of the delegated entity's credentialing policies and procedures. The predelegation audit reports provided evidence that Colorado Access conducted a predelegation audit of each of the delegates. The delegation oversight review reports, which were reviewed on-site, provided evidence that Colorado Access conducted ongoing monitoring of the delegates. The Practitioner Credentialing and Recredentialing policy also stated that each month, a list of practitioners approved by each delegate		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	was presented to the Credentials Committee for approval. The review of the Credentials Committee minutes provided evidence that the Credentials Committee reviewed the list of providers who were credentialed by each respective delegated entity.		
	Required Actions: None		
	2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes)	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section III (pgs 4-5) 2. Provider Manual (pg 60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy stated that Colorado Access does not make credentialing and recredentialing decisions based solely on ethnic/national identity, gender, age, sexual orientation, type of practice, or types of patients the practitioner may specialize in treating. The policy also stated that Colorado Access will not discriminate—in terms of participation, reimbursement, or indemnification—against any health care professional who is acting within the scope of his or her license or certification under state law solely on the basis of that license or certification. In addition, the policy described the Credentials Committee process and described how the committee, the chief medical officer, and the associate medical director designee applied the criteria in the credentialing policies to each case prepared and reviewed for credentialing and recredentialing. The policy stated that all participating Credentials Committee members signed an acknowledgment form stating that they do not discriminate when making credentialing and recredentialing decisions. ABC provided an example of the Credentials Committee Non-Discrimination Acknowledgement form used by the Credentials Committee. The Provider Manual informed providers of ABC's policy not to discriminate during the credentialing and recredentialing processes.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section V (pg 5) 2. CR312-Practitioner Rights, Section II.B (pg 3) and Attachment C (pg 7) 3. 1a. CR301-Attachment A: CO Health Care Professional Credentials Application (pg 23) 4. Provider Manual (pg 60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy stated that if an application contained information that varied substantially from the information acquired during the credentialing process, the practitioner would be given the opportunity to correct the information and/or explain the discrepancy. Providers were notified in the credentialing application that they would be notified if information received during the credentialing process varied from the information provided by the applicant and that the applicant had the right to correct any erroneous information. The Practitioner Rights policy stated that such notification would occur in writing using a standard form. ABC provided a copy of the template form for review.		
	Required Actions: None		
	2.I. The process for ensuring that practitioners are notified of the credentialing/recredentialing decision within 60 calendar days of the committee's decision	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section XVI (pg 14) 2. Credentialing Accuracy Monitoring Oct08-Mar09 3. Credentialing Accuracy Monitoring Apr09-Sept09 4. QIC Meeting Minutes 12.8.09 5. QIC Meeting Minutes 6-9-09	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy stated that practitioners undergoing initial credentialing are notified in writing within 60 calendar days of the committee's credentialing decision.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/recredentialing program	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section II (pg 4), IX (pg 7), and XIV.K (pgs 13-14)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy stated that the chief medical officer or the associate medical director designee is responsible for clinical aspects of the credentialing program and serves as chair of the Credentials Committee. The policy also stated that the chief medical officer or the associate medical director designee is authorized to approve practitioners for participation who meet criteria. The Credentials Committee minutes reviewed on-site provided evidence of the medical director's involvement and participation in the committee.		
	Required Actions: None		
	2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/recredentialing process, except as otherwise provided by law	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section VII (pg 6), XV (pg 14), and Attachment C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy described the processes and procedures used for ensuring the confidentiality of information obtained during the credentialing and recredentialing processes. Processes included signed confidentiality statements by staff with access to credentialing and recredentialing materials, locked file cabinets for storage of hard copy files, shredding of copied materials, and password protection security of electronic files. ABC provided a sample of the Committee Participant Confidentiality Agreement form.		
	Required Actions: None		
	2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section XVII (pg 14)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Findings: The Practitioner Credentialing and Recredentialing policy described annual audits for accuracy of the provider directory information. Colorado Access staff stated that the claims system was used to query provider contact information, which was verified against the information contained in the credentialing database, Apogee.		
	Required Actions: None		
	2.M. The right of practitioners to review information submitted to support their credentialing/recredentialing application	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section V (pg 5) 2. CR312-Practitioner Rights, All 3. 1a. CR301-Attachment A: CO Health Care Professional Credentials Application (#12, pg 23) 4. Provider Manual (pg 60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy included the provision that practitioner applicants have the right to review information submitted in support of their credentialing/recredentialing application. The Practitioner Rights policy described Colorado Access' processes for allowing practitioners the access to their information. Providers were informed of this right in the credentialing application and in the Provider Manual.		
	Required Actions: None		
	2.N. The right of practitioners to correct erroneous information	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section V (pg 5) 2. CR312-Practitioner Rights, Section II (pg 3) and Attachment B (pg 6) 3. 1a. CR301-Attachment A: CO Health Care Professional Credentials Application p. 23 4. Provider Manual (pg 60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Findings: The Practitioner Credentialing and Recredentialing policy included the provision that practitioners have the right to correct any erroneous information obtained during the credentialing/recredentialing process. The Practitioner Rights policy described Colorado Access' processes for correcting erroneous information. Attachment B to the Practitioner Rights policy was a form providers may use to request correction. Providers were notified of this right in the credentialing application and in the Provider Manual.		
	Required Actions: None		
	2.O. The right of practitioners, upon request, to receive the status of their application	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section V (pg 5) 2. CR312-Practitioner Rights, Section III (pg 3) 3. 1a. CR301-Attachment A: CO Health Care Professional Credentials Application (#12, pg 23) 4. Provider Manual (pg 60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy included the practitioner's right to receive the status of their credentialing application, upon request. The Practitioner Rights policy described Colorado Access' processes for informing practitioners of their application status, upon request. Providers were notified of this right in the credentialing application and in the Provider Manual.		
	Required Actions: None		
	2.P. The right of the applicant to receive notification of their rights under the credentialing program	**Documents Submitted/Location Within Documents:** 1. CR312-Practitioner Rights, Section IV (pg 4) 2. 1a. CR301-Attachment A: CO Health Care Professional Credentials Application (Schedule A, pgs 22-23) 3. Provider Manual (pg 60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Rights policy stated that providers are notified of their rights via the Provider Manual and in the credentialing application. The credentialing application and the Provider Manual included each of the applicant rights.		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Required Actions: None		
	2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions ◆ Collecting and reviewing sanctions or limitations on licensure ◆ Collecting and reviewing complaints ◆ Collecting and reviewing information from identified adverse events ◆ Implementing appropriate interventions when it identified instances of poor quality, when appropriate	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section XI (pg 8) 2. CR318-Ongoing Monitoring of Practitioner Sanctions, Grievances, and Occurrences of Adverse Events, All 3. QM201-Investigation of Potential Clinical Quality of Care Grievances and Referrals, All	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy stated that ongoing monitoring activities between credentialing cycles included review for Medicare/Medicaid sanctions, Colorado State licensure sanctions, practitioner-specific member grievances, and occurrences of adverse events. The Ongoing Monitoring of Sanctions, Grievances, and Occurrences of Adverse Events policy (Ongoing Monitoring policy) stated that monitoring for State and Medicare/Medicaid sanctions occurred monthly. The Ongoing Monitoring policy also stated that if a provider had been disciplined, Colorado Access monitored compliance with the corrective actions. The Investigation of Potential Clinical Quality of Care Grievances and Referrals policy described the processes for peer review and Colorado Access' response when practitioners were determined to have quality-of-care issues. The Sanction Monitoring Report, which was presented each month to the Credentials Committee, provided evidence that the BHO regularly monitored practitioner sanctions, licensure issues, Office of Inspector General (OIG) sanctions, and other adverse events for practitioners in the network and presented the information to the Credentials Committee for review. The Credentials Committee meeting minutes for each month in the review period provided evidence that the Sanction Monitoring Report was presented to the committee and reviewed by the committee.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	2.R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality	**Documents Submitted/Location Within Documents:** 1. CR213-Adverse Actions and Hearing and Appeals Process for Practitioners, All 2. CR318-Ongoing Monitoring of Practitioner Sanctions, Grievances, and Occurrences of Adverse Events, Section III (pgs 4-5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Adverse Actions and Hearing and Appeal Process for Practitioners policy (Adverse Actions policy) described the range of actions available to Colorado Access in response to an administrative action or a peer review action taken against a practitioner. Actions included imposition of a corrective action plan or reduction, suspension, or termination of the practitioner's network participation. The Credentials Committee meeting minutes provided evidence that the committee pended or denied credentialing to providers who did not meet the credentialing criteria.		
	Required Actions: None		
	2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities	**Documents Submitted/Location Within Documents:** 1. CR213-Adverse Actions and Hearing and Appeals Process for Practitioners, Section III (pg 6-7)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Adverse Actions policy described Colorado Access' processes for reporting adverse actions to the appropriate agency, including the applicable State licensing board, the National Practitioners Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB), as applicable. Colorado Access staff stated that during its regular check to ensure that providers maintained proper licensing, it was identified that one provider had lost its license from the State licensing board. Since the provider no longer contained the proper licensure to practice, Colorado Access terminated the agreement with the provider.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	2.T. A well defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service	**Documents Submitted/Location Within Documents:** 1. CR213-Adverse Actions and Hearing and Appeals Process for Practitioners, Section II (pg 6) and Attachment C (pgs 10-16) 2. Provider Manual (pg 61)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Adverse Actions policy described the practitioner appeal and hearing processes. Practitioners were notified of their right to request a hearing in the Provider Manual.		
	Required Actions: None		
	2.U. How the Contractor makes the appeal process known to practitioners	**Documents Submitted/Location Within Documents:** 1. CR213-Adverse Actions and Hearing and Appeals Process for Practitioners, Attachment A (pg 8) 2. Provider Manual, Section XI (pg 61)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Adverse Actions policy included a template letter that informed practitioners of the actions Colorado Access took, the reasons for the actions, and the practitioner's right to request a hearing.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR2—Element A	3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners.	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section IX (pgs 7-8) 2. Credentialing Committee Roster 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy described the Colorado Access Credentials Committee and its responsibilities. The Credentials Committee minutes listed the committee's membership, which consisted of a psychologist and medical doctors from different disciplines.		
	Required Actions: None		
NCQA CR2—Element B	4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioner who do not meet established thresholds ◆ Medical director or equally qualified individual review and approval of clean files	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section IX (pg 7) 2. CR307-Credentialing and Recredentialing Practitioner Review Classification, Section I.B.1-2 (pgs 2-3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy described the Credentials Committee's responsibilities, which included a review of credentialing and recredentialing files for applicants who did not meet the minimum criteria. The Practitioner Review Classification policy described the criteria for applicants who met the criteria for clean files that may be reviewed by the chief medical officer, and for those files that must be reviewed by the committee. The Credentials Committee minutes provided evidence that the Credentials Committee reviewed all files that did not cleanly meet the credentialing criteria. The minutes provided evidence that the committee also reviewed the list of practitioners whose files were considered "clean" and who were approved by the medical director.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR3— Element A Element B	5. The Contractor conducts timely verification (using primary sources) of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification includes: ◆ A current, valid license to practice ◆ A valid DEA or CDS certificate ◆ Education and training, including board certification, if applicably ◆ Work history ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section VIII (pgs 6-7) and XIV (pgs 9-13) 2. Provider Manual (pgs 59-60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy described the processes for primary source verification and for the time limits for verifying each element at the primary source. The time limits specified in the policy for application and verifying licensure, clinical privileges, work history, malpractice history, and licensure sanctions was 180 calendar days, which was consistent with NCQA requirements. The policy stated that no time limit was required for the DEA certificate and the work history, which was also NCQA-compliant. For board certification verification, however, the policy stated the time limit was within one year of the committee's decision. This time frame was not compliant with the NCQA requirement of 180 days, which was required in the *2008 MBHO Standards and Guidelines*. The on-site review of credentialing files provided evidence that practitioner information was verified at the primary source within 180 days of the committee's decision. Although NCQA changed its guidelines for time limits to 365 days in 2009, the MBHO standard of 180 days for board certification verification supersedes the NCQA standard of 365 days. The Colorado Access policy would be strengthened by clarifying that the BHO line of business board certification verification time limit requirement is 180 days.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR4—Element A NCQA CR7—Element C	6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation ◆ Lack of present illegal drug use ◆ History of loss of license and felony convictions ◆ History of loss or limitation of privileges or disciplinary activity ◆ Current malpractice insurance coverage (minimums= physician—.5mil/1.5mil; facility—.5mil/3mil) ◆ The correctness and completeness of the application	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section X (pg 8) 1a. CR301 Attachment A: CO Health Care Professional Credentials Application (pgs 19-21, 24-26)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy stated that Colorado Access requires all practitioners to complete the Colorado Health Care Professional Credentials Application. The application included each of the required attestations. The review of credentialing and recredentialing files provided evidence that each file contained a completed and signed application and attestation from the provider.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR5—Element A	7. The Contractor receives information on practitioner sanction before making a credentialing decision, including ◆ State sanctions, restrictions on licensure or limitations on scope of practice ◆ Medicare and Medicaid sanctions	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section VIII (pg 7), XIV.A (pg 10), XIV.H (pgs 12-13)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy stated that in support of credentialing or recredentialing applications, State licensure sanctions and Medicare/Medicare sanctions are researched using the required databases. The policy included the time frames for verification prior to credentialing or recredentialing. The on-site demonstration of Colorado Access' credentialing system and the credentialing and recredentialing files reviewed on-site provided evidence that Colorado Access received information on State sanctions, restrictions on licensure, and Medicare and Medicaid sanctions for each credentialed practitioner.		
	Required Actions: None		
NCQA CR6—Element A	8. The Contractor has a process to ensure that the offices of all practitioners meets its office-site standards. The organization sets standards for ◆ Office site criteria ▪ Physical accessibility ▪ Physical appearance ▪ Adequacy of waiting and examining room space ▪ Availability of appointments ◆ Medical/treatment record criteria ▪ Secure/confidential filing system ▪ Legible file markers ▪ Records are easily located	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section VIII (pg 7), XIV.I (pg 13) 2. CR302-Office Site Visit for Practitioner Credentialing, All 3. Provider Manual (pg 61)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Office Site Visit for Practitioner Credentialing policy delineated Colorado Access' criteria for office site visits. The policy stated that an office site assessment will include physical appearance, physical accessibility, and the adequacy of waiting room and		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	exam/treatment room space. The policy also stated that the office site visit included assessment of medical record-keeping practices, including practices for confidentiality, file organization, and documentation. The policy stated that the standard for acceptable performance is compliance with the confidentiality of records requirements and 80 percent overall compliance. The site visit form, attached to the policy, included the specific requirements for each standard, which included a review for all the NCQA standards. Providers were informed of the site review standards via the Provider Manual. Colorado Access staff stated that provider organizations were required to submit a copy of accreditation certification and/or State of Colorado Department of Human Services site visit information as part of the credentialing process. A review of the credentialing files provided evidence that Colorado Access collected these documents. Colorado Access staff stated that no additional site visits of provider office sites had been performed this year because Colorado Access had not received member complaints regarding a provider's office site, which would trigger a site visit according to Colorado Access policy.		
	Required Actions: None		
NCQA CR6—Element B	9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints ◆ Instituting actions to improve offices that do not meet thresholds ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds ◆ Monitoring member complaints for all practitioner sites at least every six months ◆ Documenting follow-up visits for offices that had subsequent deficiencies	**Documents Submitted/Location Within Documents:** 1. CR302-Office Site Visit for Practitioner Credentialing, All	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Office Site Visit for Practitioner Credentialing policy included the process for determining office sites that require an office site visit. The policy contained the provision that having one complaint that falls into the Level 1 or Level 2 category would not trigger an office site visit. The policy described the instances that would trigger a site visit, such as a Level 3 complaint or two or more Level 1 or Level 2 complaints in a 12-month period. The Colorado Access thresholds for what triggers a site visit were compliant with NCQA guidelines. Colorado Access staff stated that no additional site visits of provider office sites had been performed this		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	year because Colorado Access had not received member complaints regarding a provider's office site, which would trigger a site visit according to Colorado Access policy. The Office Site Visit for Practitioner Credentialing policy also stated that if an office did not meet Colorado Access' threshold for acceptability, a corrective action plan would be developed and a follow-up site visit would be scheduled every six months until the performance standards were met. The Colorado Access Investigation of Potential Clinical and QOC Grievances and Referrals policy described Colorado Access' process for referring Level 3 complaints to the Credentials Committee for review and follow-up. The policy also stated that if the circumstances of the QOC incident precluded waiting for the next scheduled Credentials Committee meeting, the quality management department would notify the appropriate Colorado Access medical director or physician designee for immediate action. The policy also described the actions Colorado Access would take for a Level 3 incident, which included requesting a corrective action plan from the involved provider or practitioner or termination of the provider.		
	Required Actions: None		
NCQA CR7— Element A Element B Element D NCQA CR8	10. The organization formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information includes: ◆ A current, valid license to practice ◆ A valid DEA or CDS certificate ◆ Board certification ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner ◆ State sanctions, restrictions on licensure, or limitations on scope of practice ◆ Medicare and Medicaid sanctions	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section IX (pg 7) Section VIII (pgs 6-7), Section XIV (pgs 9-14) 2. Provider Manual (pg 59)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Credentialing and Recredentialing policy stated that practitioners were recredentialed every 36 months and described the verification criteria required for recredentialing, which met NCQA requirements. Providers were informed in the Provider Manual that recredentialing occurred every three years. The recredentialing files reviewed on-site provided evidence that the above information was validated at the primary source.		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Required Actions: None		
NCQA CR11—Element A	11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with state and federal regulatory bodies.	**Documents Submitted/Location Within Documents:** 1. CR305-Organizational Provider Assessment, Section III (pg 4) 2. OPAG Committee Roster 2009-10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Organizational Provider Assessment policy included the procedures for assessment of organizational providers with which ABC contracts. The procedures included the process for obtaining applicable state licenses, certifications, and evidence of eligibility to participate in federal health care programs, as evidenced by the OIG database query. Colorado Access stated that its online credentialing system, Apogee, conducted automatic verification of the OIG database monthly. The on-site demonstration of Apogee provided evidence that the credentialing system completed this activity.		
	Required Actions: None		
	11.B. The Contractor confirms whether the provider has been reviewed and approved by an accrediting body.	**Documents Submitted/Location Within Documents:** 1. CR305-Organizational Provider Assessment, Section III (pgs 4-5), Section IV (Pgs 5-6) 2. Provider Manual pgs 61-62	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Organizational Provider Assessment policy included the process for obtaining a copy of any applicable accreditation certificates when contracting with and assessing organizational providers. The on-site review of credentialing and recredentialing files provided evidence that the BHO collected accreditation information and certificates from providers that were accredited.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	11.C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	**Documents Submitted/Location Within Documents:** 1. CR305-Organizational Provider Assessment, Section VI.E (pg 10)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Organizational Provider Assessment policy stated that nonaccredited facilities were subject to an on-site assessment by Colorado Access. The credentialing file review provided evidence that the BHO conducted an on-site quality assessment for unaccredited providers.		
	Required Actions: None		
	11.D. At least every three years, the Contractor confirms that the organizational provider continues to be in good standing with state and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider is not reviewed and approved by an accrediting body.	**Documents Submitted/Location Within Documents:** 1. CR305-Organizational Provider Assessment, Section I (pg 2), and VI.D (pgs 9-10)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Organizational Provider Assessment policy contained the procedures for reassessment of organizational providers every three years, which included verifying that the provider was in good standing with state and federal regulatory agencies and whether it was accredited. If the provider was not accredited, an on-site visit was conducted. The recredentialing files reviewed on-site provided evidence that Colorado Access confirmed the regulatory status of providers.		
	Required Actions: None		
	11.E. The selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.	**Documents Submitted/Location Within Documents:** 1. CR305-Organizational Provider Assessment, Sections III and IV (pgs 4-7)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	Findings: The Organizational Provider Assessment policy included the assessment process and criteria for each type of organizational provider. The Facility Site Assessment form included a review of appointment availability, credentialing/recredentialing policies and practices, various aspects of clinical operations, safety policies and practices, office/site appearance, treatment record-keeping practices, confidentiality procedures, and medication safety practices.		
	Required Actions: None		
NCQA CR11—Element A	12. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.	**Documents Submitted/Location Within Documents:** 1. CR305-Organizational Provider Assessment, Attachment D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Organizational Provider Assessment policy stated that the site visit for nonaccredited facilities included a review of staff hiring and credentialing processes. The example of the Facility Site Assessment form included review for a credentialing and recredentialing process that included primary source verification. The credentialing files reviewed provided evidence that the BHO reviewed the credentialing process of its organizational providers.		
	Required Actions: None		
NCQA CR11—Element B	13. The Contractor's organizational provider assessment policies and process includes at least: ◆ Inpatient facilities ◆ Residential facilities ◆ Ambulatory facilities	**Documents Submitted/Location Within Documents:** 1. CR305-Organizational Provider Assessment, Section I (pg 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Organizational Provider Assessment policy stated that Colorado Access' organizational providers may include CMHCs, hospitals, home health organizations, nursing homes, residential facilities, rehabilitation facilities, and other types of facilities. The provider directory provided evidence that the BHO contracted with inpatient facilities, residential facilities, and ambulatory facilities.		
	Required Actions: None		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
NCQA CR11—Element D	14. The Contractor has documentation that organizational providers have been assessed.	**Documents Submitted/Location Within Documents:** 1. CR305-Organizational Provider Assessment, Section II (pg 4) 2. Organizational Provider Database (available for demonstration during site review)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Colorado Access Organizational Provider Assessment policy described the BHO's procedures for assessing organizational providers. The demonstration of Colorado Access' online credentialing system, Apogee, provided evidence that the BHO assessed organizational providers as part of the credentialing process.		
	Required Actions: None		
NCQA CR12—Element A—H	15. If the Contractor delegates any credentialing activities, the Contractor: ◆ Has a written delegation document with the delegate ◆ Retains the right to approve, suspend, and terminate individual practitioners, providers, and sites. This right is reflected in the delegation agreement ◆ Audits credentialing files annually against NCQA standards ◆ Performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations ◆ Evaluates regular reports ◆ The organization identifies and follows up on opportunities for improvement, if applicable	**Documents Submitted/Location Within Documents:** 1. CR301-Practitioner Credentialing and Recredentialing, Section VI 2. QM203-Delegation, All (note: all QM203 attachments can be found in the Standard IX folder) 3. Delegation Agreements folder 4. 2009 Denver Health Executive Summary 5. 2009 NJH Executive Summary 6. 2009 UPI Executive Summary 7. Provider Manual (pg 62) 8. 2009 UPI Audit Action Plan	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Each of Colorado Access' credentialing delegation agreements included provisions that: (1) Colorado Access retained the right to review individual practitioners or providers and to exclude from participation or terminate the participation of any individual		

Standard VIII—Credentialing and Recredentialing			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	practitioner or provider from the Colorado network; (2) periodically, not less than annually, Colorado Access would conduct a review or audit of the delegate's policies, procedures, and records pertaining to the delegated functions; (3) if the delegate was NCQA-certified, any requirements outside of NCQA standards would be reviewed annually, and non-NCQA-certified delegates would receive a full annual review against NCQA standards; (4) Colorado Access monitored the performance of the delegate by reviewing reports of credentialing activities monthly; and (5) if applicable, the delegate would submit an action plan to Colorado Access, which would perform follow-up activities as required. The Practitioner Credentialing and Recredentialing policy described the process for delegation. The delegation oversight review reports, which were reviewed on-site, provided evidence that Colorado Access conducted ongoing monitoring of the delegates. Colorado Access provided evidence of requiring a corrective action plan for one of its organizational providers. The corrective action documentation provided evidence that Colorado Access continued to monitor the organizational provider until corrective actions were completed. Colorado Access staff members stated that they conduct an annual site visit of the delegated providers. The Practitioner Credentialing and Recredentialing policy also stated that each month, a list of practitioners approved by each delegate is presented to the Credentials Committee for approval. A review of the Credentials Committee minutes provided evidence that the Credentials Committee reviewed the list of providers who were credentialed by each respective delegated entity. The February 2009 site review reports provided evidence that Colorado Access completed the review for FY 2009. Colorado Access staff stated that the review for FY 2010 was scheduled to occur in February 2010, after the date of this on-site compliance audit.		
	Required Actions: None		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	39	X	1.00	=	39
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	39	**Total Score**		=	39

Total Score ÷ Total Applicable	=	100%

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.230(a)(1) Contract: II.H.1	1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor.	**Documents Submitted/Location Within Documents:** 1. QM203-Delegation, All 2. Provider Manual (pgs 58, 62)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC delegated managed care functions included credentialing, claims, grievances, and the after-hours handling of telephone intake, assessment, and crisis counseling. ABC's Delegation policy described the delegation process, including the development of a written agreement with each delegate and the BHO's responsibilities for ongoing monitoring. The policy also stated that ABC retained ultimate accountability for delegated activities. Information regarding oversight of delegated functions through the QAPI program was addressed in ABC's Provider Manual.		
	Required Actions: None		
42CFR438.230(b)(1) Contract: II.H.1	2. Before any delegation, the Contractor evaluates a prospective subcontractor's ability to perform the activities to be delegated.	**Documents Submitted/Location Within Documents:** 1. QM203-Delegation, Section II (pg 5), and all relevant attachments mentioned in Section III 2. ProtoCall Pre-delegation Executive Summary	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
	Findings: ABC's Delegation policy required that a predelegation assessment be completed prior to entering into an agreement with a delegate. The policy described the role of the quality program manager in the review process and required that the predelegation evaluation include a review of relevant policies and procedures, file audits, and interviews with staff. At the interview, staff stated that ABC had not entered into any new delegation agreements for the period under review.		
	Required Actions: None		

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR 12—Element D	3. There is a written agreement with each delegate.	**Documents Submitted/Location Within Documents:** The following delegation agreements are located in the" Delegation Agreements" folder: 1. Denver Health - 2009 Amended & Restated Credentialing Delegation Agreement 2. DST - 2009 Amended & Restated Delegation Agreement 3. MHCD - 2008-09 Executed Delegation Agreement 4. MHCD - 2009-10 Executed Delegation Agreement 5. National Jewish - 2009 Delegation Agreement 6. ProtoCall - 2009 Executed Delegation Agreement 7. UPI - 2009 Amended Restated Delegation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC had delegation agreements in place with University Physicians, Inc.; National Jewish Medical and Research Center; and the Denver Health and Hospital Authority for the provision of credentialing services. The BHO also had fully executed delegation agreements with DST Health Solutions (claims), the Mental Health Center of Denver (grievances), and ProtoCall (after-hours handling of telephone intake, assessment, and crisis counseling). All of the delegation agreements identified the scope of delegated activities, included a listing of reporting requirements, and described the process for handling any concerns related to problem performance.		
	Required Actions: None		

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR12— Element A Element B Element C	4. The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate For delegation of Credentialing only, the agreement: ◆ Is mutually agreed upon ◆ Describes the responsibilities of the Contractor and the delegated entity ◆ Describes the delegated activities ◆ Requires at least semiannual reporting to the Contractor ◆ Describes the process by which the Contractor evaluates the delegated entity's performance ◆ Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement ◆ Includes a list of allowed uses of PHI ◆ Includes a description of delegate safeguards to protect the information (PHI) from inappropriate uses ◆ Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards	**Documents Submitted/Location Within Documents:** The following delegation agreements are located in the" Delegation Agreements" folder: 1. Denver Health - 2009 Amended & Restated Credentialing Delegation Agreement 2. DST - 2009 Amended & Restated Delegation Agreement 3. MHCD - 2008-09 Executed Delegation Agreement 4. MHCD - 2009-10 Executed Delegation Agreement 5. National Jewish - 2009 Delegation Agreement 6. ProtoCall - 2009 Executed Delegation Agreement 7. UPI - 2009 Amended Restated Delegation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
	◆ Includes a stipulation that the delegate will provide individuals with access to their PHI ◆ Includes a stipulation that the delegate will inform the Contractor if inappropriate use of the information (PHI) occur ◆ Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends ◆ Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making		
	Findings: ABC's written agreements with each of its delegates specified the activities and reporting requirements delegated to each entity. The delegation agreements also included language regarding the revocation of delegated duties as appropriate based on nonperformance. The agreements addressed all applicable NCQA requirements regarding the delegation of credentialing. NCQA requirements related to safeguarding PHI did not apply since the delegation arrangements with the parties conducting credentialing activities did not include the handling of protected information.		
	Required Actions: None		

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.230(b)(3)	5. The Contractor monitors the delegate's performance on an ongoing basis. The Contractor subjects subcontractor/delegate to a formal review according to a periodic schedule established by the State, consistent with industry standards or state MCO laws and regulations.	**Documents Submitted/Location Within Documents:** 1. QM203 (7-7-09), Section III (pgs 6-7), V (pg 8) 2. 2009 Denver health Executive Summary 3. 2009 DST Executive Summary 4. 2009 MHCD Executive Summary 5. 2009 NJH Executive Summary 6. 2009 UPI Executive Summary 7. Delegation Oversight Subcommittee Report July09 8. Delegation Oversight Subcommittee Report Jan10	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Delegation policy indicated that the BHO conducted annual audits to evaluate each delegate's compliance with requirements in the delegation agreement. The policy also stated that ABC conducted ongoing monitoring and oversight of its delegates through the review of reports submitted as deliverables. ABC provided several examples of executive summaries that documented findings and recommendations, if any, following annual reviews of the delegates responsible for credentialing, claims, and grievances. At the time of the site review, ABC also provided an annual delegation desk audit of ProtoCall completed January 20, 2010. The audit included a review of policies and procedures in the areas of confidentiality, consumer rights, and safeguarding PHI.		
	Required Actions: None		

Standard IX—Subcontracts and Delegation			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.230(b)(4)	6. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action.	**Documents Submitted/Location Within Documents:** 1. QM203-Delegation, Section III (pgs 6-7), 2. 2009 DST Audit Action Plan 3. 2009 MHCD Audit Action Plan 4. 12a. 2009 MHCD Audit CAP Response 5. 12b. MHCD Annual Delegation Audit Results 6. 2009 NJH Action Plan 7. 2009 UPI Audit Action Plan	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The ABC Delegation policy stated that the BHO would conduct follow-up when areas of deficiency or opportunities for improvement in meeting requirements under the delegation agreement were identified. ABC provided copies of several action plans used by the BHO to communicate and monitor delegate performance in addressing areas of deficiency. Any ongoing issues related to delegate performance were also addressed by the ABC Delegation Oversight Committee. For example, Delegation Oversight Committee meeting minutes for January 2010 indicated that DST Health Solutions had been placed on corrective action to address issues related to provider maintenance and quality improvement. During the interview, ABC provided copies of e-mails, meeting minutes, and other documentation to support that the BHO was actively tracking delegate performance related to corrective action plans.		
	Required Actions: None		

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	0
Total Applicable		=	5	**Total Score**		=	5

Total Score ÷ Total Applicable	=	100%

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.240(a)	1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program.	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description, All 2. FY10 ABC Work Plan, All 3. FY09 ABC QAPI Annual Evaluation, All 4. CY09 MBQIC Agendas and Minutes 5. CY09 QIC Agenda and Minutes 6. CY09 QI BOD Reports 7. CY09 BOD Minutes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC had a comprehensive QAPI program in place. Colorado Access published the Fiscal Year 2009–2010 QAPI Program Description, which described its quality program across all lines of business, including ABC. The program description included a list of goals and objectives related to quality improvement, defined the QAPI program governance structure, and described the role and responsibilities of the various committees that were part of the program. ABC also produced the Fiscal Year 2009–2010 QAPI Program Work Plan, which detailed quality improvement activities to be addressed in the upcoming fiscal year. ABC provided meeting minutes that documented that the BHO actively addressed quality improvement issues on an ongoing basis. For example, meeting minutes from a MBQIC meeting held November 3, 2009, documented a discussion regarding a secret shopper program used to evaluate access to care among high-volume mental health providers serving adults.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.240(b)	2. The QAPI Program includes the following basic elements: ◆ Performance improvement projects ◆ The submission of performance measurement data	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description, Section V.A (pgs 11-15) 2. FY10 ABC Work Plan (pgs 2-5, 14) 3. FY09 ABC QAPI Annual Evaluation (pgs 4-6, 31-3, 37-41) 4. ABC PIP Coord of Care-Beh/Phys 5. ABC PIP Coord of Care-Psych ER and MH 6. FY09 ABC BHO PM Submission	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC had two PIPs in place. The purpose of one of the PIPs was to evaluate and improve coordination of care between Medicaid physical health and behavioral health providers for members diagnosed with schizophrenia, schizo-affective disorder, and bipolar disorder. The focus of the second PIP was to increase coordination of care between emergency service providers and providers of outpatient care through the use of targeted interventions, including the use of peer specialists who conducted outreach to members. ABC also collected and reported performance measurement data for a wide range of utilization metrics and data related to coordination of care, accessibility, member satisfaction, and other quality measures detailed in both the Colorado Access Fiscal Year 2009–2010 QAPI Program Description and the ABC Fiscal Year 2009–2010 QAPI Program Work Plan. ABC provided an example of a report submitted to the Department that contained data regarding hospital admission rates and average length of stay.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.240(b)(3)	3. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description (pgs 11-15) 2. FY10 ABC Work Plan (pgs 2-5, 12) 3. FY09 ABC QAPI Annual Evaluation (pgs 4, 36-42) 4. FY10 UM Program Description, All 5. Avg Daily Census Nov 2009 6. Monthly ER Report Oct09 7. Monthly Inpatient Report Nov 09 8. ABC ER Heavy Hitter Report Dec 2009 9. Provider Manual (pgs 58-59) 10. FY10 Access to Care Plan (pgs 8-14) 11. CCS307-Utilization Review Determinations 12. CCS302-Medical Criteria for Utilization Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Fiscal Year 2009–2010 QAPI Program Work Plan included a wide range of utilization measures employed by the BHO to monitor for both underutilization and overutilization of services. ABC provided several reports, including the Average Daily Census Report, Monthly Emergency Room Report, and ABC Emergency Room Heavy Hitter Report, that were used by the BHO to identify potential patterns of overutilization. ABC also reviewed data regarding follow-up posthospitalization to detect possible underutilization of services. During the interview, staff stated that patterns of potential underutilization or overutilization were addressed by the QIC and that changes to practice had been made based on these findings. For example, staff reported that a decision was made to eliminate prior-authorization requirements for outpatient services based, in part, on utilization information.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.240(b)(4)	4. The Contractor's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description (pgs 12 – 13, 16,19, 20) 2. FY10 ABC Work Plan 3. FY09 ABC QAPI Annual Evaluation (pgs 17-18, 20-23, 27, 36) 4. FY10 UM Program Description, All 5. Provider Bulletin Jan 2009-coord of care between providers for those with special needs 6. Provider Manual, Special Populations (pg 35), Special Population Standards (pg 74), and Quality Management (pgs 58-59) 7. ADM205-Nondiscrimination 8. ADM206-Culturally Sensitive Services for Diverse Populations 9. ADM207- Effective Communication with Limited English Proficient Persons and Sensory-Impaired/Speech-Impaired Persons 10. ABC Partnership Newsletter FY09 Q1-Access to Services	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Both ABC's Fiscal Year 2009–2010 QAPI Program Work Plan and Fiscal Year 2008–2009 QAPI Program Evaluation addressed a variety of performance measures to assess the quality and appropriateness of care provided to members with special health care needs. In addition, the BHO conducted a PIP aimed at improving coordination between physical and behavioral health providers for members diagnosed with schizophrenia, schizo-affective disorder, and bipolar disorder. The BHO reported penetration rates by race and ethnicity to ensure that culturally and linguistically appropriate services were provided to members. ABC also published the January 2009 Provider Bulletin, which addressed the importance of coordination of care when treating members with special health care needs.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.240(e)(2)	5. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program.	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description, All 2. FY10 ABC Workplan, All 3. FY09 ABC QAPI Annual Evaluation, All 4. CY09 MBQIC Agendas and Minutes 5. CY09 QIC Agenda and Minutes 6. CY09 QI BOD Reports 7. CY09 BOD Minutes	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC had a process in place for evaluating the impact and effectiveness of the QAPI program. ABC published the Fiscal Year 2008–2009 QAPI Program Evaluation, which included a summary of key metric trending, a review of study findings for each measure included in the QAPI work plan, and intervention strategies to further improve performance in FY 2010. In addition, ABC evaluated the QAPI program throughout the year through the sharing of quality data at QIC and MBQIC meetings. For example, an agenda for a November 10, 2009, QIC meeting indicated that staff provided a quarterly update to the committee regarding access-to-care indicators.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.236(b)	6. The Contractor's QAPI program addresses practice guidelines. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field ◆ Considers the needs of the Contractor's members ◆ Are adopted in consultation with contracting health care professionals ◆ Are reviewed and updated periodically as appropriate	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description (pg 12) 2. FY10 ABC Work Plan (pg 5) 3. FY09 ABC QAPI Annual Evaluation (pgs 33-34) 4. CY09 MBQIC Minutes folder (01_06_09, 05_05_09, 11_03_09) 5. 2009- 2010 Guideline Track 6. ADHD Guideline 7. Depression Guideline 8. Bipolar Treatment Guideline 9. Metabolic Monitoring Guideline 10. CCS311-Clinical Practice Guidelines, All 11. CCS308-Preventive Health Services, Section I.C (pg 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Clinical Practice Guidelines policy stated that all practice guidelines adopted by the BHO must: 1) be based on valid and reliable clinical evidence or the consensus of health care professionals in the field, 2) consider the needs of members, 3) be adopted in consultation with contracted health care professionals, and 4) be updated periodically as appropriate. ABC adopted several clinical practice guidelines, including practice protocols to guide treatment of attention deficit/hyperactivity disorder (ADHD), major depression, and bipolar disorder. The BHO also had a guideline regarding the metabolic monitoring of adult members prescribed atypical antipsychotics. Minutes from a MBQIC meeting held November 3, 2009, documented that the practice guidelines for ADHD and metabolic monitoring were reviewed and approved by the committee for continued use.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.236(c)	7. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members.	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description p 12 2. FY10 ABC Work Plan p 5 3. FY09 ABC QAPI Annual Evaluation p 33-4 4. MBQIC 01_06_09, 05_05_09, 11_03_09 Agenda/Minutes 5. ABC Provider Bulletin_Feb 2009-Guidelines 6. Provider Manual (pgs 20-22) 7. Member Handbook(pg 28) 8. ABC website: member-www.coaccess.com/health-and-wellness 9. ABC website: Provider-www.coaccess.com/practice-guidelines 10. CCS311-Clinical Practice Guidelines, All 11. CCS308-Preventive Health Services, Section V (pg 4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Clinical Practice Guidelines policy stated that practice protocols were disseminated to all affected providers and to members and potential members upon request. ABC posted all adopted practice guidelines on its Web site and included information regarding changes or additions to the guidelines in periodic Provider Bulletins. Information regarding the guidelines, including a telephone number to call to request hard copies of the documents, was also included in the ABC Provider Manual. ABC also published quarterly Partnership newsletters for members and families that included information regarding best practices in the treatment of behavioral health disorders.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.236(d)	8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description p12 2. FY10 UM Program Description 3. Provider Manual (pgs 33-38). Also see the following sections: • Summary of Provider Responsibilities (pg 14) • Authorizations (pg 33) • QM Provider Responsibilities (pg 59) 4. ABC Member Handbook, Criteria (Guidelines) for Services (pgs 5-6) 5. CCS311-Clinical Practice Guidelines 6. CCS308-Preventive Health Services, Section I.C (pg 2), III (pg 3), and V (pg 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Clinical Practice Guidelines policy required that decisions regarding utilization management, member education, covered services, and other areas to which the clinical practice guidelines applied were consistent with the guidelines. The Colorado Access 2009–2010 Utilization Management Program Description stated that the BHO ensured consistency between practice guidelines, coverage of services, and utilization management criteria through a review by a single committee (MBQIC) of all documents related to these areas. The ABC Provider Manual directed practitioners to provide services that were based on published clinical practice guidelines, when available. At the interview, staff stated that educational materials that were consistent with practice guidelines were also available to members through quarterly newsletters and information provided to members and families through ABC service coordinators.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.242(a)	9. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data that is used to support administration of the Contractor's Program..	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description p11-2 2. FY09 ABC Annual QAPI Evaluation 3. FY10 Q1 Appeals Reporting 4. FY10 Q1 Grievance Reporting 5. Avg Daily Census Nov 2009 6. Monthly ER Report Oct09 7. Monthly IP Report Nov 09 8. Monthly Membership Report Oct 2009 9. ISCAT FY10 (12-18-09) 10. IT data flow	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC had a robust health information system in place to collect, analyze, and report data in support of its QAPI program. ABC published the Fiscal Year 2008–2009 QAPI Program Evaluation, which included comprehensive data regarding member demographics as well as an analysis of data related to a wide range of quality measures included in the BHO's QAPI work plan. ABC provided several examples of periodic data reports produced by its information system, including the Monthly Emergency Room Report, Monthly Inpatient Report, and Quarterly Grievances and Appeals reports.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.242(a)	10. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description (pgs 11-15) 2. FY10 ABC Work Plan 3. FY09 ABC Annual QAPI Evaluation 4. FY10 Q1 Appeals Reporting 5. FY10 Q1 Grievance Reporting 6. Avg Daily Census Nov 2009 7. Monthly ER Report Oct09 8. Monthly Inpatient Report Nov 09 9. Monthly Membership Report Oct 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's Fiscal Year 2009–2010 QAPI Program Work Plan included several metrics related to utilization and grievances and appeals. For example, ABC produced reports on utilization, including inpatient bed day use and hospital recidivism within 30 days of discharge. The BHO provided grievances and appeals reports that included data regarding the number of grievances and appeals per 1,000 members as well as information regarding the timeliness of resolution. During the interview, ABC staff reported that the BHO had not disenrolled any members during the period under review.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.242(b)	11. The Contractor collects data on member and provider characteristics and on services furnished to members.	**Documents Submitted/Location Within Documents:** 1. 2010 CoA QAPI Program Description p11-5 2. FY10 ABC Work Plan 3. FY09 ABC Annual QAPI Evaluation 4. Monthly Membership Report Oct 2009 5. ABC Network Adequacy Report FY10 Q1 6. Avg Daily Census Nov 2009 7. Monthly ER Report Oct09 8. Monthly Inpatient Report Nov 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC's FY 2008–2009 QAPI Program Evaluation included penetration rate data stratified by race/ethnicity and hospital readmission data by age band. The BHO's First Quarter Network Adequacy Report for Fiscal Year 2009–2010 described the number of individual practitioners and organizational providers that were part of the network. The report also included information regarding the number of providers who spoke languages other than English. ABC produced reports that included provider-specific data regarding inpatient hospital and emergency room utilization.		
	Required Actions: None		

Standard X—Quality Assessment and Performance Improvement			
References	**Requirement**	**Evidence Submitted by the BHO**	**Score**
42CFR438.242(b)	12. The Contractor ensures that data received from providers is accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data ◆ Screening the data for completeness, logic, and consistency ◆ Collecting service information in standardized formats to the extent feasible and appropriate.	**Documents Submitted/Location Within Documents:** 1. FY09 ABC Claims Validation Report 2. ABC Flat File Requirements 3. FY10 Q1 Claims Timeliness and Accuracy Monitoring 4. Dec 09 IBNR Report 5. Dec 09 IBNR Report Notes 6. ABC Flat and 837 Encounter File QA DS Review Process 7. ABC Provider Manual 8. ABC Provider Website http://www.coaccess.com/access-behavioral-care-provider-information 9. CLM301-Timing Filing and Prompt Payment of Claims	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: ABC used several methodologies to ensure that data received by its subcontractors were accurate, timely, and complete. ABC provided a copy of the Fiscal Year 2009–2010 1st Quarter Claims Timeliness and Accuracy Monitoring Report, which displayed data regarding the timeliness and accuracy of data submitted by providers. The accuracy and completeness of data were also evaluated through an ABC annual encounter validation audit submitted to the Department. A description of the claims process was included in the ABC Provider Manual, including instructions regarding acceptable formats for the submission of claims.		
	Required Actions: None		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	12

Total Score ÷ Total Applicable	=	100%

Appendix B. Grievance Record Review Tool for Access Behavioral Care

The completed grievance record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Site Review Report
for Access Behavioral Care

Plan Name:	Access Behavioral Care
Review Period:	July 1, 2009–December 15, 2009
Date of Review:	February 18, 2010
Reviewer:	Gretchen Thompson
Participating Plan Staff Member:	Rhiannon Longmore, Stephanie Dohrman, and Reyna Garcia

1	2	3	4	5	6	7	8	9	10	11
File #	Case ID #	Date Grievance Received	Date of Acknowledg-ment Letter	Acknowledg-ment Sent in 2 W-days?*	Date of Written Notice of Disposition	# of Days to Notice	Resolved and Notice Sent in 15 W-days?*	Not Involved in Previous Level of Review	Appropriate Level of Expertise?	Resolution Letter Includes Required Content
1	***	5/21/09	5/22/09	Y ☒ N ☐ N/A ☐	7/2/09	30	Y ☐ N ☒ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: On June 16, 2009, a notice of extension was filed. Despite the extension, the grievance was resolved outside of the required time frame. The resolution did not contain the results of the investigation or the disposition process.										
2	***			Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments: The file was an internally generated quality-of-care concern. The grievance was not filed by the member or a DCR.										
3	***	6/30/09	6/30/09	Y ☒ N ☐ N/A ☐	7/8/09	8	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
4	***	6/26/09	6/30/09	Y ☒ N ☐ N/A ☐	7/6/09	6	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
5	***	7/17/09	7/20/09	Y ☒ N ☐ N/A ☐	7/20/09	3	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
6	***	7/20/09	7/21/09	Y ☒ N ☐ N/A ☐	9/30/09	72	Y ☐ N ☒ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: On August 10, 2009, ABC sent a 14-day extension to the member. Despite the extension, the grievance was resolved outside of the required time frame. Staff members stated that they scheduled a meeting to occur between the mental health center and the member and did not close the grievance until after the meeting occurred. This grievance did not involve a clinical issue.										
7	***	7/30/09	7/31/09	Y ☒ N ☐ N/A ☐	9/2/09	33	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: On August 19, 2009, ABC sent a 14-day extension to the member. The grievance was resolved within the required time frame. The resolution did not contain the results of the investigation or disposition process.										
8	***			Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments: This was not a member grievance.										
9	***	10/2/09	10/9/09	Y ☐ N ☒ N/A ☐	10/15/09	13	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										

1	2	3	4	5	6	7	8	9	10	11
File #	Case ID #	Date Grievance Received	Date of Acknowledg-ment Letter	Acknowledg-ment Sent in 2 W-days?*	Date of Written Notice of Disposition	# of Days to Notice	Resolved and Notice Sent in 15 W-days?*	Not Involved in Previous Level of Review	Appropriate Level of Expertise?	Resolution Letter Includes Required Content
10	***	9/18/09	10/8/09	Y ☐ N ☒ N/A ☐	10/8/09	18	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
11	***	10/9/09	10/13/09	Y ☒ N ☐ N/A ☐	10/13/09	4	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☒ N/A ☐
Comments: This grievance did not involve a clinical issue. The resolution did not contain the results of the investigation or disposition process.										
12	***	10/30/09	10/30/09	Y ☒ N ☐ N/A ☐	11/17/09	18	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐
Comments: The resolution did not contain the results of the investigation or disposition process.										
13				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
14				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
15				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
# Applicable Elements				10			10	10	3	10
# Compliant Elements				8			8	10	3	6
Percent Compliant				80%			80%	100%	100%	60%

# Applicable Elements	**43**
# Compliant Elements	**35**
Percent Compliant	**81.4%**

*W-days = Working days

Appendix C. Site Review Participants for Access Behavioral Care

Table C-1 lists the participants in the FY 2009–2010 site review of **ABC**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Gretchen Thompson	Executive Director, State & Corporate Services
Tom Cummins	Consultant
ABC Participants	**Title**
Carrie Bandell	Director, Quality Management
Robert Bremer	Executive Director
Laura Coleman	Director of Clinical Services
Stephanie Dohrman	Grievance and Appeals Manager
Rich Duncan	Manager, Behavioral Health
Reyna Garcia	Director of Customer Services
Alexis A. Giese	Vice President Behavioral Health
Rene Hays	Corporate Compliance Officer/Director, Human Resources
Rhiannon Longmore	Outcomes and Quality Coordinator
Claudine McDonald	Director, Office of Member and Family Affairs
Mike McKitterich	Vice President, Clinical Services
Cynthia Pechon	Staff Attorney
Travis Perez	Manager, Contract Systems
Jennifer Rogers	Credentialing
Gary Smith	Director, Provider Contracting
Marie Steckbeck	Vice President of Operations
Department Observers	**Title**
Jerry Ware	Quality/Compliance Specialist
Marceil Case (participated telephonically)	Behavioral Health Specialist

Appendix D. Corrective Action Plan Process for FY 2009–2010 for Access Behavioral Care

ABC is required to submit to the Department a corrective action plan (CAP) for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the health plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the BHO must submit documents per the timeline that was approved.

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting. The BHO will submit the CAP using the template that follows. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must address the planned intervention(s) to complete the required actions and the timeline(s) for the intervention(s).
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO 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**
	The Department will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan, or ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the plan, the BHO should implement all the planned interventions and submit evidence of such interventions to HSAG via e-mail or through the FTP site, with an e-mail notification regarding the FTP posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may require that, based on the nature and seriousness of the noncompliance, the BHO submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

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

The template for the CAP follows.

Table D-2—FY 2009–2010 Corrective Action Plan *for* ABC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
VI. The Grievance System					
7. The Contractor acknowledges each grievance in writing within two working days of receipt.	Of the 10 grievance files reviewed, only 8 grievance files provided evidence that the BHO acknowledged the grievance within two working days. ABC must ensure that all grievances are acknowledged in writing within two working days of receipt of the grievance.				
9. The Contractor must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the Contractor receives the grievance. The notice includes: ◆ The results of the disposition/ resolution process	Of the 10 grievance files reviewed, 8 grievances were resolved within the required time frame, 9 grievance files provided evidence that the resolution letter contained the correct date of disposition, and 6 of the grievance files provided evidence that the resolution letter contained the results of the investigation and disposition process.				

Table D-2—FY 2009–2010 Corrective Action Plan *for* ABC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring/Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
◆ The date it was completed	The BHO must ensure that all grievances are resolved within the required time frame and that resolution letters contain all of the required content, including the date on which the grievance was resolved and the results of the investigation and disposition process.				

Appendix E. Compliance Monitoring Review Activities for Access Behavioral Care

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

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template, and for other review activities. ◆ HSAG staff members provided an orientation on September 22, 2009, for the BHO and the Department to preview the FY 2009–2010 compliance monitoring review process and to allow the BHO to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff members to the review team. ◆ Prior to the review, HSAG representatives responded to questions from the BHO related to the process and federal managed care regulations to ensure that the BHO was prepared for the compliance monitoring review. HSAG maintained contact with the BHO as needed throughout the process and provided information to the BHO's key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the BHO's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ Since the BHOs had just completed the RFP/contracting process, with new organization having been formed, HSAG used only the BBA Medicaid managed care regulations to develop HSAG's monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The BHO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the standards. ◆ Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ The 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.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original-source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents it needed and had identified during its desk audit. ◆ HSAG requested and reviewed additional documents it needed and had identified during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with BHO staff members to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 2009–2010 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 and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions to be required of the BHO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2009–2010 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG coordinated with the Department to incorporate the BHO's comments and finalize the report. ◆ HSAG distributed the final report to the BHO and the Department.