Colorado Medicaid
Community Mental Health Services Program

FY 2011–2012 Site Review Report

for

Access Behavioral Care

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

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Overview of FY 2011–2012 Compliance Monitoring Activities

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

This is the eighth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2011–2012 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The BHO's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to Medicaid member appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid appeals that were filed between January 1, 2011, and September 30, 2011. For the record review, the BHO received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each of the elements evaluated. For cases in which the reviewer was unable to determine compliance due to lack of documentation, a score of *U* (unknown) was used and did not impact the overall record review score. Compliance with federal regulations was evaluated through review of the four standards and appeal records. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2011–2012 site review activities for **Access Behavioral Care** (**ABC**), a line of business for Colorado Access. The period under review is January 1, 2011, through the dates of the on-site review, November 1 and 2, 2011. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the BHO was successful in completing corrective actions required as a result of the 2010–2011 site review activities. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the appeals record review. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action process the BHO will be required to complete for FY 2011–2012 and the required template for doing so.

Methodology

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

The four standards chosen for the FY 2011–2012 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

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

Summary of Results

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

Table 1-1 presents the score for **ABC** for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

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)
V	Member Information	19	19	18	1	0	0	95%
VI	Grievance System	26	26	24	2	0	0	92%
VII	Provider Participation and Program Integrity	15	15	15	0	0	0	100%
IX	Subcontracts and Delegation	8	8	8	0	0	0	100%
	Totals	**68**	**68**	**65**	**3**	**0**	**0**	**96%**

Table 1-2 presents the scores for **ABC** for the Appeals Record Review. Details of the findings for the record review follow in Appendix B—Appeals Record Review Tool.

Table 1-2—Summary of Scores for Appeals Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals Record Review	54	54	54	0	0	100%

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

Overall Summary of Performance

For the four standards reviewed by HSAG, **ABC** earned an overall compliance score of 96 percent. **ABC**'s strongest performances were in Standard VII—Provider Participation and Program Integrity and Standard IX—Subcontracts and Delegation, both of which earned a compliance score of 100 percent. In addition, **ABC** earned a score of 100 percent on the on-site appeals record review. Although HSAG identified required actions in Standard V—Member Information, (95 percent compliant) and Standard VI—Grievance System (92 percent compliance), **ABC** demonstrated strong performance overall and an understanding of the Medicaid managed care regulations.

Standard V—Member Information

Summary of Findings and Opportunities for Improvement

ABC's member materials were available in multiple languages. The member handbook included all of the required information and presented the information using easy-to-understand language. The member handbook described available services, benefit limitations by type of service, how to access emergency services, and how to get an appointment. Every page of the member handbook referred members to the **ABC** toll-free customer service line for questions or assistance. **ABC** informed its members and providers that interpretation services were available and instructed its members and providers on how to access interpretation services.

The member handbook stated that members may choose any provider in the network and instructed members to call the Customer Service telephone number for assistance with finding a provider. The member welcome packet included a copy of the provider directory, which listed by city the name, address, telephone number, and non-English languages spoken for each network provider. The directory noted which providers were not accepting new patients and informed members that the most updated provider listing is available on its Web site.

The member handbook included a comprehensive description of services available, free of charge, including outpatient treatment, inpatient services, emergency care, home-based services, vocational services, senior services, medications, wrap-around services, and various services for special needs members. The handbook provided locations and contact information for major service providers and referred members to the complete provider directory included in the welcome packet and on the **ABC** Web site. In addition, the handbook described service authorization and use of utilization review (UR) criteria, how to get information from the Department of Health Care Policy and Financing (the Department) regarding the covered medication list. The handbook described peer support groups and a "wellness recovery action plan" as methods to assist members with recovery and maintaining wellness.

The member handbook included information about advance directives. **ABC** may want to consider adding a statement to its advance directives information informing members that **ABC** has no conscientious objection to providing services based on moral or religious grounds. While this additional statement is not required, it would clarify the organization's position to members and providers.

Summary of Strengths

ABC used multiple member communications (newsletters, the provider directory, and several places in the member handbook) to inform its members that all written materials were available in alternative formats and translations. HSAG reviewed alternative formats of the member handbook, notice of action letters, newsletters, and **ABC**'s Web site. **ABC** provided documentation of having had one letter translated into 10 different languages. **ABC** also had a process for maintaining a list of employees and providers who spoke non-English languages for easy reference when meeting the needs of non-English-speaking members.

Summary of Required Actions

The member handbook depicted the time frame for requesting a State fair hearing as 20 calendar days. Under the continuation of services section the timely filing for appeals when requesting the continuation of previously authorized services was, "Within 10 calendar days from the date on the letter saying what action **ABC** has taken or intends to take, or before the *authorization* ends, whichever is less time." **ABC** must revise the member handbook and other member communications to specify the accurate time frames for requesting a State fair hearing for appeals related to a new request for services (30 days from the date of the notice of action). The handbook must also accurately reflect the required time frame for filing an appeal or requesting a State fair hearing if requesting the continuation of previously authorized services (within 10 days from date of the notice of action or before the effective date of the termination or change in services, whichever is later).

Standard VI—Grievance System

Summary of Findings and Opportunities for Improvement

ABC demonstrated good communication with members and providers regarding their right to file grievances and appeals and to request State fair hearings. **ABC** also communicated the availability of assistance with filing grievance and appeals. And when reminding members of the requirement to follow oral requests for appeal with a written request, **ABC** specifically offered, "We can help you put it in writing." **ABC**'s member handbook included information about the process for members to request continuation of previously authorized services during the appeal or State fair hearing. While a certain portion of this language was technically correct, **ABC** may want to consider revising the member handbook language regarding this requirement. The handbook states, "…ten days pass after we mail the original notice to you that we are denying the appeal." HSAG recommends removing the word "original," as it may be confusing and lead the member to believe this refers to the notice of action. **ABC** maintained a grievance and appeal database, individual appeal records, and reported grievances and appeals to the Department quarterly, as required.

Summary of Strengths

The on-site record review demonstrated good communication with members during the appeal process, and provided examples of designated client representatives (DCRs) or providers filing the appeal, and members providing additional information for consideration. The records also provided evidence that individuals who made the appeal decision were individuals not involved in the previous level of review and had the appropriate clinical expertise to do so. The appeals records also demonstrated that **ABC** met all the required time frames for appeals acknowledgement, extending the time frame for resolution, and providing notice of the appeal resolution.

Summary of Required Actions

ABC's appeal resolution letter contained required information, but included an incorrect time frame for requesting a State fair hearing. **ABC** must modify its appeal resolution letter to include the correct time frame (30 days from the notice of action) for requesting a State fair hearing.

The Member Appeal Process policy included the provision for continuation of benefits in the appeal section and the State fair hearing section of the policy. The provision for timely filing was accurate in the appeals section (within 10 calendar days, or before the effective date of the intended action, whichever is later); however, in the State fair hearing section of the policy, the time frame was depicted as 30 days. **ABC** must revise its applicable policies to accurately reflect the timely filing requirement for appeals and State fair hearings when continuation of benefits (services) is requested (within 10 calendar days, or before the effective date of the intended action, whichever is later, when also requesting the continuation of previously authorized services).

Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

ABC's credentialing and recredentialing policies clearly delineated its procedures to evaluate potential providers and to re-evaluate existing providers. All applicable policies were NCQA-compliant and included processes for ongoing monitoring that included site visits, medical record review, claims audits, and review of multiple databases for providers with exclusions, sanctions, and/or limitations by any federal or State agency. **ABC** provided evidence that it had an agreement with each provider that included all of the required provisions.

ABC clearly communicated its requirement that all employees, providers, contractors, and vendors participate in and comply with all quality assessment and performance improvement programs including its corporate compliance plan and standards of business conduct. **ABC** employed mechanisms to ensure employees and contractors had ample opportunity to confidentially report any cases of suspected fraud, waste, or abuse and its policies strictly prohibited any form of retaliation.

Summary of Strengths

ABC provided numerous documents that detailed a robust and comprehensive program to guard against fraud and abuse. The Fraud, Waste, and Abuse policy delineated **ABC**'s processes for investigation. During the on-site review, **ABC** provided documentation of an instance of suspected fraud. **ABC**'s investigation was very complex and followed its written processes impeccably. **ABC** identified the suspected fraud through its claims monitoring process, conducted a preliminary investigation and immediately notified the Department upon confirmation of the suspected fraud. **ABC** conducted an intensive, thorough investigation while providing ongoing and frequent communication with the Department. At the conclusion of the investigation, **ABC** provided a final, written report to the Department and notified appropriate agencies. **ABC** also provided timely transfer of all members to other providers.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

ABC had a process for evaluating potential delegates prior to implementing delegation agreements. Two predelegation assessments were completed during the review year and **ABC** documented the processes and results in the Delegation Oversight Committee meeting minutes. **ABC** provided evidence that it had an agreement with each delegate that included each of the required provisions. There was evidence that **ABC** provided information about its grievance system processes to each delegate.

Summary of Strengths

With multiple delegates, **ABC** had comprehensive processes for oversight of the delegated activities, and conducted both ongoing monitoring and formal review (annual audits) of each delegate. **ABC** provided evidence of having required and followed up on required corrective actions, when necessary.

Summary of Required Actions

There were no corrective actions required for this standard.

3. Follow-Up on FY 2010–2011 Corrective Action Plan

for **Access Behavioral Care**

Methodology

As a follow-up to the FY 2010–2011 site review, each BHO that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the BHO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with **ABC** until the BHO completed each of the required actions from the FY 2010–2011 compliance monitoring site review.

Summary of 2010–2011 Required Actions

As a result of the FY 2010–2011 compliance review, **ABC** was required to complete required actions as follows:

- There was inconsistency among **ABC**'s policies and documents regarding the time frame for making expedited authorization decisions. One record in the on-site denials record review was out of compliance with the required decision time frame. **ABC** was required to ensure that authorization decisions were made within the required time frames.
- Authorization records contained extension letters; however, the letters were sent to the provider and not to the member, as required. (If **ABC** had sent the extension letters to the member, the records would have been in compliance with the time frame requirements.) If extending the time frame for making standard or expedited authorization decisions, **ABC** was required to provide the enrollee with written notice of the reason for the extension and include the right to file a grievance if the member disagrees with the decision to extend the decision time frame.

Summary of Corrective Action/Document Review

ABC submitted its CAP to HSAG and the Department in May 2011. HSAG and the Department determined that if the CAP was implemented as written, **ABC** would achieve compliance with the specified requirements. **ABC** submitted documentation to demonstrate the implementation of its plan in June 2011. After careful review of all documentation, HSAG and the Department concluded that **ABC** had successfully addressed all required actions.

Summary of Continued Required Actions

ABC successfully completed all FY 2010–2011 corrective actions. There were no required actions continued from FY 2010–2011.

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor provides all enrollment notices, informational materials and instructional materials relating to members in a manner and format that may be easily understood. ◆ The Contractor makes written information available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency and informs members of how to access those formats. *42CFR438.10(b)(1),(d)* *Contract: II.F.4.a, d, g*	**Documents:** ◆ ADM207 ◆ OMFA201 ◆ ABC Member Handbook ◆ Provider Directory **Description:** ◆ Colorado Access policy ADM207-Effective Communication with LEP and SI-SI Persons states, "Colorado Access will provide all clinical and non-clinical information, enrollment notices, informational materials, member handbooks, correspondence, newsletters, and instructional materials relating to members and potential members in a manner and format that may be easily understood" **(Section I., pg 3)**. It also states that "Member information will be made available in alternative formats and in an appropriate manner that takes into consideration the needs and/or disability of those who, for example, are visually limited or have limited reading proficiency" **(Section I.D., pg 4)**. ◆ OMFA201 Printed Member Marketing/ Informational Material requires that all member marketing and informational materials meet statutory, regulatory or contractual requirements, including but not limited to, translation in to another language or meeting low literacy levels **(Section III.B. pg 3)**. We use the Microsoft Word literacy level function to review the reading level of all member materials. ◆ In addition, we follow health literacy guidelines promulgated by the Harvard School of Public Health Literacy Studies Program (http://www.hsph.harvard.edu/healthliteracy/index.html) and the Health Literacy Toolkit produced by the Agency for Healthcare Research and Quality (AHRQ) (http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	♦ The Member Handbook informs members they can contact Customer Service if special help is needed with the Handbook **(Intro Page)**. We have not had any requests by ABC members, but the Access Advantage (AA) Member Handbook is available on tape and some materials for AA are also available in Braille. We would do the same if necessary for an ABC Member. ♦ The Provider Directory states that assistance is available in Spanish. This is indicated in the Provider Directory in Spanish **(pg i).**	
Findings: The Effective Communication with Limited English Proficiency and Sensory-Impaired/Speech-Impaired Persons policy stated that all member informational materials or communications would be provided to members in an easy-to-understand language and format, at the 6th grade reading level (measured by the Flesch-Kincaid scale), in non-English languages, and for the visually-impaired. The Printed Member Marketing/Informational Materials policy stated that all materials must be reviewed and approved prior to distribution by the Colorado Access Office of Member and Family Affairs (OMFA) for compliance with cultural and Limited English Proficiency (LEP) standards. The member handbook informed members of the availability of the handbook in large print, on tape, or in another language and included the telephone number for ABC's Member Services department. The provider directory included an introductory statement that the directory was available in large print, Braille, or on tape, and a statement written in Spanish concerning the availability of the directory in Spanish. The provider directory also provided the customer service telephone number. The member welcome letter, distributed in the member welcome packet on enrollment, was written in English and Spanish.		
Required Actions: None.		
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. ◆ The Contractor educates members on: • The availability and use of the mental health system. • Appropriate preventative health care procedures. • Self care. • Appropriate health care utilization.	**Documents:** ♦ New Member Packet ♦ Partnership Newsletters ♦ CFAB Minutes (available upon request) ♦ Provider Manual ♦ ABC FY11Q4 Phone Stats Report **Description:** ♦ Colorado Access employs a number of mechanisms to help ABC members understand the requirements and benefits of the plan. The first introduction members receive is through our New Member	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
• How to navigate the mental health system. • How to locate information and updates to the Colorado Prescription List (PDL) program. *42CFR438.10(b)(3)* *Contract: II.F.4.b, h*	Packet **(see New Member Packet folder)**. ♦ Members are also routinely informed about the plan through the quarterly Partnership Newsletters and Member and Family Advisory Board meetings **(see Partnership Newsletters folder and CFAB minutes folder)**. ♦ Members also often receive information about our plan through contracted providers. Providers are encouraged to distribute Section IX: Office of Member and Family Affairs to our members **(Provider Manual, pg 54)**. ♦ Members are told on page 18 of the ABC Member Handbook that the Office of Member and Family Affairs can help with understanding the mental health system. ♦ Members frequently receive information as needed directly from our Customer Service Call Center and from our Services Coordinators **(see attached call volume reports titled "Q4 FY11 ABC Phone Stats Rpt")**. ♦ Members can find information about medication and the Colorado Prescription List program in the ABC Member Handbook on page 7.	

Findings:
The Printed Member Marketing/Informational Materials policy stated that all new enrollees to Access Behavioral Care (ABC) receive a welcome packet that includes the member welcome letter, provider directory, member handbook, and quarterly newsletters, which contain information about member benefits. The policy also stated that an updated member handbook is distributed when there are substantial changes to member services. The member welcome letter referenced the member handbook as the source for a description of ABC's services, how to access those services, and a description of how to choose a provider within the ABC network.

The member handbook provided a general description of services available, free of charge, including outpatient treatment, inpatient services, emergency care, home-based services, vocational services, senior services, medications, wrap-around services, and various services for special needs members. The handbook provided location and contact information for major service providers and referred members to the complete provider directory included in the welcome packet and on the ABC Web site. In addition, the handbook addressed services that may require payment, if the member chooses to receive non-covered or non-authorized services, described service authorization and use of utilization review (UR) criteria, benefit limitations by type of service, how to access emergency services, how to get an appointment, and how to get information from the Department of Health Care Policy and Financing (the

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
Department) regarding the covered medication list. The handbook described peer support groups and a "wellness recovery action plan" as methods to assist members with recovery and maintaining wellness. Each page of the member handbook referred members to the ABC toll-free customer service line for questions or assistance. The monthly and quarterly customer services call volume reports documented a significant number of calls for clinical or pharmacy questions.		
Required Actions: None.		
3. The Contractor makes its written information available in the prevalent non-English languages in its particular service area and notifies its members that written information is available in prevalent non-English languages and how to access those materials. *42CFR438.10(c)(3) and (5)* *Contract: II.F.4.c*	**Documents:** ♦ ADM207 ♦ OMFA201 ♦ Member Handbook ♦ Provider Directory ♦ Partnership Newsletters **Description:** ♦ Colorado Access policy ADM207-Effective Communication with LEP and SI-SI Persons states, "Colorado Access will provide all clinical and non-clinical information, enrollment notices, informational materials, member handbooks, correspondence, newsletters, and instructional materials relating to members and potential members in a manner and format that may be easily understood" **(Section I., pg 3)**. It also states that "Member information will be made available in alternative formats and in an appropriate manner that takes into consideration the needs and/or disability of those who, for example, are visually limited or have limited reading proficiency" **(Section I.C., pg 3)**. ♦ OMFA201 Printed Member Marketing/ Informational Material requires that all member marketing and informational materials meet statutory, regulatory or contractual requirements, including but not limited to, translation in to another language or meeting low literacy levels **(Section III.B. pg 3)**. We use the Microsoft Word literacy level function to review the reading level of all member materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	♦ The Member Handbook informs members they can contact Customer Service if special help is needed with the Handbook **(Intro Page)**. We have not had any requests by ABC members, but the Access Advantage (AA) Member Handbook is available on tape and some materials for AA are also available in Braille. We would do the same if necessary for an ABC Member. ♦ The Provider Directory states that assistance is available in Spanish. This is indicated in the Provider Directory in Spanish **(pg i).** ♦ Every quarterly Partnership Newsletter informs Members that the Newsletter can be made available in large print, on tape, or in another language.	

Findings:
The Effective Communication with Limited English Proficiency and Sensory-Impaired/Speech-Impaired Persons policy stated that all member informational materials or communications would be provided to members in an easy-to-understand language and format, including in non-English languages. The Printed Member Marketing/Informational Materials policy stated that all materials must be reviewed and approved by the Colorado Access OFMA prior to distribution. This policy also stated that Colorado Access would provide written non-English information and interpreter services requested by the member, caregiver, or provider at all points of contact.

The member handbook informed members of the availability of the handbook in another language through the ABC Member Services department. The handbook included a notification written in Spanish of the availability of the handbook in Spanish. The Provider Directory also included an introductory statement regarding the availability of the directory in Spanish, and provided instructions to call the customer service telephone number for assistance. The member welcome letter was written in English and Spanish.

During the on-site interview, ABC staff members stated that they had received requests for translation of materials into a number of languages (other than Spanish), and that ABC complied with each request. Staff members reported that the subcontractor, ViaLanguage, was available to translate documents into any other language, as requested by ABC. In addition, member information could be requested in Braille, and staff members stated that magnets have been produced with the member services telephone number printed in Braille. Member information was also available in audio format for visually impaired, or audio translation through the interpreter services.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. *42CFR438.10(c)(4)&(5)* *Contract: II.F.4.c, f*	**Documents:** ♦ ADM207 ♦ Member Handbook ♦ Provider Manual ♦ Language reference form ♦ ADM214 **Description:** ♦ Colorado Access policy ADM207-Effective Communication with LEP and SI-SI Persons, states in Sections II and IV that the costs of interpretation services will be borne by Colorado Access or the provider. ♦ The member handbook outlines member rights, including the right to "get services from a provider who speaks your language or get interpretation services in any language needed" **(pg 20)**. ♦ The Provider Manual states that "Language interpreters and auxiliary aids will be provided without cost to the individuals being assisted" **(pg 19)**. Providers are also informed that Colorado Access "employs multilingual staff available to assist members and providers, as well as access to the AT&T language line translation services" **(pg 19)**. ♦ Colorado Access currently employs 13 staff fluent in Spanish, one in Cambodian, one in Italian, and one in Russian **(see language reference form)**. Staff listed on this form according to ADM214-Language Pay Differential, have passed an independently administered language fluency test.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Effective Communication with Limited English Proficiency and Sensory-Impaired/Speech-Impaired Persons policy and the provider manual stated that language interpretation/translation and/or auxiliary aids would be provided by Colorado Access at no cost to the individuals being assisted. The policy stated that oral interpreter services are available at the request of the member, the member's caregiver, or the provider in any language and at all points of contact. The policy also stated that interpreter services were provided through bilingual ABC staff members in prevalent non-English languages or through the AT&T Language Line. The policy stated that the OMFA was responsible to maintain a list of Colorado Access staff members who are multilingual and disseminate the list through the Colorado Access intranet on at least an annual basis. The employee language reference form listed bilingual staff members

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
available for Spanish, Cambodian, Italian, and Russian interpretation and information on how to access these individuals. In addition, the provider manual stated that language interpretation services were available to assist providers in communicating health care needs, and included instructions on how to request interpreter services. The member handbook stated that members have the right "to receive services from a provider who speaks their language or get interpretation services in any language," and informed members in English and Spanish about how to obtain the handbook in another language or to obtain assistance related to any information in the handbook. During the on-site interview, ABC staff members stated that sign language interpretive services were also available upon request.		
Required Actions: None.		
5. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information, upon request [information required at 438.10(f)(6) and 438.10(g)(and (h)]. *42CFR438.10(f)(2)* *Contract: II.F.4.m*	**Documents:** ♦ COA_83_DOI_2010 ♦ Partnership Newsletters folder **Description:** ♦ Through the annual DOI mailing, Colorado Access notifies Members that they may contact Customer Service for information about services and benefits and request a copy of the Member Handbook **(COA_83_DOI_2010)**. This mailing is also sent to Members in Spanish**.** ♦ Every quarterly Partnership Newsletter includes a "Have Questions? Need Help?" box that contains contact information, including web address and TTY line. We provide more detailed information at least once a year, and usually more often in the Newsletters. In the 1st Quarter 2011 Newsletter there is a section titled, "Access Behavioral Health Can Help!" and "Access to Services". In the 2nd Quarter 2011 Newsletter, there was a section titled, "Also on our Web site…". In the 3rd Quarter 2011 Newsletter there was a section titled, "What Access Behavioral Care Can Do For YOU!". Also announced in the newsletter was the Partnership meeting (Member and Family Advisory Board) with special guest speaker, Reyna Garcia, Sr. Director, Customer Service. Her presentation highlighted the Customer Service department and what they do. She emphasized that members could contact them directly to request information about Access Behavioral Care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The member handbook stated that members have the right to ask for information at any time about providers, benefits, fees, access to services, member rights, and operational processes of ABC (listed in detail) and provided the customer service telephone number on each page of the handbook. Each edition of the quarterly member newsletters prominently displayed the customer service telephone number for members to ask questions or obtain assistance. The annual member letter informed members of their right to receive information about their mental health benefits. The letter included a detailed description of the types of information available in the member handbook and provided the local and toll-free telephone numbers for members to request a copy of the member handbook.		
Required Actions: None.		
6. The Contractor gives written notice of any significant change (as defined by the State) in the information [required at 438.10(f)(6) and 438.10(g)] provided to members at least 30 days before the intended effective date of the change. *42CFR438.10(f)(4)* *Contract: II.F.4.k*	**Documents:** ♦ CS212 ♦ Member Handbook **Description:** ♦ CS212-Member Rights and Responsibilities states that "Colorado Access will develop and maintain written policies and procedures that address member rights and responsibilities as required by federal and state statute, rules and regulations or contract requirements.(pg 2)" ♦ The Member Handbook states that Members will be given written 30 days notice of any changes in benefits or services **(pg 6)**.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The member handbook informed members of the right to be notified promptly of any changes in benefits, services, or providers. The handbook stated that members would be notified in writing 30 days before any increase or decrease in mental health benefits or services. The Printed Member Marketing/Informational Materials policy stated that members receive a member handbook on enrollment and that, if a significant change in members' rights or services occurs, all members are sent a supplement to the handbook. In addition, the policy stated that the most recent handbook was available on ABC's Web site and that members are sent a current handbook upon request. During the on-site interview, ABC staff members stated that there have been no significant changes requiring member notification within the last year.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
7. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary mental health care from, or was seen by, the terminated provider. *42CFR438.10(f)(5)* *Contract: II.F.4.l*	**Documents:** ♦ Member Handbook ♦ CCS306 **Description:** ♦ CCS306-Delivering Continuity of Care and Transition of Care for Members states, "At the time Colorado Access is notified of a network transition (i.e. provider group termination or vendor contract termination), a transition plan is prepared by Colorado Access to provide a coordinated approach to the transition **(Section III., pg 4)**." **Section III.B.4**, states that a good-faith effort will be made to provide written notice to Members will be informed within 15 days **(pg 5)**. ♦ The Member Handbook states that Members will be informed within 15 days of learning that a Member's provider is leaving the network **(pg 6)**. ♦ In practice, when a notice is received from a provider by Network Services, the ABC Operations Manager is notified. A query is run to determine if this provider is currently seeing any Members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Delivering Continuity and Transition of Care for Members policy stated that a good-faith effort would be made to provide written notification of provider termination to the member within 15 days after receipt of notice of provider termination. The notice would describe how the service would be replaced and that ABC would assist the member with transition to a new provider. The member handbook stated that members would be notified by ABC in writing within 15 days of learning that their provider was leaving the network.

During the on-site interview, ABC staff members described the case of a provider who was terminated by ABC after an intensive investigative process. Staff members reported that the provider had been seeing many members who had been refugees and spoke several non-English languages. ABC developed a member transition plan that involved significant coordination to transfer members to appropriate providers for continuing treatment. Once the members' primary languages were identified, the provider termination letter was translated into 10 languages and sent to members as soon as they could be located. The transition process was completed within 30 days. HSAG reviewed documentation of these member transitions on-site. Staff members stated that although other provider terminations had occurred, those providers had no active members to notify.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
8. The required information (438.10(f)(6) and 438.10(g) is furnished to members within a reasonable time after notification from the State of the recipient's enrollment and includes: ◆ Notice that the member has been enrolled in the Community Mental Health Services Program operated by the Contractor and that enrollment is mandatory. ◆ The Contractor's hours of operation. *42CFR438.10(f)(3)* *Contract: II.F.4.i, j*	**Documents:** ♦ New Member Packet ♦ Welcome Letter **Description:** When the state notifies Colorado Access of a newly enrolled member, a new member packet is sent to the member by mail. The packet includes a Welcome Letter, a Member Handbook, a Provider Directory, and a Notice of Privacy Practices; the Colorado Access hours of operation are listed on the "Welcome" page of the member handbook. Included in the New Member Packet is a welcome letter notifying the member that they have been enrolled in the Community Mental Health Services Program through Colorado Access and that enrollment is mandatory.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Printed Member Marketing/Informational Materials policy stated that members would receive an ABC Welcome Packet upon notification by the Department of the Member's enrollment into the BHO. The welcome packet included a welcome letter, member handbook, and provider directory. The welcome letter and the member handbook both informed the member that the member was automatically enrolled in Access Behavioral Care because they are a Medicaid recipient in Denver County. The member handbook described the office hours of operation on the welcome page and in the introductory statement, and included the toll-free telephone number for members to contact ABC. During the on-site interview, ABC staff members described that member packets are distributed each month based on a mailing list produced from the monthly enrollment file from the Department. The mailing list is sent to the printing and mailing vendor, who is required to send the packets by the end of each month.		
Required Actions: None.		
9. The member information materials sent following enrollment include: ◆ Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers, including identification of providers who are not accepting new patients.	**Documents:** ♦ ABC304 ♦ Member Handbook ♦ On-line Provider Directory Link: https://providers.coaccess.com/ProviderSearch/home.jsf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Any restrictions on freedom of choice among network providers. *42CFR438.10(f)(6)(i) and (ii)* *Contract: II.F.4.i.1, 2*	**Description:** ♦ ABC304-Consumer Choice of Behavioral Health Providers states, "Colorado Access will promote awareness among consumers and families of their ability to choose care providers within the network through the Member Handbook and other materials. Additionally, Colorado Access will assist with provider choice for consumers by providing consumers and families with a Provider Directory of participating providers" **(Section IV)**. ♦ The Member Handbook instructs members to call Customer Service if they need assistance locating a provider who speaks a certain language **(pg 12)**. ♦ The Handbook also states that Members have the right to ask us for information at any time about the names, locations, and phone numbers, languages spoken by our contracted providers **(pg 22)**. ♦ Our on-line Provider Directory allows Members to search based on provider name, specialty, geographic area, languages spoken by the provider/clinic, and if they are accepting new patients.	

Findings:

The member welcome packet included a copy of the provider directory, which listed by city the name, address, telephone number, and non-English languages spoken for each network provider. The directory noted which providers were accepting only existing patients. The written directory also referred members to the Colorado Access Web site for the most updated provider listing. The Web site allowed members to search providers by languages spoken and by providers accepting or not accepting new patients. The provider directory introductory page stated that members must choose a provider from within the ABC network.

The member handbook stated that members may choose any provider in the network and referred members to the provider directory included in the welcome packet or to the on-line directory to select a provider. The handbook also instructed members to call the customer service telephone number for assistance with finding a provider with a certain specialty, who speaks another language, or has a particular cultural background. In addition, it instructed members to call for assistance to transfer from an out-of-network to in-network provider.

During the on-site interview, ABC staff members stated that providers are required to notify ABC 30-60 days prior to ceasing acceptance of new patients. If a provider is temporarily unable to provide access to a new member within the required time frame, the member is referred back to Member Services for assistance in selecting another provider.

Required Actions:

None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
10. The member information materials sent following enrollment include the following member rights and protections as specified in 42CFR438.100(b)(2)–(3) and in the Medicaid managed care contract. Members have the right to: ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. ◆ Request and receive a copy of his or her medical records, and request that they be amended or corrected. ◆ Be furnished health care services in accordance with federal healthcare regulations for access and availability, care coordination and quality. ◆ Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its providers, or the State Medicaid agency treats the member. *42CFR438.10(f)(6)(iii)* *Contract: II.F.4.i.3*	**Documents:** ◆ New Member Packet ◆ ABC Member Handbook **Description:** When the state notifies Colorado Access a New Member Packet is mailed to the member. The packet includes a Member Handbook. Member rights are listed on page 20 & 21 of the Member Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The Member Rights and Responsibilities policy stated that ABC communicates member rights and responsibilities using its member handbook, provider manual, new provider orientation, provider and member bulletins, Web site, newsletters, and other mechanisms. The member handbook listed member rights as stated in the requirements, which included the right to respect and dignity, treatment options, participation in care decisions, freedom from restraint, copies of medical records, access and availability of necessary services, and free exercise of rights.		
Required Actions: None.		
11. The member information materials sent following enrollment include the following additional member rights. Members have the right to: ◆ Have an independent advocate. ◆ Request that a specific provider be considered for inclusion in the provider network. ◆ Receive a second opinion. ◆ Receive culturally appropriate and competent services from participating providers. ◆ Receive interpreter services for members with communication disabilities or for non-English speaking members. ◆ Prompt notification of termination or changes in services or providers. ◆ Express an opinion about the Contractor's services to regulatory agencies or the media without the Contractor causing any adverse effects upon the provision of covered services. *Contract: II.F.4.j.3*	**Documents:** ◆ CS212 ◆ Member Handbook ◆ Q3 2010 Partnership Newsletter **Description:** ◆ CS212: Member Rights and Responsibilities outline ABC Members' rights policies. ◆ Member rights in accordance are outlined in the Member Handbook **(pgs 20-21)**. ◆ Additional rights are also listed in this section. ◆ The right to request that a specific provider be included in the network is also outlined on **page 20**. ◆ Members are periodically reminded that they should be aware of their rights in the Partnership Newsletter **(see** Q3 2010 Partnership Newsletter)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The member handbook listed member rights as stated in the requirements including the right to an independent advocate, request a specific provider, second opinion, culturally appropriate services, interpreter services, notification of changes in services, and to express an opinion about ABC's services.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
12. Members are informed in these materials about: ◆ Assistance available through the Medicaid Managed Care Ombudsman program. ◆ Appointment Standards for routine, urgent and emergency situations. ◆ Procedures for requesting a second opinion. ◆ Procedures for requesting accommodation for special needs. ◆ Procedures for arranging transportation. ◆ Information on how members will be notified of any changes in services or service delivery sites. ◆ Procedures for requesting information about the contractor's quality improvement program. ◆ Information on any member and/or family advisory board(s) the contractor may have in place. *Contract: II.F.4.j.4–11*	**Documents:** ◆ ABC Member Handbook ◆ Partnership Newsletter **Description:** ◆ In the Member Handbook on page 26, contact information for the Ombudsman for State Managed Care is located. Members are encouraged to call the Ombudsman if they have questions. The contact information is routinely in the Partnership Newsletter (see 1st and 3rd Quarter 2011 newsletters). ◆ Routine appointment standards are described on page 13 of the member handbook in the section titled "What to expect when you call for an appointment." The 1st Quarter 2011 Newsletter has a section titled, "Access to Services" that explains appointment standards. ◆ Emergent and Urgent are described on pages 8-9 in the Member Handbook. The 1st Quarter 2011 Newsletter has a section titled, "Access to Services" that explains urgent care appointment standards. ◆ The procedures for getting a second opinion are described on page 14. ◆ On page 12 of the Member Handbook the procedure is described for getting assistance for special needs. ◆ Transportation assistance procedure is listed on page 13. ◆ On page 6 of the Member Handbook members are told they will be notified by mail 30 days before any change will occur with services or a provider. ◆ The "Asking for Information" section on page 23 lists information members have the right to ask about at any time. Included in this list is the right to ask for the ABC Quality Improvement Program. ◆ Information regarding the Member and Family Advisory board is on page 17. The Partnership meeting is announced in every	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	newsletter and is also listed on our Web site at http://www.coaccess.com/member-and-family-advisory-board ♦ The Member Handbook is referenced in Partnership Newsletter and is also available at http://www.coaccess.com/sites/default/files/ABC_handbook_0210.pdf	

Findings:
The member handbook described how the member can contact the Department concerning a grievance and provided contact information for the Medicaid ombudsman. In addition, the front page of most quarterly newsletters contained a description of Medicaid ombudsman services and provided contact information.

The member handbook described when and how to get a second opinion and included telephone numbers for assistance from ABC's Customer Service department. The handbook outlined the expected time frames for getting a provider appointment for routine and urgent situations, included contact information for assistance in getting appointments, and provided contact numbers for obtaining transportation to appointments. The member handbook also defined expected provider response times to emergency mental health situations. A quarterly newsletter contained a reminder regarding routine and urgent appointment time frames with contact information for assistance. The member handbook stated that members with special service needs or requests would be assisted by the Behavioral Health Service Coordinator in finding a specialist, finding a provider with language or cultural similarities, or working with providers outside the ABC network. The handbook stated that members would be notified in advance in writing of any changes in benefits or services or if their provider terminated from the network.

The member handbook described the role of the Member and Family Advisory Board and when the board meets, and extended an invitation to members and families to participate. In addition, each quarterly member newsletter included an article pertaining to the Advisory Board activities, including upcoming agendas and how to participate. The handbook described the quality improvement program and the member's right to information concerning quality improvement activities, and stated that results were available in the member newsletter, on the ABC Web site (address provided), or upon request through the customer service telephone line.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
13. The member information materials sent following enrollment also include the following information regarding the grievance, appeal, and fair hearing procedures: ◆ The right to file grievances and appeals. ◆ The requirements and time frames for filing a grievance or appeal (including oral filing). ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing, and the rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ 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 time frames specified for filing, and the service authorization has not expired. • The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The right that providers may file an appeal on behalf of the member with the member's written consent. *42CFR438.10(f)(6)(iv) and438.10 (g)(1)(i–vii)* *Contract: II.F.4.i.4 and II.F.4.i.13*	**Documents:** ◆ ABC Member Handbook **Description:** ◆ The Members Rights are listed on page 20&21 and include the right to file a grievance, an appeal (pg24) or request a state fair hearing. ◆ The ABC Member Handbook includes a section titled Grievances and Appeals (pg. 24-30). On page 25 members are told that they have 30 days to file a grievance from the time the problem happened. ◆ The right to a State Fair Hearing is described and explained in detail including the method to obtain as State Fair Hearing and the rules regarding representation (pg. 29 & 30). ◆ Members are notified on page 30 that they can call Colorado Access or the Ombudsman for Medicaid Managed Care to request help in filing a grievance or an appeal. Contact information for the Ombudsman program is communicated to members in the 1st and 3rd Quarter member newsletter (Partnership). ◆ In the first paragraph of the Grievance and Appeal section on page 24 the toll free number for the Grievance and Appeal Department is given. ◆ Member Handbook Page 27 explains that members may have to pay for services that you get during the appeal if you lose the appeal for services that you get during the appeal if you lose the appeal. ◆ At the top of page 27 of the Member Handbook members are told that a provider may help file an appeal as DCR.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The member handbook included a statement regarding the member's right to file appeals and grievances. The "Grievance and Appeals" section of the member handbook addressed in detail the grievance and appeals processes and included the definition of a grievance and an appeal, examples of when to file a grievance and an appeal, and the time frames for filing. The handbook informed members how to file a grievance or an appeal, included contact numbers for assistance, the process for resolving a grievance and an appeal, information for contacting the Department for a second level review of a grievance, and how to request a State fair hearing. The handbook included contact information for the Medicaid ombudsman and other advocate groups for help with grievances and appeals. The handbook outlined the process for requesting a State fair hearing and representation at the State fair hearing. The handbook also described the circumstances for continuation of benefits and the payment implications if the appeal or hearing decision is not in favor of the member. The member handbook depicted the time frame for requesting a State fair hearing as 20 calendar days. Under the continuation of services section the timely filing for appeals when requesting the continuation of previously authorized services was, "Within 10 calendar days from the date on the letter saying what action ABC has taken or intends to take, or before the authorization ends, whichever is less time." During the on-site interview ABC staff members stated that member handbook changes regarding the time frame for requesting a State fair hearing were in process and the member page of ABC's Web site had been modified to reflect this correction. Staff members stated that future mailings of new member packets would reflect the change. Staff members stated that the description of the appeals process in the notice of action letter had also already been corrected.		
Required Actions: ABC must revise the member handbook and other member communications to specify the accurate time frames for requesting a State fair hearing for appeals related to a new request for services (30 days from the date of the notice of action). The handbook must also accurately reflect the required time frame for filing an appeal or requesting a State fair hearing if requesting the continuation of previously authorized services (within 10 days from date of the notice of action or before the effective date of the termination or change in services, whichever is later).		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
14. The member information materials sent following enrollment include: ◆ The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. ◆ Procedures for obtaining benefits including authorization requirements. ◆ The extent to which and how members may obtain benefits, from out-of-network providers. *42CFR438.10(f)(6)(v) through (vii)* *Contract: II.4.i.5–7*	**Documents:** ◆ ABC Member Handbook **Description:** ◆ On page 4 of the ABC Member Handbook the amount, duration and scoped of benefits is broken down by service type. Also on pages 8-11 Emergency benefits are explained in detail with a summary of Emergency Services on page 11. Routine services are summarized in a table on page 16. ◆ Procedures for authorization and the requirements for authorization are found on pages 5 & 6 of the ABC Member Handbook. ◆ On page 13 of the ABC Member Handbook members are instructed to call Colorado Access and speak with a service coordinator to request services from an out of network provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The member handbook provided a description of covered services in several places, including detailed instructions on how and when to access emergency services, a table of routine covered services with authorization requirements and a description of the pre-authorization process. Members were instructed throughout the handbook to call the customer service telephone line for any questions, including how to get access to an out-of-network provider.		
Required Actions: None.		
15. The member information materials sent following enrollment include the extent to which and how after hours and emergency coverage are provided, including: ◆ What constitutes an emergency medical condition, emergency services, and post-stabilization care services with reference to the definitions in 42CFR438.114(a). ◆ The fact that prior-authorization is not required for emergency services. ◆ The process and procedures for obtaining emergency and post-stabilization services,	**Documents:** ◆ ABC Member Handbook ◆ CCS309 **Description:** ◆ In the ABC Member Handbook, page 8 Emergency and Urgent situations are defined. On page 10 post-stabilization services are described. ◆ "How To Get Emergency Mental Health Services" section of the ABC Member Handbook describes that emergency services do not require prior authorization (pg. 10). ◆ The process for obtaining emergency services is located on page 9-10.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
including the use of the 911-telephone system or its local equivalent. ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services. ◆ The fact that the member has the right to use any hospital or other setting for emergency care. *42CFR438.10(f)(6)(viii)* *Contract: II.F.4.i.8*	◆ At the top of page 9 there is a sample list of Emergency Rooms. o Under this list members are told they can go to any hospital Emergency Room. ◆ CCS309-This policy states that Colorado Access will maintain a process to ensure members have direct access to emergency care and post-stabilization services (pg 2). This policy also states that no authorization is required for emergency services (pg 3) .	
Findings: The member handbook description of how to access emergency services included the use of 911 and listed locations of in-network emergency facilities. The handbook defined emergency services, urgent care, and post-stabilization care and provided examples of emergencies. The handbook stated that emergency services at any facility—in or out-of-network—are covered and explained that pre-authorization is not required for emergency care.		
Required Actions: None.		
16. The member information materials sent following enrollment include the poststabilization care services rules at 422.113(c) and include: ◆ The contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are pre-approved by a plan provider or other plan representative. ◆ The contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are not pre-approved by a plan provider or other plan representative.	**Documents:** ◆ ABC Member Handbook ◆ CCS309 **Description:** ◆ CCS309, Sections V.C - VII outline ABC's post-stabilization financial responsibility. ◆ This information is communicated in more understandable terms to Members within the ABC Member Handbook. The Handbook states that Post-Stabilization services are those services that the provider who saw you in an emergency says you need before you can go home or go to another place for care (pg 10). ◆ Members are informed that all their care is free (pgs 1 and 3) and that emergency care is free even if delivered by a non network	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ That charges to members for poststabilization services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the Contractor. ◆ That the organization's financial responsibility for poststabilization services it has not approved ends when: • A plan physician with privileges at the treating hospital assumes financial responsibility for the member's care; • A plan physician assumes responsibility for the member's care through transfer; • A plan representative and the treating physician reach an agreement concerning the member's care; or • The member is discharged. *42CFR438.10(f)(6)(ix) and 42CFR422.113(c)* *Contract: II.F.4.i.9*	provider. ♦ The Member Handbook also states that no authorization is necessary for emergency services. If authorization is required for post stabilization or other services, the provider will contact ABC. The Member does not need to seek authorization (pg 10).	
Findings: The Emergency and Poststabilization Care policy included the required provisions regarding poststabilization care and financial responsibility. The member handbook defined, in simple terms, post-stabilization services and stated that post-stabilization care requires pre-authorization, which is the responsibility of the provider, not the member.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
17. The member information materials sent following enrollment include: ◆ Policies on referral for specialty care and other services not provided by the member's care provider. ◆ That no fees will be charged for covered mental health services provided to members. ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract including how transportation is provided. *42CFR438.10(f)(6)(x) through (xii)* *Contract: II.F.4.i.10–12*	**Documents:** ♦ ABC Member Handbook ♦ CCS310 **Description:** ♦ The ABC Member Handbook states that members have the right to ask at any time a about referrals for specialty care or programs (pg. 23). CCS310 states that Colorado access will maintain a process to arrange for referrals for specialty care. Members can do this by calling Colorado Access and request assistance with making a referral. Also in CCS310, section II.D states that Colorado Access will arrange for specialty care outside of the network if network providers are unable to meet the specialty need. Again members can call Colorado Access to get assistance. ♦ On page 3 of the ABC Member Handbook is a section explaining that all Mental Healthcare is free of charge. In the Members Rights section of the ABC Member Handbook it states that members have the Right to know about any fees. There are no fees or copayments for any covered mental health services (pg. 20). ♦ On page 6 of the ABC Member Handbook is an explanation of how to access "Other Medicaid Services", included in this section are contact numbers for Health Colorado. ♦ Transportation assistance information is found on page 13 of the ABC Member Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The member handbook described that mental health services received through ABC were free of charge within the stated limits of the coverage and authorization processes. The handbook explained that coverage for physical health services would be provided under another Medicaid program, and directed members to *Health*Colorado telephone numbers for information. The handbook provided telephone numbers for access to transportation services. The member rights section included a statement regarding the member's right to "receive medically necessary covered services from a provider who is not in the Access Behavioral Care network if we are otherwise unable to provide them." The handbook instructed members that they have a right to information about referrals to specialty care or programs and to call ABC to obtain information.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
18. Advance directives requirements: The Contractor maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the BHO. Advance directives policies and procedures include: ◆ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. ◆ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. ◆ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. ◆ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ◆ The provision that the decision to provide care to a member is not conditioned on whether the	**Documents:** ♦ CCS303 ♦ ABC Member Handbook **Description:** ♦ CCS303-Advance Directives states, "Colorado Access will provide all adult members with written information on its Advance Directives policies and a description of applicable State law, and have mechanisms in place to inform providers of their rights and responsibilities related to Advance Directives." ♦ Members are also given information about Advance Directives in the ABC Member Handbook on page 14. ♦ Members can also get information about Advanced Directives by calling customer services or by accessing the Web site at: http://www.coaccess.com/advance-directives ♦ Members were informed in the 3rd Quarter 2011 member newsletter about where to find information on Advance Directives.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. ◆ Provisions for ensuring compliance with State laws regarding advance directives. ◆ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ◆ Provisions for the education of staff concerning its policies and procedures on advance directives. ◆ Provisions for community education regarding advance directives that include: • What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. • Description of applicable state law concerning advance directives. The member information materials regarding advance directives include: ◆ The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. ◆ The Contractor's policies respecting implementation of advance directives.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the Colorado Department of Public Health and Environment. *42CFR438.10(g)(2) and 42CFR422.128* *Contract: II.F.4.i.14*		

Findings:
The Colorado Access Advance Directives policy—applied to all lines of Colorado Access business—stated that information regarding advance directives, as defined by Colorado law, would be provided to all adult members and/or their DCR. The policy stated the following:

- Facilities (health care organizations) are required to provide information on admission regarding moral or conscientious limitations on the ability to execute advance directives.
- If a facility or individual provider has a conscientious objection to following specific advance directives, Colorado Access will facilitate transfer of the member to another provider.
- Members are responsible for providing advance directives to providers.
- Execution of advance directives must be recorded in the member's medical record.
- Member discrimination and provision of care based on whether a member has executed advanced directives is prohibited.
- Member information regarding advance directives must reflect any changes in State law within 90 days of the change.
- Complaints regarding advance directives may be filed with the Colorado Department of Public Health and Environment.
- Colorado Access will not attempt to persuade/dissuade members regarding the development of advance directives.
- Colorado Access will educate its staff members regarding advance directives policies.
- Members would be informed regarding their rights and processes related to advance directives in the member handbook, and providers would be educated regarding their responsibilities related to advance directives in the provider manual.

The policy also addressed exceptions to carrying out advance directives as defined in State statute.

The member handbook described the members' rights to participate in decisions about their mental health care, to refuse or stop treatment, and to receive written information about advance directives. The advance directives section of the member handbook described the purpose of advance directives and defined the three types of advance directives recognized by Colorado law. Members were informed that they are not required to have an advance directive, but to inform and provide copies to providers, family, and representatives if they have one. Members were also informed of what to do if advance directives are not followed, including the contact information for the Colorado Department of Public Health and Environment to file a complaint regarding failure to follow advance directives. The member handbook referred members to the Colorado Access Web site for more information about advance directives.
The Colorado Access Web site contained detailed information on advance directives, including a concise description of types of advance directives, a

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
detailed training manual on advance directives, a copy of the entire Colorado Access policy regarding advance directives, and links for more information from other entities. The Web site information is accessible to members and the public. Information in the provider manual regarding the provider responsibilities for advance directives included retaining the member's advance directives in the medical record and informing the member and ABC of any conscientious objections to carrying out advance directives. The manual stated that ABC would provide information concerning advance directives to the members and instructed providers that, if a provider was not able to give the member information about advance directives because the member was incapacitated, the provider must directly give advance directives information to members when they are no longer incapacitated. During the on-site interview, staff members stated that ABC has no moral, religious, or conscientious objections to providing services. Staff members stated that as a behavioral health organization, given the nature of auto-enrollment, advance directive information is routinely sent to members in the enrollment packet, and also available through providers, on the Colorado Access Web site, and annually through the member newsletter; therefore, incapacitated members have ample opportunity to access the information via the Web site, providers, or family members who had received the materials, once no longer incapacitated.		
Required Actions: None.		
19. The member information materials sent following enrollment include: ◆ Notice that additional information that is available upon request, includes information on: • The structure and operation of the Contractor. • Physician incentive plans. *42CFR438.10(g)(3)* *Contract: II.F.4.i.15*	**Documents:** ♦ ABC Member Handbook **Description:** ♦ The ABC Member Handbook informs members they have the right to ask at any time how Colorado Access structured and operates and physician incentive plans (pg. 23).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The member handbook described the member's right to request information on how ABC is structured and how it operates and to ask about physician incentive plans.		
Required Actions: None.		

Results for Standard V—Member Information							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	19	**Total Score**		=	18

Total Score ÷ Total Applicable	=	95%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has a system in place that includes a **grievance** process, an **appeal** process, and access to the **State fair hearing** process. *42CFR438.402(a)* *Contract: II.F.10* *Grievance and Appeal State Rule (version 11—January 2011): 8.209*	**Documentation:** ♦ ADM203 ♦ ADM219 ♦ QM201 ♦ ABC Member Handbook ♦ CCS307 **Description:** ♦ ADM203 states Colorado Access has a grievance process available to Members and Authorized Representatives / Designated Client Representatives (DCRs), to voice expressions of dissatisfaction (Policy Statement, pg 2). ♦ ADM219 states "Colorado Access has an appeal process for members that includes procedures for timely hearing and resolution of appeals between members and Colorado Access or providers through whom the member receives care. The appeal process is available to members who are dissatisfied with any part of an action, organization determination or adverse determination" (Policy Statement, pg 2). ♦ QM201 addresses quality of care grievances and concerns (pg 1). ♦ The grievance process is the responsibility of the Director of Customer Service. Grievances are managed by the Manager of Grievances and Appeals and handled by the Grievance and Appeal Coordinator. ♦ An internally designed Microsoft Access database manages grievance data. ♦ The ABC Member Handbook explains in detail how to file a grievance (pg 24), an appeal (pg 26), and also how to access the state fair hearing process (pg 29). Members are sent the Member Handbook when they are enrolled as Colorado Access Members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	In CCS307, the ABC Utilization Review Determination process is outlined. Section II.G includes how members or their DCR have a right to appeal adverse determinations (pg 17).	
Findings: The Member Grievance Process policy described ABC's grievance processes. The Investigation of Potential Clinical Quality of Care Grievances and Referrals policy described the processes for handling grievances related to the quality of care provided. The Member Appeal Process policy described ABC's internal appeal processes and internal processes to assist members with accessing the State's fair hearing process. The ABC member handbook informed members of their right to file grievances and appeals and to request a State fair hearing and informed members how to do so. The provider manual informed providers about ABC's member grievance and appeal processes and how members may access the State's fair hearing process. Through on-site review of a printed report from the grievance and appeals database, review of appeals records, and discussions during the on-site interview, HSAG confirmed ABC's grievance and appeal processes.		
Required Actions: None.		
2. The Contractor defines Action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole, or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals. ◆ For a resident of a rural area with only one MCO or PIHP, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: • The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. • The provider is not part of the network, but is the	**Documentation:** ◆ CCS307 ◆ ADM203 ◆ ADM219 **Description:** ◆ In CCS307(pg2), ADM219(pg11) and ADM203 (pg2) Action is defined the same as follows: "A notice from Colorado Access regarding the following: 1. The denial or limited authorization of a requested service, including the type or level of service; 2. The reduction, suspension or termination of a previously authorized service; 3. The denial, in whole or in part, of payment for a service; 4. The failure to provide services in a timely manner, as defined by the State; 5. The failure to act within the time frames provided for the resolution of grievances and appeals;	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the BHO's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42CFR438.400(b)* *(42CFR438.52(b)(2)(ii)* *State Rule: 8.209.2*	6. The denial of a Medicaid member's request to exercise his or her right under 42 CFR 438.52(b)(2)(ii) to obtain services outside the network for members in rural areas with only one Medicaid managed care organization."	
Findings: The Member Grievance Process, the Member Appeal Process, and the Utilization Review Determinations policies, each included the required definition of an action. The ABC member handbook described situations under which members were entitled to an appeal or access to a State fair hearing. The ABC member handbook information regarding when to file an appeal was consistent with the federal health care definition of an action, and was at the required readability level. The on-site appeals record review demonstrated that appeals and ABC's appeal process was based on the correct interpretation of actions and appeals.		
Required Actions: None.		
3. The Contractor defines Appeal as a request for review of an Action. *42CFR438.400(b)* *State Rule: 8.209.2*	**Documentation:** ♦ ADM219 **Description:** ADM219 defines Appeal as "a request for review of an action" (Definitions, pg 11).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeals Process policy stated the definition of appeal as a request for review of an action. The ABC member handbook informed members about the situations (actions) under which members have the right to an appeal. The on-site review of appeals records confirmed ABC's appeal process.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
4. The Contractor defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action. *42CFR438.400(b)* *State Rule: 8.209.2*	**Documentation:** ♦ ADM203 **Description:** ADM203 defines Grievance (pg 3).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Grievance policy defined grievance, as required. The ABC member handbook informed members, in a manner that was easily understood, of their right to file grievances and provided examples of possible grievance situations.		
Required Actions: None.		
5. The Contractor has provisions for who may file: ◆ A member may file a grievance, a BHO-level appeal, and may request a State fair hearing. ◆ A provider may file a grievance on behalf of a member, given that the State permits the provider to act as the member's authorized representative. ◆ A provider, acting on behalf of the member and with the member's written consent may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member, given that the State permits the provider to act as the member's authorized representative. *42CFR438.402(b)(1)* *State Rule: 8.209.2*	**Documentation:** ♦ ADM203 ♦ ADM219 ♦ ABC Member Handbook ♦ CCS307 **Description:** ♦ ADM203 Defines Designated Client Representative (DCR) to include treating providers with written authorization by the member. (pg 3). ♦ The ABC Member Handbook explains on page 24 who can be a DCR and also how authorize a DCR. The DCR form is on the last page of the ABC Member Handbook and also at: http://www.coaccess.com/sites/default/files/DCR_form.pdf ♦ CCS307 Section II.G explains Colorado Access has established a grievance process that includes a grievance and appeal process and access to a State Fair Hearing for members or DCRs (pg 17). ♦ In the ABC Member Handbook on page 25 it explains that a member or their DCR can file grievance by calling or by writing Colorado Access. Page 27 explains that a member or	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	their DCR can ask for an appeal. Further down on page 27 a section called "How to Ask For an Appeal," which states a member or their DCR can call or write to request an appeal. ♦ ADM219 Section III states: "ABC members, DCRs, or the legal representative of a deceased member's estate may request a review of an action through the appeal process either verbally or in writing and shall follow and oral appeal with a written appeal" (pg 11) ♦ On page 29 of the ABC Member Handbook there is an explanation on "How to Request a State Fair Hearing" which states that a member or their DCR can call or write to the Office of Administrative Courts to request a State Fair Hearing.	
Findings: The Member Grievance Process policy stated that members or designated client representatives (DCRs) may express dissatisfaction through the grievance process. The grievances section of the provider manual stated that ABC requests that providers relay member concerns to ABC and that providers can call directly to file a grievance on behalf of the member. The Member Grievance Process policy defined a DCR as including a treating health care professional. The Member Appeals Process policy stated that members or DCRs may file appeals. The definition of DCR in the Member Appeal Process policy also included treating health care professionals. The provider manual stated that ABC strives to educate members about their rights to file grievances and appeals and that providers can help by informing members of these rights. Members were informed in the grievance and appeals section of the ABC member handbook regarding how to use a DCR and that a DCR may be a provider. The ABC member handbook also stated "your provider may file an appeal for you or help you with an appeal as your DCR." The ABC member handbook informed members how they or a DCR may request a State fair hearing. The State fair hearing section of the Member Appeals Process policy stated that ABC provides assistance to members or DCRs wishing to request a State fair hearing. The on-site appeals record review included appeals that had been filed by members, their DCRs or providers on behalf of the member.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
6. The Contractor accepts grievances orally or in writing. *42CFR438.402(b)(3)(i)* *State Rule: 8.209.5.D*	**Documentation:** ♦ ADM203 ♦ ABC Provider Manual ♦ ABC Member Handbook **Description:** ♦ ADM203 defines a grievance as "An oral or written expression of dissatisfaction communicated by a member or a DCR about any matter other than an action, including but not limited to quality of care or services provided, aspects of interpersonal relationships such as rudeness of provider or employee, or the Failure to respect the member's rights" (pg 3) ♦ The Member Handbook informs Member that grievances can be filed orally or in writing (pg 25). ♦ Providers are instructed within the Provider Manual (pg 57) to reference the Member Handbook. The Provider Manual, Appendix B, Forms, contains an online link to the Member Grievances Form.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Member Grievance Process policy defined a grievance as an oral or written expression of dissatisfaction about any matter other than an action, and provided examples of common grievances. The policy also stated that members (or DCRs) may express dissatisfaction through the grievance process either orally or in writing. The ABC member handbook provided members the option to call the grievance and appeals department, complete the grievance form provided in the ABC member handbook, or write a letter. The handbook provided the address and the telephone number for filing. The provider manual informed providers that grievances may be oral or written. During the on-site interview, ABC staff members reported that the majority of grievances are filed orally. During the on-site interview, ABC staff members described the delegation of grievance processing to the Mental Health Center of Denver (MHCD) and ABC's overall grievance process. While some grievances are filed directly with ABC, others are filed at MHCD. Staff members reported processing grievances filed at MHCD as a shared process, with MHCD being instrumental in investigating and solving the issues and ABC being responsible for acknowledging and providing notice of resolution to members. MHCD staff members have access to a shared drive where the grievance information is loaded and ABC staff members access the information to send the acknowledgement and resolution notices.

Required Actions:
None.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
7. Members have 30 calendar days from the date of the incident to file a grievance. *42CFR438.402(b)(2)* *State Rule: 8.209.5.A*	**Documentation:** ♦ ADM203 ♦ ABC Member Handbook (pg 25) **Description:** ♦ ADM203 states that Colorado access will accept a grievance within 30 calendar days of the incident (Section I.A.1, pg 3). ♦ The ABC Member Handbook states Members should file their grievance within 30 calendar days.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Grievance Process policy included the provision that ABC will accept grievances within 30 days of the incident. Members were informed via the ABC member handbook of the 30-calendar-day filing time frame. Providers were informed of the 30-calendar-day filing time frame via the provider manual.		
Required Actions: None.		
8. The Contractor sends written acknowledgement of each grievance within two working days of receipt. *42CFR438.406(a)(2)* *State Rule: 8.209.B*	**Documentation:** ♦ ADM203 ♦ FY10 Q1-4 ABC Grievance and Appeals Report ♦ ABC 2-Day Grievance Acknowledgement Letter 9-8-11 **Description:** ♦ As specified in ADM203, grievance acknowledgement letters are sent within 2 business days using the State approved acknowledgment letter template (Section I.A.2, pg 3). ♦ Any grievance not acknowledged within the required 2 business days is reported on the quarterly grievance and appeals report.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Grievance Process policy included the provision that ABC sends a grievance acknowledgement letter within two business days of receipt of the grievance. ABC's Quarterly Grievance and Appeals reports for January–March 2011, April–June 2011, and July–September 2011 indicated that all grievance acknowledgement letters were sent within the required two-business-day time frame during these quarters. HSAG reviewed a grievance acknowledgement letter template and a printed report from the grievance database, which demonstrated ABC's mechanism for tracking timeliness of acknowledgement letters.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
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 BHO receives the grievance. *42CFR438.408(b)(1) and (d)(1)* *State Rule: 8.209.5.D.1, 8.209.5.F*	**Documentation:** ♦ ADM203 ♦ FY11 Q1-4 ABC Grievance and Appeals Report ♦ ABC Grievance Resolution Letter 9-8-11 **Description:** ♦ ADM203 states: "Grievances are resolved as expeditiously as the member's health condition requires, within fifteen (15) business days from receipt of the grievance if an extension is not required. In most cases, a written resolution notice that explains the resolution of the grievance and the date it was completed is sent to the member or DCR. In the case of a QOC resolution, the written notice will not include peer-review results, which are protected by law" (Section I.A.4, pg 3). ♦ Grievance resolution letters are mailed to Members using the State approved template. ♦ Noncompliance is documented in the quarterly Grievance and Appeals Report.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Grievance Process policy included the provision that ABC sends a grievance resolution letter within 15 business days of receipt of the grievance. ABC's Quarterly Grievance and Appeals reports for January–March 2011, April–June 2011, and July–September 2011 indicated that all grievance resolution letters were sent within the required time frames during these quarters (with five grievance resolutions having been extended with the appropriate notice). ABC provided a grievance resolution letter template for review. On-site ABC provided an example of a printed report from the grievance database documenting the receipt and resolution dates of grievances.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
10. The written notice of grievance resolution includes: ◆ The results of the disposition/resolution process. ◆ The date it was completed. *State Rule: 8.209.5.G*	**Documentation:** ♦ FY10 Q1-4 ABC Grievance and Appeals Report ♦ ABC Grievance Resolution Letter 9-8-11 **Description:** See state approved Grievance Resolution Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Grievance Process policy indicated that for grievances other than quality of care (QOC) grievances, the letter explains the resolution and the date it was completed. The policy stated that for QOC grievances, the notice will not include peer review results, which are protected by law. ABC provided a grievance resolution template letter. The grievance resolution template letter included fields for the outcome of the grievance and the date the resolution process was completed. The template also included the address for the Department and informed the member that he or she may send a letter to the Department if he or she is not happy with the resolution of the grievance. ABC provided an example of a grievance resolution letter that had been sent during the review period. The letter included the required content and included information about contacting the Department if unhappy with the resolution.		
Required Actions: None.		
11. Members may file an appeal within 30 calendar days from the date of the notice of action. *42CFR438.402(b)(2)* *State Rule: 8.209.4.B*	**Documentation:** ♦ ADM219 ♦ Notice of Action Letter (see Appeals Letters folder) ♦ ABC Member Handbook (pg 27) **Description:** ♦ ADM219 states: "A member, DCR, or legal representative must submit an appeal of the notice of action within thirty (30) calendar days from the date of the notice of action" (Section III.C, pg 12) ♦ Members are informed they may file an appeal of an Action within 30 calendar days in the Member Handbook (pg 27)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeals Process policy included the provision that members may file an appeal within 30 calendar days of the date of the notice of action. Members were informed of the 30-calendar-day filing time frame via the ABC member handbook and the notice of action letter. Providers were notified of the 30-calendar-day filing time frame via the provider manual.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
12. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42CFR438.402(b)(3)(ii)* *State Rule: 8.209.4.F*	**Documentation:** ♦ ADM219 ♦ ABC Member Handbook (pg 28) **Description:** ♦ ADM219 states: "ABC members, DCRs, or the legal representative of a deceased member's estate may request a review of an action through the appeal process either verbally or in writing and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal" (Section III, pg 11).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeals Process policy included the provision that appeals may be filed verbally or in writing, and, unless the member requests expedited resolution, verbal appeals must be followed by a written, signed appeal. The ABC member handbook informed members that appeals may be filed by writing, or that the member may start the appeal by calling first. Members were also informed of the filing requirements via the notice of action letter. The notice of action template letter included an attachment of pages from the grievance and appeals sections of the ABC member handbook. During the on-site interview, staff members reported that the attachment is routinely sent with the notice of action letter. Appeals records reviewed on-site included written requests, some of which had followed a verbal request for the appeal.		
Required Actions: None.		
13. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms required, putting oral requests for a State fair hearing into writing, 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. *42CFR438.406(a)(1)* *State Rule: 8.209.4.C*	**Documentation:** ♦ ADM203 ♦ ADM219 ♦ ABC Member Handbook ♦ ABC Notice of Action Letter (see Appeals Letter folder) **Description:** ♦ ADMS203 states: "Colorado Access will provide members with 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	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	TTY/TTD and interpreter capability" (Section I.A.7, pg4). ♦ ADM219 section III.B states: "Colorado Access will make reasonable effort to provide assistance to a member, DCR, or legal representative in navigating the appeal process including but not limited to, completing any necessary appeal forms, putting oral quests for a State Fair Hearing into writing, and providing interpretive services and toll-free numbers that have TTY/TTD capability when necessary (pg 12)" ♦ The ABC Member Handbook informs Members that we will help Members with grievances (pg 24) and appeals (pg 30). ♦ ABC Notice of Action letters, at the beginning and end of the informational letter states that we will help the Member with any part of the appeal process. ♦ All Members are provided toll-free numbers, any language interpretation services needed, or necessary hearing impaired assistive technologies. This is stated in all ABC Member information.	
Findings: The Member Grievance Process and the Member Appeal Process policies, both included the provision that ABC will provide any reasonable assistance navigating the processes, including assistance with forms, interpreter services, and toll-free telephone numbers. The ABC member handbook offered assistance writing or filing grievances and appeals. The rights section of the ABC member handbook informed members of the right to receive interpretation services in any language needed. The attachment to the notice of action letter template provided a telephone phone number to call for help with any part of the appeal process. During the on-site interview, ABC staff members reported that if members are unable to put requests for an appeal in writing, customer service staff offer to work with the member to assist with writing the appeal.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
14. The Contractor sends the member a written acknowledgement of each appeal within two working days of receipt, unless the member or the designated client representative (DCR) requests an expedited resolution. *42CFR438.406(a)(2)* *State Rule: 8.209.4.D*	**Documentation:** ♦ ADM219 ♦ ABC Member Appeal Acknowledgement Letter ♦ ABC Grievance and Appeals Report **Description:** ♦ ADM219 states: "Upon receipt of an appeal, a written acknowledgement of the appeal is provided to the member, DCR, or legal representative within two (2) business days of receipt, unless the member or DCR requests an expedited resolution" (Section III.F, pg 12). ♦ ABC Member Appeal Acknowledgement Letter ♦ See ABC Quarterly Grievance and Appeal Report for monitoring.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeal Process policy included the provision that ABC sends a written acknowledgement to the member within two business days following the receipt of the appeal. ABC's Quarterly Grievance and Appeals reports for January–March 2011, April–June 2011, and July–September indicated that all appeal acknowledgement letters were sent within the required two-business-day time frame during these quarters. On-site, ABC staff members provided a printed report from the appeals database that demonstrated documentation of receipt and acknowledgement of appeals. The on-site record review demonstrated that acknowledgement letters were sent within the required time frames in all cases reviewed (including the expedited cases, in which acknowledgement letters were sent within 24 hours).		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
15. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date). ◆ The member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The contractor must inform the member of the limited time available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents considered during the appeals process. ◆ That included, as parties to the appeal, are: • The member and his or her representative; or • The legal representative of a deceased member's estate. *42CFR438.406(b)* *State Rule: 8.209.4.G, 8.209.4.H, 8.209.4.I*	**Documentation:** ♦ ADM219 ♦ Notice of Action Letter/Appeal Information **Description:** ♦ ADM219 states: "ABC members, DCRs, or the legal representative of a deceased member's estate may request a review of an action through the appeal process either verbally or in writing and shall follow and oral appeal with a written appeal" (Section III, pg 11). ♦ ADM219 states: "Colorado Access will make a reasonable effort to provide an opportunity for the member, DCR, or legal representative to examine the records and documents associated with their appeal and to present evidence and allegations of fact or law, in person or in writing. For an expedited appeal request, Colorado Access will inform the member, DCR or legal representative, via the notice of action/appeal information and the Consumer Handbook, of the limited time available to present this information" (Section III.K, pg 14). ♦ See Notice of Action Letter for appeal information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The ABC member handbook and the appeal information attachment to the notice of action letter informed members to call in order to start the appeal process, as well informed members how to follow the oral appeal in writing, or to file in writing. The Member Appeal Process policy included the provisions to allow members to examine documents associated with the appeal, and to present evidence in person or in writing. The ABC member handbook and the appeal information attachment to the notice of action letter informed members of the right to provide ABC with more information and tell them why ABC should change the decision, as well as the right to review records having to do with the appeal. The handbook also informed members that, for expedited appeals, the time available to review records or provide additional information is short. The Member Appeal Process policy described parties to the appeal, as required. HSAG reviewed appeals during the on-site record review that were initially filed verbally, and included written follow-up. The verbal request date was the date entered as the appeal date. The appeals record review also included examples of cases in which members provided additional information.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
16. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: ◆ For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal. ◆ For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42CFR438.408(b)(2)&(d)(2)* *State Rule: 8.209.4.J, 8.209.4.L*	**Documentation:** ♦ ABC Contractor Information and Analysis Report ♦ ADM219 **Description:** ♦ See ABC Grievance and Appeals Report. ♦ ADM219 states that standard resolution to appeals will be completed within 10 business days of receipt (Section III.H.I.1, pg 13). ♦ ADM219 states that for expedited appeals written notice will be sent within 3 business days of receipt (Section III.H.I.2, pg 13). Also at the end of Section III.I.2, ADM219 states that Colorado Access will make reasonable efforts to give verbal notification of the resolution within 3 business days (pg 13).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeal Process policy included the 10-business-day resolution time frame for standard appeals and the three-business-day resolution time frame for expedited appeals. The policy also included the provision for reasonable effort to provide oral notice for expedited appeals. ABC's Quarterly Grievance and Appeals reports for January–March 2011, April–June 2011, and July–September indicated that all appeal resolution letters were sent within the allowable time frames, with five appeal resolutions having been extended, as allowed. The on-site appeals record review demonstrated that the resolution letters were sent in all cases reviewed. During the on-site interview, staff members reported that verbal notice is provided, when possible, for expedited cases.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
17. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: • The right to request a State fair hearing, and how to do so. • The right to request that benefits while the hearing is pending, and how to make the request. • That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action. *42CFR438.408(e)* *State Rule: 8.209.4.M*	**Documentation:** ♦ ADM219 ♦ ABC Member Appeal Action Upheld ♦ ABC Member Appeal Action Reversed ♦ ABC Member Appeal Member Info **Description:** ♦ See ABC Member Appeal Action Upheld and Reversed Letters. Both templates show the date the decision was made and the process. ♦ ADM219 (Section III.I.3) states that for resolution notices not in wholly favor of the member the written notice shall include the right to a State Fair Hearing and how to do so, the right to receive benefits during the hearing and that the member may be held liable for the cost of these benefits if the decision is upheld (pg 13). ♦ Within 10 days members will receive a notification letter of resolution. For resolutions that are not resolved wholly in favor of the member they will receive the ABC Member Appeal Action Upheld letter and the ABC Member Appeal Member Info letter. The Upheld letter states the member has a right to a State Fair Hearing and states how a member can get a hearing. ♦ The **ABC Member Appeal Member** Info letter also states that members can request benefits while the hearing is pending and that they could be liable for said services if the decision is upheld (pg 3).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeal Process policy included the provision to include the required content in the appeal resolution letters. The appeal resolution template letters included the required information. The on-site appeals record reviews demonstrated that appeal letters addressed each of the required elements; however, the filing time frame for requesting a State fair hearing was incorrect in the template and in the resolution letters. (This specific time frame will be scored in requirement 20 of this standard.)		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
18. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: ◆ Were not involved in any previous level of review or decision-making. ◆ Have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. *42CFR438.406(a)(3)(ii)* *State Rule: 8.209.4.E, 8.209.5.C*	**Documentation:** ♦ ADM219 ♦ ADM203 **Description:** ♦ ADM203 (Section I.A.3, pg 3) and ADM219 (Section III.H, pg 13) Both policies state those individuals who make decisions on grievances or appeals were not a part of any previous level of review. ♦ ADM219 (Section III.H.1-2, pg 13) states that a licensed physician not involved with any previous level of review will review if the decision was based on lack of medical necessity or involves clinical issues. ♦ ADM203 (Section I.A.3, pg 3) states that when a grievance is filed for a denial of an expedited appeal an individual with the appropriate clinical expertise in treating the member's condition will review the request for an expedited appeal.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Grievance Process policy stated that grievance resolution decisions are made by a designated employee who was not involved in any previous level of review or decision-making and has appropriate clinical expertise when grievances involve clinical issues or denial of a request for expedited resolution. The Member Appeal Process policy stated that appeal decisions are made by licensed physicians who were not involved in any previous level of review and who has the appropriate clinical expertise in treating the member's condition or disease. The on-site review of appeal records demonstrated that individuals who made decisions on the appeals were ABC's psychiatrists and were not the individual who had made the original decision.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
19. The contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) 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. ◆ If the Contractor extends the time frames, it must—for any extension not requested by the member—give the member written notice of the reason for the delay. *42CFR438.408(c)* *State Rule: 8.209.4.K, 8.209.5.E*	**Documentation:** ♦ ADM203 ♦ ADM219 **Description:** ♦ ADM219 (Section III.J, pg 13) states for appeals the contractor may extend the time frames by 14 days for both standard and expedited appeals if the member requests the extension, if the contractor shows it is in the member's best interest for additional information, and prior written notice will be given for any delay. ♦ ADM203 (Section I.A.5, pg 4) states for grievances the contractor may extend the time frames by 14 days for both standard and expedited appeals if the member requests the extension, if the contractor shows it is in the member's best interest for additional information, and prior written notice will be given for any delay.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Both the Member Grievance Process policy and the Member Appeal Process policy included the provision that resolution of grievances or appeals (applicable to the policy) may be extended by up to 14 calendar days if the member requests the extension or the BHO indicated that it would be in the best interest of the member. The ABC member handbook informed members that ABC could ask for more time to review grievances and appeals and that the member or DCR could ask for additional time for appeal. The Member Appeal Information letter informed members that ABC may request more time to make the decision, or the member or DCR may request more time. Both policies included the provision that prior written notice of the reason for delay be sent to the member for extensions not requested by the member or DCR. ABC provided an appeal extension letter template. The on-site appeals record review demonstrated that, in each of the extended appeals cases, extension letters were sent to the members.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
20. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action. *42CFR438.402(b)(2)(ii)* *State Rule: 8.209.4.N*	**Documentation:** ♦ ADM219 **Description:** ♦ ADM219 (Section III.S.1, pg 15) states: "ABC members may request a State Fair Hearing at any time during the appeal process but no later than thirty (30) calendar days from the date of the notice of action. The member need not exhaust ABC's appeal process."	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Appeal Process policy included the provision that members may request a State fair hearing at any time during the appeal, but not later than 30 calendar days from the date of the notice of action, and that members need not exhaust ABC's appeal process prior to requesting a State fair hearing. Members were incorrectly informed in the Appeal Information attachment (attached to notices of action and appeal resolution letters) of the previous 20-calendar-day time frame for requesting a State fair hearing. Members were informed in the member handbook that they may request a State fair hearing instead of using ABC's internal appeal process, at any time during the ABC appeal, or if not happy with ABC's decision on the appeal. (See the Member Information standard, requirement 13 for scoring specific to the member handbook information about State fair hearing request time frames.)		
Required Actions: ABC must review member communication used during the appeal process to ensure that members receive current information regarding the time frame for requesting a State fair hearing.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
21. The Contractor maintains an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice. *42CFR438.410* *State Rule: 8.209.4.P–.R*	**Documentation:** ♦ ADM219 **Description:** ♦ ADM219 (Section III.E, pg 12) states: "If Colorado Access or the treating provider determines that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, an expedited appeal may be requested." ♦ ADM219 (Section III.D, pg 12) states: "Colorado Access will not impose any punitive action against a member, DCR, or legal representative for filing a standard or expedited appeal, or supporting a request for a standard or expedited appeal." ♦ ADM219 (Section III.I.2, pg 13) states: "If a request for an expedited appeal resolution is denied, Colorado Access will make a reasonable effort to give the member, DCR, or legal representative prompt verbal notice of the denial and provide written notice to the member, DCR, or legal representative within two (2) calendar days. The appeal will then follow the process for a standard resolution."	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeal Process policy described ABC's expedited review process, which included the required components. ABC provided an example of a notice to deny the expedited process. The ABC member handbook described the expedited ("Rush") appeal review process in a manner that was easily understood. There were three expedited appeals reviewed during the on-site record review. Although these appeals may not have met the medical criteria for expedited review, ABC processed them as expedited appeals based on the member's request.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
22. The Contractor provides for continuation of benefits while the BHO-level appeal and the State fair hearing are pending if: ◆ The member or the provider files timely*—defined as on or before the later of the following: • Within 10 days of the Contractor mailing the notice of action. • The intended effective date of the proposed action. ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. **This definition of timely filing only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.* *42CFR438.420(a) and (b)* *State Rule: 8.209.4.S*	**Documentation:** ◆ ADM219 **Description:** ◆ ADM219 (Section III.L.1-4, pg 14) states: "Colorado Access will provide for the continuation of benefits of a previously authorized service while an appeal is pending when all of the following criteria are present: 1. the member/provider files the appeal before the service ends, or within ten (10) calendar days of the date the Notice of Action was received; and 2. the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; and 3. the services were ordered by an authorized provider; and 4. the original period covered by the original authorization has not expired; and the member requests an extension of benefits."	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The Member Appeal Process policy included the provision for continuation of benefits in the appeal section and the State fair hearing section of the policy. The provision for timely filing was accurate in the appeals section (within 10 calendar days, or before the effective date of the intended action, whichever is later); however, in the State fair hearing section of the policy, the time frame was depicted as 30 days. (See the Member Information standard, requirement 13 for scoring specific to the member handbook information about continuation of benefits.)

Required Actions:
ABC must revise its applicable policies to accurately reflect the timely filing requirement for appeals and State fair hearings when continuation of benefits (services) is requested.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten days pass after the Contractor mails the notice providing the resolution (that is against the member) of the appeal, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. ◆ A State fair hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. *42CFR438.420(c)* *State Rule: 8.209.4.T*	**Documentation:** ♦ ADM219 **Description:** ♦ ADM219 (Section III.M.1-4, pg 14) states that upon a members request Colorado Access continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs: 1. The member withdraws the appeal. 2. Ten days pass after Colorado Access mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10 day time frame, has requested a State Fair Hearing decision with continuation of benefits until a State Fair Hearing Decision is reached. 3. A State Fair Hearing Office issues a decision adverse to the member. 4. The time period or service limits of the previously authorized service has been met.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeals Process policy included the provision under both the appeals and State fair hearing sections of the policy. There were no examples of appeals related to the termination, suspension, or reduction of previously authorized services. ABC may want to consider revising the member handbook language regarding this requirement. The handbook states, "…ten days pass after we mail the original notice to you that we are denying the appeal." HSAG recommends removing the word "original," as it may be confusing and lead the member to believe this refers to the notice of action.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
24. Effectuation of Appeal Resolution: ◆ If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. *42CFR438.420(d), 42CFR438.424* *State Rule: 8.209.4.U–W*	**Documentation:** ◆ ADM219 **Description:** ◆ ADM219 (Section III.O, pg 14 and Section III.S.6, pg 16) States that Colorado Access may recover the cost of the services furnished to the member. ◆ ADM219 (Section III.R, pg 15 and Section III.S.9, pg 16) States that if Colorado Access or the State Fair Hearing Officer reverses a decision to deny authorization, Colorado Access must pay for those services. ◆ ADM219 (Section III.Q, pg 15 and Section III.S.8, pg 16) States that if Colorado Access or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, Colorado Access will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeals Process policy included the required provisions regarding effectuation of the appeal resolution for cases in which continued benefits were requested. Members were informed in the member handbook under both the appeal and State fair hearing sections that the member may have to pay for services continued during the appeal or State fair hearing if the decision was not in favor of the member. The handbook also informed members that if the decision was in favor of the member, ABC would pay for the services.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
25. The Contractor maintains records of all grievances and appeals and submits quarterly reports to the Department. *42CFR438.416* *State Rule: 8.209.3.C*	**Documentation:** ♦ ADM203 ♦ ADM219 ♦ Contractor Information and Analysis Reports FY11 Q1-4 **Description:** ♦ ADM203 (Section I.A.8, pg 4) states that Colorado Access maintains records on all grievances and reports to the Department Quarterly. ♦ ADM219 (Section III.T, pg 16) states that Colorado Access will maintain records on all appeals and report to the Department quarterly. ♦ See FY11 Q1-4 Contractor Information and Analysis Reports for quarterly submitted reports.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Appeal Process policy and the Member Grievance Process addressed the documentation of grievances and appeals using the grievance and appeal database. ABC provided copies of quarterly grievance and appeal reports submitted to the Department. On-site review of the appeals records and a printed report of the grievance and appeals database provided evidence of ABC's grievance and appeals record keeping. During the on-site interview, ABC described anticipating a new grievance and appeal database to be implemented in the current fiscal year. The new database will provide additional features including an embedded tickler system.		
Required Actions: None.		
26. The Contractor must provide the information about the grievance system specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing. • The rules that govern representation at the State	**Documentation:** ♦ ABC Provider Manual ♦ ABC Member Handbook **Description:** ♦ The Provider Manual (pg 57) refers providers to grievance information located within the Member Handbook (pgs 24-30). ♦ The Provider Manual, Section XII: Clinical Appeals and Grievances informs provider about the grievance system in accordance with 42CRF438.10 (pgs 63-67).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. • 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 or State fair hearing is pending, if the final decision is adverse to the member. ◆ The member's right to have a provider file a grievance or an appeal on behalf of the member, with the member's written consent. *42CFR438.414* *State Rule: 8.209.3.B*		
Findings: Sections VIII and XII of the provider manual addressed member grievances and appeals and included all of the required information regarding the member grievance system. During the on-site interview, ABC staff members reported that grievance system training was also available for new providers.		
Required Actions: None.		

Results for Standard VI—Grievance System							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	26	**Total Score**		=	24

Total Score ÷ Total Applicable	=	92%

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has a robust and thorough process, described in written policies and procedures, to evaluate potential providers before they provide care to members, and to reevaluate them periodically thereafter. The Contractor has adopted NCQA credentialing and recredentialing standards and guidelines for provider selection. *42CFR438.214(a)* *Contract: II.G.3.a, Exhibit O: I.A, I.B.3*	**Documentation:** ♦ CR301 ♦ CR302 ♦ CMP206 ♦ CR306 ♦ CR307 ♦ CR312 ♦ CR213 ♦ CR318 ♦ PNS202 ♦ ADM223 ♦ Provider Manual (pgs 59-62) ♦ Credentialing Committee Roster 2011 **Description:** ♦ Credentialing functions are the responsibility of the Director of Provider Contracting. Credentialing staff consist of the Manager of Credentialing Program and two, Credentialing Program Coordinators. ♦ Colorado Access maintains a credentialing committee consisting of physicians from within our network and chaired by a Colorado Access Medical Director. Minutes will be made available upon request during the site review. ♦ All Colorado Access credentialing and recredentialing policies and procedures adhere to NCQA MBHO Standards and Guidelines for Credentialing and Recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Selection and Retention of Providers policy outlined the process for identifying potential licensed provider participants in the network, and outlined the factors evaluated to ensure network adequacy. The policy stated that, once identified, providers must meet the credentialing criteria, as determined through administrative verification of applicant information and review by the Credentials Committee.		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**

The Practitioner Credentialing and Recredentialing policy and related policies defined the comprehensively defined the procedures related to credentialing of network practitioners including:

- Definitions of behavioral health practitioner categories subject to credentialing/re-credentialing
- Application requirements and application tracking processes
- The practitioner's right to review and correct information in his or her file and to be informed of the status of his or her application
- Processes for maintaining confidentiality of credentialing files
- Processes and criteria for verification and documentation of supporting information
- Procedures for on-site evaluation of provider offices to assess the physical environment and record keeping practices.
- The requirement to complete the credentialing process prior to network participation
- Non-discrimination policies and procedures to decline network participation based on network need
- The uniform application of credentialing criteria to all applicants
- The time frame and notification requirements for the initial credentialing decision
- The hearing and appeals process for denied applicants
- Credentials Committee responsibilities
- Oversight and accountability of the credentialing process, including the Senior Medical Director, the Credentials Committee, the Board of Directors and the Delegation Oversight Committee
- Criteria for processing files and categorizing files for the Credentials Committee into "meeting criteria" or "requiring additional discussion" categories
- The process for delegating credentialing and oversight of credentialing delegates
- Ongoing monitoring of participating practitioners between credentialing cycles
- Re-credentialing practitioners at least every 36 months following initial credentialing
- The process to ensure that provider directories contain current credentialing information

The provider manual stated that no practitioner may deliver services within the network until they have been through the credentialing process and have an executed contract. The manual also described the types of practitioners subject to credentialing, the criteria for credentialing, the process, practitioner rights, practice site review guidelines, hearing and appeals processes, and notification processes. The manual stated that practitioners were subject to credentialing review on initial application to the network and every three years thereafter, and included a statement of non-discrimination. The manual listed the criteria for assessing organizational providers and stated that practitioners within these entities were not individually credentialed by ABC. The manual informed providers that credentialing processes were in compliance with NCQA guidelines.

Required Actions:
None.

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
2. The Contractor has policies and procedures that describe methods of ongoing provider monitoring and that include: ◆ The frequency of monitoring. ◆ How providers are selected to be reviewed. ◆ Scoring benchmarks. ◆ The way record samples will be chosen. ◆ How many records will be reviewed. (The Department encourages a survey checklist for the actual provider visits.) *Contract: Exhibit O: I.A.2*	**Documentation:** ♦ SDML ♦ CR318 ♦ QM201 ♦ QM201 attachment B ♦ QM302 ♦ QM302 attachment C **Description:** ♦ Annually Colorado Access through Provider Network services mails providers the SDML letter which advises providers of their responsibility to screen all employees or ownership interests for exclusion as a Medicaid provider. Providers are to do this screening monthly. See SDML letter. ♦ On a monthly basis, Provider Network Services checks the OIG exclusion database (CR318: Section II.A.1, pg 3) ♦ Prior to each credentialing committee meeting, credentialing staff check the DORA Registrations Online Disciplinary report for all credentialed providers (CR318: Section II.B.1-2, pg 3). ♦ Per NCQA guidelines, CR301, Section XIV.I (pg 13) requires Colorado Access to conduct a site visit upon receiving a complaint related to the physical accessibility, physical appearance, or adequacy of waiting- and examining- room space. Policy CR302 establishes the formal process for provider site visits, including the Office Site Visit Evaluation Form and Instructions (Appendix A). ♦ Member quality of care concerns (QOCCs) or adverse events are reviewed by a Medical Director. If warranted, cases are referred to the Credentials Committee for review (CR318, Section II.C, pg 4). This process is	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	specified within QM201 (Policy Statement, pg 1). If a quality of care concern is suspected, an investigation follows the procedures outlined in QM201 (Section I pg 3). If a quality of care concern is substantiated after review by the Medical Director, appropriate interventions are specified on the Quality of Care Clinical Review form (QM201, Attachment B pg 8). ♦ QM302 describes the Review of Provider Medical Records. o In section QM 302 II.B.1 it states: "Participating practitioners or providers selected for medical record review will be determined by criteria established by medical directors, designees, and/or quality improvement committees. Criteria may include, but are not limited to, volume of members paneled or accessing care, quality of care and/or documentation issues (pg3)." o Section II.B.2 states that a minimum of 10 records will be reviewed (pg5). o QM302, Attachment C is the audit tool which is used to review and score provider records.	

Findings:
The Review of Provider Medical Records policy stated that medical record audits were performed annually based on regulatory and accreditation standards. The medical record requirements were outlined in the policy and the provider manual. The policy stated that criteria for selection of the provider practice to receive a medical record audit was established by the medical director or quality improvement committees based on volume of members, quality of care, or documentation concerns. The policy stated that the medical record standards to be evaluated were determined prior to the audit. A minimum of 10 randomly selected records of members with visits within the review period were reviewed for the selected provider practice. An audit tool was used for the reviews, and scoring goals were established by the vice president of clinical services, the medical director, or the QI Committee. The policy included the Clinical Record Review Scoring Tool.

During the on-site interview, ABC staff members described the annual medical record documentation audit as including review of a random sample of records from each selected provider. In addition, a national audit service reviewed higher cost claims to validate appropriateness of charges. Staff members

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
stated that an outpatient provider profile report was produced for MHCD using an algorithm that screened all members assigned to the CMHC. The report included an aggregate summary of performance and utilization measures, which ABC reviewed with MHCD and addressed opportunities for improvement. ABC tracked follow-up data to determine progress. Staff members stated that this process was not currently applied to individual providers as samples were too small. ABC staff members described participation in the state-wide BHO collaborative project to address provider monitoring and compliance.		
Required Actions: None.		
3. The Contractor monitors covered services rendered by provider agreements for: ◆ Quality ◆ Appropriateness ◆ Patient outcomes ◆ Compliance with: • Medical record requirements • Reporting requirements • Applicable provisions of the BHO's contract with the Department. *Contract: II.G.10.a.3–4*	**Documentation:** ♦ SDML ♦ CR318 ♦ QM201 ♦ QM201 attachment B ♦ QM302 ♦ QM302 attachment C **Description:** ♦ Annually Colorado Access through Provider Network services mails providers the SDML letter which advises providers of their responsibility to screen all employees or ownership interests for exclusion as a Medicaid provider. Providers are to do this screening monthly. See SDML letter. ♦ On a monthly basis, Provider Network Services checks the OIG exclusion database (CR318: Section II.A.1, pg 3) ♦ Prior to each credentialing committee meeting, credentialing staff check the DORA Registrations Online Disciplinary report for all credentialed providers (CR318: Section II.B.1-2, pg 3). ♦ Per NCQA guidelines, CR301, Section XIV.I (pg 13) requires Colorado Access to conduct a site visit upon receiving a complaint related to the physical accessibility, physical appearance, or adequacy of waiting- and examining- room space. Policy CR302 establishes the formal process for provider site visits, including the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Office Site Visit Evaluation Form and Instructions (Appendix A). ♦ Member quality of care concerns (QOCCs) or adverse events are reviewed by a Medical Director. If warranted, cases are referred to the Credentials Committee for review (CR318, Section II.C, pg 4). This process is specified within QM201 (Policy Statement, pg 1). If a quality of care concern is suspected, an investigation follows the procedures outlined in QM201 (Section I pg 3). If a quality of care concern is substantiated after review by the Medical Director, appropriate interventions are specified on the Quality of Care Clinical Review form (QM201, Attachment B pg 8). ♦ QM302 describes the Review of Provider Medical Records. o In section QM 302 II.B.1 it states: "Participating practitioners or providers selected for medical record review will be determined by criteria established by medical directors, designees, and/or quality improvement committees. Criteria may include, but are not limited to, volume of members paneled or accessing care, quality of care and/or documentation issues (pg3)." o Section II.B.2 states that a minimum of 10 records will be reviewed (pg5). o QM302, Attachment C is the audit tool which is used to review and score provider records.	

Findings:
The Professional Provider Agreement required the provider to participate in and comply with ABC's Quality Management program and to submit medical records and other information, as requested. The provider manual described the components of the ABC Quality Assessment and Performance Monitoring Program and the contractual obligation of the provider to participate in the program.

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
The Ongoing Monitoring of Practitioner Sanctions, Grievances, and Occurrences of Adverse Events policy stated that performance indicators for practitioner-specific review included those collected through the Quality Assessment and Performance Improvement (QAPI) program, the utilization management system, the grievance system, enrollee satisfaction surveys, or other activities. The policy stated that grievances regarding quality of care concerns or potential adverse events were peer reviewed and could be referred for Credentials Committee review. In addition, a trending report of each practitioner's history of complaints or adverse events was produced every six months and retained in the provider's credentialing file for re-credentialing review. The policy stated that any grievances that may indicate safety or other quality concerns at the site of care resulted in an on-site visit and assessment. The Office Site Visit for Practitioner Credentialing policy stated that on-site investigation of member complaints evaluated physical appearance and accessibility, adequacy of waiting and treatment rooms, appointment availability, and medical record processes. The on-site evaluation and scoring tool was attached to the policy. The Review of Provider Medical Records policy stated that medical records were reviewed annually for quality and appropriateness based on regulatory and accreditation standards that were included in the policy. The policy included the Clinical Record Review Scoring Tool, which addressed chart organization and presence of individual service plans and treatment documentation. Medical record requirements were also outlined in the provider manual. The Quality Improvement Committee minutes demonstrated the committee had reviewed results of monitoring access to care standards, evaluation of after-hours availability, trending and patterns of grievances and appeals, and analysis of performance measures. The committee meeting minutes also documented discussions of Quality Improvement Program goals for 2011, which included improvement in utilization measures (i.e., recidivism) and expansion of core performance measures. During the on-site interview, ABC staff members stated that the Quality Improvement Committee provided a physician-specific summary of any quality of care concerns to the Credentials Committee every six months. Individual provider quality of care concerns were identified through readmission reviews or member grievances.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
4. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the provider take corrective action. *Contract: II.G.10.a.5*	**Documentation:** ♦ QM201 ♦ ABC Provider Manual, Section on Quality Management beginning on page [58] ♦ Template Contract for Health Center Provider Agreement, Section B.11 ♦ Griffith Center Corrective Action Letter 7-21-11 ♦ Record Audit Summary 2010 **Description:** ♦ QM201 establishes a process to investigate and resolving quality of care concerns directly related to the quality of the medical or behavioral healthcare of providers. ♦ As stated in the ABC Provider Manual, participation in ABC's Quality Assessment and Performance Improvement Program is a contractual obligation of every ABC provider. This involves adhering to applicable ABC policies, procedures, and standards, submitting claims and data as required, and participating in performance improvement studies. Further, Contractor's Credentials Committee, acting as a professional review committee, may reduce, suspend or terminate a practitioner's network participation (professional review action) based on the findings associated with a review of the practitioner's professional competence or professional conduct which adversely affects, or could adversely affect the health or welfare of a member or members. If a proposed professional review action is to be taken against a provider, the provider will be notified of the Credentials Committee decision and provided the opportunity to request a hearing. ♦ Pursuant to Section B.11of the Contractor's Template Contract for Health Center Provider Agreement, the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	quality of services provided to members is monitored under the applicable contractor Quality Management Program. If the quality of care furnished by the provider is found to be unacceptable under an applicable Quality Management Program, contractor gives written notice to the provider to correct the specified deficiencies within the time period specified in the notice. If the provider fails to correct the specified deficiencies within the specified time period, the provider may be subject to corrective action. ♦ As outlined in QM302, Section II.D (pg 3), providers who have a total record audit score of < 80% are asked to submit a corrective action. See Griffith Center Corrective Action Letter 7-21-11 as an example. All record audits are summarized each year (see Record Audit Summary 2010).	

Findings:

The Professional Provider Agreement template stated that, if the quality of care furnished by Provider was found to be unacceptable under the Quality Management Program, Colorado Access would give written notice to the provider to correct the specified deficiencies, and the provider agreed to correct such deficiencies within the time period specified.

The Investigation of Potential Clinical Quality of Care Grievances and Concerns policy stated that a corrective action plan from the provider may be required as a result of peer review of a quality of care grievance or adverse event. The policy stated that provider response to a corrective action was placed in the provider's file for monitoring by the quality management department. The policy also stated that all provider quality of care file information was confidential and protected under the peer review laws. Clinical grievances aggregate information was reported quarterly to the QI committees.

The Review of Provider Medical Records policy stated that audit results were reported to the appropriate medical staff and/or QI committees and identification of need for improvement across the provider network may result in organization-wide corrective interventions. QI committees or executive medical managers directed follow-up with individual providers who had not met the scoring goals. A record of results was retained in the provider's quality file. HSAG reviewed a sample corrective action letter to a provider that explained the results of the audit performed, the purpose of the audit, and the requirement that the provider submit a corrective action plan.

During the on-site interview, staff members confirmed that quality of care concerns are investigated by the quality management department and may result in corrective actions with the provider. Staff members reported that there were four quality of care concerns were investigated in the last year, but none

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Requirement	**Evidence as Submitted by BHO**	**Score**
required corrective action and no patterns were identified. Staff members described the ongoing monitoring of MHCD performance measures, in which results were discussed with MHCD to determine areas for improvement and changes tracked through the ongoing monitoring process.		
Required Actions: None.		
5. The Contractor's provider selection policies and procedures include provisions that 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. ◆ Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42CFR438.12(a)(1) and (2)* *42CFR438.214(c)* *Contract: II.G.3.b, II.G.4.a*	**Documentation:** ◆ PNS202 ◆ Provider Manual **Description:** ◆ Colorado Access policy PNS202 clearly states that we do not "discriminate in its selection process against providers that serve high-risk populations or who specialize in conditions that require costly treatment" and we do not "discriminate with respect to 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." ◆ The Provider Manual outlines our non-discrimination policy on page 18. It states that the Colorado Access non-discrimination policy extends to "all programs and activities offered by Access Behavioral Care or offered through a contractor or other entity with whom we arrange to carry out our programs and activities."	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Selection and Retention of Providers policy contained a non-discrimination statement that addressed non-discrimination based solely on the practitioner's license or certification and providers who serve high-risk or costly populations, as required. The Credentialing and Re-Credentialing section of the provider manual stated that ABC does not discriminate based on the "type of practice, or types of clients the practitioner may specialize in treating," and does not discriminate against any health care professional that is acting within the scope of his or her license under state law, solely on the basis of the license.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
6. 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. *42CFR438.102(a)* *Contract: II.E.1.h.1*	**Documentation:** ◆ Provider Manual ◆ Member Handbook ◆ CS212 **Description:** ◆ CS212 outlines process by which member rights are established and maintained. Specific rights are included in the ABC Provider Manual and Member Handbook. Member rights are also posted on our webpage at http://www.coaccess.com/your-rights-and-responsibilities. ◆ The Provider Manual clearly states on pg 22 that, "Access Behavioral Care does not prohibit or restrict providers from advising members about any aspect of his or her health status or care, advocating on behalf of a member, or advising about alternative treatments regardless of whether such care is a covered service under the Medicaid contract." In addition the Provider Manual references Member rights on page 55. These rights include the right to get a full explanation about: • You or your child's mental health diagnosis and condition • What treatment and/or medication might work best • Different kinds of treatment that may be available • Participate in discussions about what you need, and make decisions about your mental health care with your providers • These rights are outlined in the Member Handbook on pages 20-22.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The provider manual stated that ABC does not restrict the provider from advocating on behalf of the member or from advising the member about treatment options, risks and consequences of treatment or non-treatment, or the right to participate in treatment decisions. The manual reminded providers of members' rights to refuse treatment and to participate in and approve their care plan. The manual encouraged providers to be familiar with the member's rights and responsibilities, which were outlined in the manual and the member handbook. The member handbook included a listing of the members' rights, including the right to receive a full explanation from providers about their condition and different treatments available and information about what to expect from treatments. The member handbook also listed the members' right to participate in decisions about their care, get a second opinion, refuse treatment, and to involve family or other caregivers in their care.		
Required Actions: None.		
7. 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. *42CFR438.102(b)* *Contract: II.E.1.h.2*	**Documentation:** ◆ Provider Manual (Page 22) **Description:** ◆ ABC does not object to any services required by the contract on moral or religious grounds as outlined in 42CFR438.102(a)(2). ◆ We ask providers to notify ABC if they object to the provision of any covered services on the basis of moral or religious reasons.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The provider manual stated that a provider must notify ABC of any services he or she objects to providing based on moral or religious grounds. Likewise, if the provider cannot execute or implement an advance directive on the basis of conscience, the provider is to issue a statement of limitation to the member or the DCR, as well as provide a copy to ABC. The Advance Directives policy stated that if an attending physician or health care facility refuses to comply with an advance directive on the basis of conscientious objections, Colorado Access will facilitate transfer of the individual to the care of another health care provider, upon request of the member or DCR. During the on-site interview, ABC staff members confirmed that ABC does not object, nor are they aware of any provider who objects, to providing services on moral or religious grounds. Staff members explained that, by the nature of being a behavioral health provider, ABC does not provide controversial procedures that would conflict with moral or religious beliefs.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
8. 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 (This requirement also requires a policy). *42CFR438.214(d)* *Contract: II.G.3.e*	**Documentation:** ♦ PNS 202 ♦ CR318 **Description:** ♦ Colorado Access Policy PNS202 section I.G states that "if the provider has not been barred from participation in federal healthcare programs under either section 1128 or section 1128A of the Social Security Act, Provider Contracting notifies Credentialing to initiate the credentialing process, as applicable and required"(pg.4). ♦ Colorado Access policy CR318 outlines the process for ongoing monitoring of contracted providers. This includes a search of the Office of Inspector General (OIG) Federal Program Exclusions Database on a monthly basis (Section II.A.1, pg 3).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Selection and Retention of Providers policy stated that administrative review of a provider's application included screening the provider against the federal debarment or suspension list and the OIG list of excluded individuals prior to completing the credentialing process. The Ongoing Monitoring of Provider Sanctions, Grievances, and Occurrences of Adverse Events policy stated that ABC screens all participating providers against the OIG Federal Program Exclusions database and against the Colorado licensure sanctions/limitations database on a monthly basis. Any identified exclusions or licensure issues are referred to the medical director for immediate action or to the next Credentials Committee meeting for review, as appropriate.

The State Medicaid Director Letter, distributed annually by ABC to contracted providers, informed providers of their responsibility to screen all employees and contractors monthly against the OIG data base of federal exclusions, to determine whether an excluded individual has ownership in the Medicaid provider organization, and to report any identified exclusions to ABC. During the on-site interview, ABC staff members described that providers and all new contractors and vendors were screened using the Fraud and Abuse Control Information System (FACIS) data base, as well as screening for disciplinary actions in the practitioner licensing data base, and that any irregularities on the report were thoroughly investigated.

Required Actions:
None.

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Requirement	**Evidence as Submitted by BHO**	**Score**
9. The Contractor may not knowingly have a director, officer, partner, employee, consultant, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or non-procurement activities under federal acquisition regulation or Executive Order 12549. *42CFR438.610* *Contract: II.G.6*	**Documentation:** ♦ CMP206 ♦ Employment Affiliations Report 9-13-2010 **Description:** ♦ CMP206 section I.A.2 specifies compliance with 42CRF438.610. In addition, to comply with this requirement, Colorado Access annually submits an Employment and Affiliations report to the Department. ♦ The Annual Employment Affiliations Report, submitted to HCPF, documents that Colorado Access does not knowingly have a director, officer, partner, employee, consultant, or owner who is debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Sanction, Exclusion, Prohibited Affiliations, and Opt-Out Screening policy stated that Colorado Access would not knowingly have a relationship with an individual or entity under sanction, debarment, or exclusion by a federal or state agency or excluded from participating in procurement or non-procurement activities under Executive Order 12549. The policy stated that Colorado Access uses the OIG database to ensure compliance with this policy. The policy also stated that this applied to a director, officer, partner, employee, consultant, vendor, contracted provider, or a person with beneficial ownership of five percent or more of Colorado Access (although Colorado Access is a non-profit corporation, so this is not applicable). The Employment and Affiliations Report, submitted annually to the Department, demonstrated that Colorado Access had no knowledge of any affiliations with debarred, suspended, or excluded individuals or entities, as defined in the policy.

During the on-site interview, staff members stated that ABC was transitioning from an annual to a semi-annual rescreening of existing employees and vendors, and used a reminder notice in the Compliance 360 system to run a semi-annual batch check. Staff members reported that any irregularities in the report were verified and referred to the legal department, if necessary. A copy of the report was entered in the employee file. A copy of the batch report was maintained in hard copy for one year and retained electronically indefinitely. ABC is anticipating automation of the process in 2012.

Required Actions:
None.

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Requirement	**Evidence as Submitted by BHO**	**Score**
10. 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. *42CFR438.12(a)(1)* *Contract: II.G.4.b*	**Documentation:** ♦ PNS202 ♦ Provider Manual **Description:** ♦ Colorado Access policy PNS202 states "If Colorado Access declines to include individual or groups of providers in its network, written notice of the reason for this decision will be given to the provider" (Section I.E, pg 3). Also "If administrative review of the credentialing application materials indicates that the provider does not meet minimum requirements for network participation, and the provider is unwilling or unable to remedy the situation, Provider Contracting will send written notice of the reason for Colorado Access' decision not to include the practitioner or practitioner group in its network." (Section I.G.1, pg 4) ♦ PNS 202, Section I.G.2 (pg 4) outlines the procedure for the credentials committee to notify providers. ♦ The ABC Provider Manual also informs providers that if they are denied inclusion in the ABC network, they will be sent a written notification, including the reason (pg 60).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:

The Selection and Retention of Providers policy outlined the process for identifying and including providers in the behavioral health network. In areas where there is an adequate network in place, a prospective provider was evaluated based on meeting required criteria and bringing needed expertise to the network. The policy stated that a decision to decline an individual provider or group of providers would include the reason for the decision in a written notice to the provider. The policy also described that, once a provider agreement is signed, the provider qualifications are reviewed and the credentialing process is completed. If the provider does not meet minimum qualification requirements or the Credentials Committee declines the provider's participation, a written notice of the reason for the decision is sent to the provider.

The provider manual described the three-year recredentialing cycle for providers and practitioners, including a list of criteria considered in the process, a statement of non-discrimination, and a statement that any decision by ABC to decline continued participation of the provider would include a reason in a

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written notification to the provider. The manual referred providers to the Colorado Access Web site for additional credentialing information. Sample letters from the provider contracting department (copied to the Department) indicated the reason for termination or denial of inclusion in the network. **Required Actions:** None.		
11. The Contractor must have administrative and management arrangements or procedures that are designed to guard against fraud and abuse and include: ◆ A mandatory compliance plan approved by the Contractor's CEO and Compliance officer. ◆ Submission of the compliance plan to the Department for review. ◆ Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards. ◆ Provisions for internal monitoring and auditing. ◆ Provision for prompt response to detected offenses and for development of corrective action initiatives. ◆ Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste, and abuse including mechanisms to identify and report suspected instances of upcoding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided. ◆ 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	**Documentation:** ◆ Corporate Compliance Plan Description dated January 2010 ◆ ADM205 ◆ ADM216 ◆ CMP201 ◆ CMP202 ◆ CMP203 ◆ CMP204 ◆ CMP205 ◆ CMP206 ◆ CMP207 ◆ CMP208 ◆ CMP209 ◆ CMP210 ◆ CMP211 ◆ CMP212 ◆ CMP213 ◆ HIP201 ◆ HIP202 ◆ HIP203 ◆ HIP204 ◆ QM302 ◆ 411 Audit Summary **Description:** ◆ Contractor's Corporate Compliance Officer (CCO) reports corporate compliance issues directly to the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
disciplinary guidelines. ◆ Effective processes to screen all provider claims, collectively and individually, for potential fraud waste or abuse. • Reporting: o The Contractor immediately reports indications or suspicions of fraud by giving a verbal report to the Contract manager. The Contractor shall then investigate its suspicions and submit its written findings to the contract manager within three business days of the verbal report. If the investigation is not complete within three business days, the Contractor shall continue to investigate and submit a final report within 15 business days (further extension may be approved by the contract manager). o The Contractor reports known, confirmed intentional incidents of fraud and abuse to the contract manager and to the appropriate law enforcement agency, including the Colorado Medicaid Fraud Control Unit. *42CFR438.608* *Contract:II.G.5.d, II.G.5.g–l*	President and CEO and to the Finance & Audit Committee and the Executive Committee of the Board of Directors, as appropriate. See Corporate Compliance Plan Description dated January 2010, above. Efforts associated with the implementation and execution of this plan fosters an environment that promotes the prevention, detection and resolution of misconduct. ♦ Compliance Plan is submitted annually to the Department at the beginning of each fiscal year. ♦ Our corporate policies, including but not limited those referenced above, articulate our commitment to comply with all applicable federal and state regulations. ♦ CMP213 states in the policy statement: "Colorado Access will establish guidelines and procedures for the timely, accurate and efficient management and implementation of internal compliance and operational reviews that support the requirements of state and federal regulatory guidelines (pg2)." ♦ CMP211 affirms in the policy statement that Colorado Access will "maintain, mechanisms to prevent, detect, investigate report and correct incidents of fraud, waste and abuse in accordance with contractual, regulatory and statutory requirements (pg 2). CMP211 in Section I outlines the mechanisms used to report fraud, waste and abuse (pg3). ♦ CMP201 states in the policy statement: "Colorado Access has established a problem resolution process and a non-retaliation policy to protect employees who report problems and concerns in good faith from retaliation. Colorado Access will foster a culture that promotes prevention, detection and resolution of	

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	instances of conduct that do not conform to applicable laws, rules, regulations, contract provisions, policies, procedures, security practices and Colorado Access Standards of Business Conduct. Any form of retaliation can undermine the problem resolution process and result in a failure of communication channels in the organization, and will not be tolerated (pg2). ♦ CMP205 section IV states: "Within thirty (30) days of receiving a reported concern/incident, the CCO will conduct a preliminary review (initial inquiry) of the concern/incident and will either respond directly or refer the issue to the appropriate management person or legal counsel for response/action. The preliminary review may include document review, interviews, audit or other investigative techniques. The CCO and those involved in the process will: o Conduct a fair and impartial review of all relevant facts; o Restrict the inquiry to those necessary to resolve the issues; and, o Conduct the inquiry with as little visibility as possible while gathering pertinent facts relating to the issue and maintaining confidentiality as appropriate." ♦ CMP211-Section I outlines the Colorado procedure for reporting Fraud, Waste and Abuse (pg3). ♦ QM302 establishes a procedure to review provider records. The provider medical record review is done annually or at the discretion of the executive director or if there are questions about quality of care or documentation (pg 3). Please see Medical Record Review Summary. ♦ Annually, Colorado Access conducts a 411 audit the	

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	specifically looks at the validity of claims. See 411 audit summary. ♦ Colorado Access, through provider contracting, uses the Unified Coding Manual to specify covered services which providers are contracted to provide. In the transaction system there are utilization limits that vary by procedure code. The transaction system through DST also checks claims for duplication. ♦ In the Colorado Access Corporate Compliance Plan 2010 section **B** (pg4) outlines who is assigned as the Corporate Compliance Officer. The Corporate Compliance Officer also serves as the Executive Director of the Colorado Access Executive Compliance Committee (pg3). The CCO reports to the CEO and has direct access to the board of directors (pg2). ♦ CMP204 states "All employees will receive education, which includes printed materials and participation in mandatory training (including refresher training) sessions, related to the organization's overall Corporate Compliance Program (pg2)." The Corporate Compliance Plan also states "all employees are required to participate in initial corporate compliance training upon hire and refresher training annually thereafter (pg3)." ♦ CMP202 in the policy state states "Colorado Access will maintain communication channels, including a telephone hotline, for the purpose of reporting problems and concerns (pg2). The policy outlines how the hotline is operated. Employees also have access to an email address that is only accessed by the CCO and Employees also have access to a compliance suggestion box in the break room. ♦ Corporate Compliance information is always posted on	

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	the company's Intranet Web site and corporate Web site. ♦ ABC has several provisions for internal monitoring to detect fraud and abuse outlined in CMP211. Auditing of claims is accomplished internally and through our delegated claims processor, DST. This auditing includes: • Colorado Access's transaction system vendor, DST has a rigorous QA process (see DST QA Program). DST, reviews 2% of each Claims Processor's daily adjudicated volume, as well as 2% of auto-adjudicated claims. Monthly audit reports are reviewed by the Director of System Performance and the Senior Director of Claims and Appeals (see 2010 DST_Claims_Audit). • As an additional check to DST's audits, internal auditors pull 3% of all claims processed daily to check for accuracy (seeCY10 Q4 Claims Monitoring Report, last graph on claims accuracy). These reports are reviewed by the Quality Improvement Committee ♦ CMP211 Section III.A.1 states: "Immediate notification of known confirmed intentional incidents of Medicaid fraud and abuse is sent to the Contract Manager at HCPF and to the appropriate law enforcement agency, including, but not limited to, (MFCU). Colorado Access will immediately report indications or suspicions of fraud by giving a verbal report to the contract manager. It will then investigate its suspicions and shall submit it's written findings and concerns to the contract manager within three (3) business days of the verbal report. If the investigation is not complete in three (3) business days, Colorado Access will continue its investigation. A final report will be delivered within fifteen (15) business days	

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	of the verbal report. The contract manager may approve an extension of time in which to complete the final report upon a showing of good cause (pg 4).	

Findings:
The Colorado Access Corporate Compliance Plan (CCP), which applied to all lines of Colorado Access business, addressed the intent of Colorado Access to comply with all federal and State laws and regulations related to the ethical conduct of business. The plan described review and approval annually by the Colorado Access board of directors. ABC staff members stated that the plan was also submitted to the Department annually. The Corporate Compliance Plan stated that Colorado Access designated the director of human resources as the corporate compliance officer (CCO), who oversees all aspects of the Corporate Compliance Program, including identifying and resolving compliance issues. The CCO reports to the president and CEO and serves as the director of the Executive Compliance Committee, which reports to the Finance and Audit Committee of the Board of Directors. The minutes of the Finance, Audit & Compliance Committee of the Board of Directors, attended by the CEO and CCO, documented approval of the CCP in June 2010. ABC staff members reported that the 2011 CCP had been approved by the Executive Compliance Committee and was, at the time of the site review, awaiting approval of the CEO prior to submission to the Department. Colorado Access had numerous policies and procedures related to compliance.

The Compliance Issue Resolution and Incident Records Management policy stated that within 30 days of a reported incident, the CCO would conduct a preliminary review to verify the circumstances of an incident and respond accordingly. The Fraud, Waste, and Abuse policy stated that ABC would immediately report suspicion of fraud verbally to the Medicaid contract manager, investigate and submit written findings within three days, and deliver a final report to the contract manager within 15 days of the verbal report. The policy also stated that ABC would report any confirmed intentional incidents of Medicaid fraud to the Department's contract manager and appropriate law enforcement agency, including the Medicaid Fraud Control Unit (MFCU).

The CCP stated that all employees undergo initial training regarding the compliance program and its Standards of Business Conduct, and receive refresher online training annually. Employees that work in high-risk areas receive specialized training pertaining to their function. The Corporate Compliance Program Education and Training policy stated that compliance program training, including HIPAA compliance, was mandatory for all employees, and that every employee was provided a copy of the Standards of Business Conduct.

The CCP stated that, in an effort to establish effective lines of communication, Colorado Access provided a confidential employee hotline, a compliance suggestion box, and an email for reporting any potential problem or questionable practice. The Problem Reporting and Non-Retaliation policy stated that knowledge of misconduct or potential violations of the Standards of Business Conduct must be immediately reported and an "open-door policy" would be maintained to encourage employees to report concerns. The policy stated that all forms of retaliation against any employee who reports a suspected offense were prohibited. The False Claims Act policy stated that all persons who reported suspicion of fraud, waste, or abuse would be protected in accordance with the whistleblower clause of the False Claims Act, and described the whistleblower provisions. The Fraud, Waste, and Abuse (FWA) policy outlined the following methods for reporting FWA concerns: contacting a direct supervisor, contacting the CCO, using the dedicated compliance email address, or

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Requirement	**Evidence as Submitted by BHO**	**Score**
calling the confidential compliance hotline. The policy also stated that Colorado Access would not discriminate or retaliate against anyone who reported a perceived problem. The FWA policy described disciplinary actions, including corrective action plans, employment termination or contract termination for employees, providers, subcontractors, consultants, and agents found to have committed fraud, waste, or abuse. The CCP described that Colorado Access has incorporated corporate compliance requirements into all employee job descriptions and that employees may be recommended for corrective action or subject to disciplinary action for failure to comply. The False Claims Act policy described examples of prohibited activities, including "billing for services that were not actually rendered, double-billing, upcoding, or unbundling." The DST Health Solutions Delegation Agreement stated that DST performed and reported a monthly audit for payment, procedural, and financial accuracy of claims. The 2010 DST Claims Audit report provided those monthly statistics. The ABC 2011 Claims Validation Summary Report described the process of annual review of encounter claims compared to medical record documentation to determine accuracy and completeness of encounter data submitted to the Department. The report included compliance results for diagnosis and procedural coding accuracy and sufficient medical record documentation. During the on-site interview, ABC staff members reported that DST, the claims adjudication subcontractor, provided ongoing screening of claims for accuracy of numerous fields of information using an automated algorithm in the claims processing system. In addition, a select high-dollar audit of individual claims over a pre-defined amount was performed on a pre-payment basis and both DST and ABC audited a random sample of 2 percent of post-processed claims each month to assure that ABC claims payment procedures were followed. ABC staff members also described a specific case of investigating fraudulent billing by a provider, which demonstrated ABC's problem identification through the monitoring of claims, a timely preliminary investigation, and immediate notification to the Department upon confirmation of suspected fraud. The case also demonstrated that ABC conducted an intensive, thorough investigation and provided ongoing frequent communications with the Department regarding the progress of the case. ABC terminated the provider and recuperated the funds. A final report was submitted to the Department and ABC provided timely transfer of all members to other providers.		
Required Actions: None.		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
12. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor's debts in the event of the Contractor'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 furnishes 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. *42CFR438.106* *Contract: II.G.11*	**Documentation:** ♦ Professional Provider Agreement Template ♦ Provider Manual, **Description:** ♦ In the Professional Provider Agreement Template, Section C.6, Member Hold Harmless. It states the following: "Provider agrees that, in no event, including nonpayment by Colorado Access, the insolvency of Colorado Access, or breach of this Agreement by any party, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against Members or persons other than Colorado Access. This provision shall not prohibit collection of Copayments on Colorado Access' or a Payer's behalf in accordance with the terms of the applicable Benefit Program. Provider further agrees that this provision: (a) shall survive the termination of this Agreement regardless of the cause giving rise to termination; (b) shall be construed for the benefit of Members; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf." ♦ The Provider Manual section on "Member Billing or Balance Billing" states that providers are prohibited from billing Members for services that ABC or the State denies payment (pg 15).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Hold Harmless clause of the Professional Provider Agreement included the required provisions and stated that in no event shall the provider charge or collect compensation from the member, with the exception of copayments, and that the provider agrees to accept the Colorado Access payment in full. The provider manual also included the hold harmless clause from the provider contract and further explains that the provider may not bill the Medicaid		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
recipient for a covered service or for any unpaid portion of the member's bill, regardless of whether the claim was paid by Medicaid or Colorado Access. The member handbook stated in several places that mental health services were free of charge if they were in-network, medically necessary, and authorized when applicable. During the on-site interview, staff members stated that if a provider was inappropriately charging members for services, ABC would be alerted through member contact with the member services department or the grievance process. Staff members stated that there have been a limited number of such occurrences, which were corrected by contacting the provider and clarifying the rules of coverage and reimbursement, and resolving the individual case with the member.		
Required Actions: None.		
13. The Contractor has a written agreement with each provider. *Contract: II.G.10.a.2*	**Documentation:** ♦ Professional Provider Agreement Template **Description:** ♦ From the contract template: Section A.17 Definition of a Participating Provider states the following "Provider, who has in effect an agreement with Colorado Access to provide Covered Services to Members." Section B.1.a Stipulates that the provision of Covered Services will be in accordance with the terms and conditions of the Agreement. ♦ PNS 202 Section I.B. requires execution of an Agreement prior to becoming a Participating Provider in the network (pg2).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Professional Provider Agreement template stated that the purpose of the agreement was to facilitate the Provider's ability to render covered services to ABC members. The agreement also defined a participating provider as a provider "who has in effect an agreement with Colorado Access to provide Covered Services to Members." Provider agreements with the core providers (MHCD, Denver Health, Aurora Mental Health Center, and Children's Hospital) were automatically renewed annually and were current. During the on-site interview, ABC staff members described that contract renewal dates were tracked through the Sharepoint data base and an Excel spreadsheet. Large provider group contracts were auto-renewed and only amended when any terms of the contract changed.		
Required Actions: None.		

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
14. Written provider agreements specify: ◆ The activities to be performed by the provider. ◆ Reporting responsibilities of the provider. ◆ Provisions for revoking the provider agreement or imposing other sanctions if the provider's performance is inadequate. ◆ Provisions for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53 *Contract: II.G.10.a.2,7*	**Documentation:** ♦ Professional Provider Agreement Template ♦ Provider Manual **Description:** ♦ Written provider agreements specify the activities to be performed by the provider in Section B, Provider Representations and Responsibilities ♦ Written provider agreements specify the reporting responsibilities of the provider in Sections B.8 (pg4), B.9 (pg 5), B.16 (pg 6), B.19 (pg 6), B.20 (pg 6), C.2(a) (pg 7), C.10 (pg 8). ♦ Written provider agreements specify provisions for revoking the provider agreement or imposing other sanctions if the provider's performance is inadequate (see Section D, Term and Termination, pg 8-9). ♦ Written provider agreements specify provisions for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53 (Section F.2, pg 13). ♦ ABC Provider Manual dependent upon what type of reporting is being described: Claims and Encounter Reporting pgs 8 & 47; Quality of Care Concerns reporting pg 23; Fraud and Abuse Reporting pg 24; Quality Management Reporting pg 58.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Professional Provider Agreement template stated that the provider was responsible for the provision of covered services in accordance with law, contract provisions, and program requirements in a non-discriminatory manner and in compliance with clinical performance standards. In addition, providers agreed to participate in the credentialing process, and comply with Colorado Access quality and utilization management programs, grievance resolution, and advance directives. Provider reporting responsibilities included notifying Colorado Access of complaints, investigations, lawsuits, or criminal actions against the provider; change of ownership or location of practice; failure of required licensures; or exclusion from State or federal

Standard VII— Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
programs. The agreement outlined reasons for restriction, suspension, or termination of the agreement, including specified legal reasons, material breach of contract, and termination without cause. The agreement specified that Colorado governmental health care agencies and the United States Department of Health and Human Services and their designees would have reasonable access to medical and other records. The provider manual addressed reporting responsibilities and methods for suspected fraud and abuse, quality of care concerns, and quality management and utilization management program data.		
Required Actions: None.		
15. The Contractor provides a copy of its claims filing requirements to every participating provider upon acceptance of the provider into the Contractor's network, and to every provider within 15 calendar days after any change in the standard form or requirements. *Contract: II.G.10.c.17*	**Documentation:** ♦ ABC Provider Manual **Description:** Section IX of the provider manual, under Timely Filing explains ABC's responsibilities and explicitly states that Colorado Access will "Notify providers of material changes in standard forms, instructions or requirements within15 calendar days." (pg 45)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Professional Provider Agreement template described the claims filing and billing for services rendered to members, including the requirement for the use of the Uniform Claim Form, time frames for timely filing, and time frames for payment of claims by Colorado Access. The agreement template prohibited collection of payment from the member, and described the risk of non-payment for claims not filed within the required time frames. The provider manual outlined provider responsibilities for verifying, completing, and submitting claims and included time frames for claims submission, electronic submission processes, required billing formats, and diagnosis and procedure coding. The manual addressed non-clean claims and resubmission, member non-liability for payment, and the provider claim appeal process. The manual also stated that ABC was responsible for notifying the provider of any changes in the claims filing processes within 15 days of the change. During the on-site interview, ABC confirmed that there have been no changes in the BHO claims filing requirements within the last year.		
Required Actions: None.		

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	15

Total Score ÷ Total Applicable	=	100%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. *42CFR438.230(a)(1)* *Contract: II.B.1*	**Documents:** ♦ ADM223 ♦ Provider Manual (pgs 58, 62) ♦ QIC Minutes (available for review on site) ♦ Delegation Oversight Committee Meeting Minutes (available for review on site) ♦ ABC Delegation Oversight Activity Grid 2011 **Description:** Colorado Access policy ADM223 states, "Colorado Access will retain ultimate accountability for any delegated activities" (Policy Statement, pg 2). ADM223 outlines the process for delegating functions to subcontractors.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Delegation policy described ABC's processes for oversight of delegates, which included ongoing monitoring, annual audits, and follow-up as needed. The Delegation Oversight Activity Grid demonstrated ABC's tracking mechanism for due dates of monitoring each delegate. The Delegation Oversight Committee (DOC) agendas and quarterly committee meeting minutes demonstrated committee review of delegation monitoring activities. Delegates and delegated activities were as follows:

- Denver Health and Hospital Authority (DHHA)—credentialing recredentialing
- DST Health Solutions (DST)—claims and data processing
- The Mental Health Center of Denver (MHCD)—grievance processing
- National Jewish Medical and Research Center (NJH)—credentialing and recredentialing
- University Physicians, Incorporated (UPI)—credentialing and recredentialing

ABC also had a unique agreement with Metro Crisis Services (MCS) which, although HSAG considered a service agreement, given the unique nature of the agreement, ABC reported treating this subcontractor as a delegate and provided evidence of ongoing monitoring.

Required Actions:
None.

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
2. Before any delegation, the Contractor evaluates (and documents in writing that it has) the prospective subcontractor's ability to perform the activities to be delegated. *42CFR438.230(b)(1)* *Contract: II.B.2, Exhibit S—II.A*	**Documents:** ♦ ADM223, Sections I, II (pg 5), and Attachments A, F, G, I, J, K, L, M ♦ Metro Crisis Services Pre-delegation Activities (see MCS Delegation folder) **Description:** Colorado Access policy ADM223 outlines general requirement for delegated entities in Section I and formal pre-delegation procedures in Section II. A recent pre-delegation audit was performed with Metro Crisis Services, which provides evidence of pre-delegation activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Delegation policy described the process for performing a pre-delegation audit, which included review of the delegate's policies and procedures and file audits. Attachments F, G, I, and M to the Delegation policy contained template file audit tools specific to the type of delegate and delegated activity (i.e., credentialing/recredentialing or grievances) and directions for completing the audits. Attachments A, K, J, and L contained templates for communication with the delegate regarding initial or ongoing monitoring and audits. The Metro Crisis Services Pre-delegation Audit Report, demonstrated that ABC conducted a review of MCS's pertinent policies, procedures, and processes prior to contracting with MCS. DOC meeting minutes also contained discussions and evidence that a potential delegate was evaluated for a possible delegation agreement, and that ABC's decision was not to enter into an agreement at that time.		
Required Actions: None.		
3. The Contractor has written policies and procedures for the monitoring of subcontractor performance, monitors the subcontractor's performance on an ongoing basis, and subjects it to a formal review according to the periodic schedule established by the State. *42CFR438.230(b)(3)* *Contract: II.B.2, Exhibit S—I.A, IV.A*	**Documents:** ♦ ADM223, Sections III-V, and Attachments A, F, G, I, J, K, L, M ♦ 2011 Denver Health Audit Results, Committee notifications (see Denver Health folder) ♦ DST Executive Summary 2011 ♦ MHCD Audit results 2011 (see MHCD folder) ♦ National Jewish Health Audit Results, Committee notifications 2011 (see NJH folder) ♦ University Physicians Inc Audit results, Committee	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
	notifications 2011 (see UPI folder) ♦ ProtoCall Audit results 2011 (see ProtoCall folder) ♦ Delegation Committee Agendas, Sept 2010, Dec 2010, Mar 2011, Jun 2011 ♦ Delegation Oversight Subcommittee Reports (see folder) **Description:** Colorado Access policy ADM223 states, "Colorado Access shall conduct an annual audit to evaluate the Entity's compliance with the requirements associated with the delegated functions. The audit results, which include an assessment of the Entity's current policies and procedures and the results of any applicable file audits, are reviewed by the Delegation Oversight Committee and the delegation status is predetermined" (Section III, pg 6). ADM223 also states, "In addition to the annual audits conducted to assess performance by the Delegate of the delegated functions, Colorado Access conducts ongoing monitoring. Ongoing monitoring is accomplished through review of reports provided to Colorado Access by the Delegate. The types of reports and frequency of reporting are outlined in the individual delegation agreements. Reporting associated with delegated credentialing shall be reviewed by the Credentials Committee while reports associated with other delegated activities such as grievances, appeals, claims processing, etc. will be reviewed by the Delegation Oversight Committee who will make recommendations for follow-up, if applicable" Section V, pg 8). Included Executive Summaries from annual delegation	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
	agreement audits are reviewed by the Delegation Oversight Sub-Committee. Minutes from Delegation Oversight Committee meetings will be made available upon request during the site review. A quarterly Delegation Oversight Sub-Committee report is submitted to the Colorado Access Quality Improvement Committee. Minutes will be available upon request during the site review.	

Findings:
The Delegation policy described the procedures for an annual audit of each delegate. The policy also described ongoing monitoring of delegates as consisting of periodic review of reports submitted by the delegate. The frequency of reporting was specific to the delegate and type of activity delegated. The DOC agendas and meeting minutes demonstrated committee review of audit results. The DOC Reports demonstrated the mechanism for reporting DOC activities to the Quality Improvement Committee. ABC's ongoing monitoring and formal review activities consisted of:

- Denver Health and Hospital Authority—Monthly reporting of DHHA credentialing and recredentialing activities and an annual on-site audit dated February 16, 2011. ABC provided the completed on-site file audit tool. The audit report summary described ABC's review of DHHA's policies and procedures, committee minutes, and other pertinent documents.
- DST Health Solutions—Weekly reporting of DST data activity and annual site audits. The site audit report provided by ABC was dated November 9, 2010, and described ABC's review of DST's internal audit policies and procedures.
- The Mental Health Center of Denver—Monthly reporting of MHCD grievance processing activities and an annual on-site audit dated August 8, 2011. ABC provided the completed on-site file audit tool. The audit report summary described ABC's review of MHCD's policies and procedures, committee minutes, and other pertinent documents. ABC staff members reported that ABC staff had real-time access to the shared drive to review grievances filed at MHCD.
- National Jewish Medical and Research Center—Monthly reporting of NJH credentialing and recredentialing activities and an annual on-site audit dated February 23, 2011. ABC provided the completed on-site file audit tool. The audit report summary described ABC's review of NJH's policies and procedures, committee minutes, and other pertinent documents.
- University Physicians, Incorporated—Monthly reporting of UPI credentialing and recredentialing activities and an annual on-site audit dated February 9, 2011. ABC provided the completed on-site file audit tool. The audit report summary described ABC's review of UPI's policies and procedures, committee minutes, and other pertinent documents.

Required Actions:
None.

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
4. The Contractor ensures that work further subcontracted by a subcontractor is monitored by the delegating subcontractor. *Contract: II.B.2, Exhibit S—IV.B*	**Documents:** ♦ ADM223, Section I.I **Description:** ADM223, Section I requires that any delegated entity that sub-delegates any portion of its delegated functions will be responsible for ensuring the sub-delegate meets all Colorado Access requirements. The delegate must conduct annual audits and oversight and provide the results of audits and action plans to Colorado Access. Currently, only UPI sub-delegates credentialing to MedAdvantage. MedAdvantage is monitored by NCQA.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Delegation policy described the process for sub-delegation stating that the delegate is responsible for monitoring compliance by its delegates. The policy stated that results of such monitoring will be made available to ABC upon request. During the on-site interview, ABC staff members confirmed that the only delegate that further delegates responsibilities is UPI which delegates a portion of credentialing/recredentialing to MedAdvantage. ABC staff members stated that ABC's credentialing staff had confirmed MedAdvantage's NCQA certification for credentialing.		
Required Actions: None.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
5. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action. *42CFR438.230(b)(4)* *Contract: II.B.2, Exhibit S—IV.C*	**Documents:** ♦ ADM223, Sections I.F-H and IV ♦ 2010 NJH Action plan table revised Feb2011 **Description:** Colorado Access policy ADM223 (Section IV) outlines the process by which delegated entity deficiencies and areas for improvements are addressed and corrected. Any improvement opportunities identified are monitored through action plan development and follow-up conducted at periodic intervals to evaluate the Entity's progress in meeting the requirements (section IV). Colorado Access policy ADM223 also states, "Action plans for improvement shall be developed by Colorado Access and the Entity and used to monitor the Entity's progress in correcting deficiencies. These action plans will be presented to the Delegation Oversight Committee on a periodic basis. Once the action plan requirements are corrected and are met, the Entity shall revert to the minimum requirement of periodic review" (Section IV, pg 7). With the last delegation audit cycle, no action plans were implemented. As evidence of the process, the most recent action plan, with National Jewish Health action plan, is submitted. This plan was closed in the 2011 audit. No further action was required.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Delegation policy described the process for responding to opportunities for improvement identified during annual audits of the delegate, and development of corrective action plans as appropriate. ABC provided an example of a corrective action plan developed in 2010, with follow-up having been completed during 2011, until compliance was achieved.		
Required Actions: None.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
6. There is a written agreement with each delegate. *42CFR438.230(b)(2)* *Contract: II.B.2, Exhibit S—III.A*	**Documents:** The following delegation agreements are located in the" Delegation Agreements" folder: ♦ Denver Health - 2009 Amended & Restated Credentialing Delegation Agreement ♦ DST - 2009 Amended & Restated Delegation Agreement ♦ MHCD Executed Delegation Agreement 0910National Jewish - 2009 Delegation Agreement ♦ ProtoCall - 2009 Executed Delegation Agreement ♦ Executed Colorado Access-MCS 7-5-11 contract ♦ UPI - 2009 Amended Restated Delegation Agreement **Description:** Colorado Access maintains written agreements for all delegated activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: ABC provided copies of signed and executed agreements for DHHA, DST, MHCD, NJH¸ and UPI and signed and executed amendments to each agreement.		
Required Actions: None.		
7. 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. ♦ Specifies that the subcontractor shall comply with the standards specified in the Contractor's agreement with the Department. ♦ Requires at least semi-annual reporting of progress	**Documents:** The following delegation agreements are located in the" Delegation Agreements" folder: ♦ Denver Health - 2009 Amended & Restated Credentialing Delegation Agreement ♦ DST - 2009 Amended & Restated Delegation Agreement ♦ Metro Crisis Services Executed Contract 7-5-11 ♦ MHCD Executed Delegation Agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
and findings to the Contractor. ◆ Describes the process which the Contractor will use to evaluate the subcontractor's performance. ◆ If the subcontractor will perform utilization management, the agreement provides that the compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services (reference 42CFR438.12(e). ◆ Includes a provision that the subcontractor shall maintain complete files of all records, documents, communications, and other materials which pertain to the operation of the subcontract or to the delivery of services under the subcontract sufficient to disclose fully the nature and extent of services/goods provided to each member and to document all activities and services under the agreement. ◆ Includes provisions permitting duly authorized agents of the Department, State and federal government to access the subcontractor's premises during normal business hours to inspect, audit, monitor, or otherwise evaluate the quality, appropriateness, timeliness, or any other aspect of the subcontractor's performance of subcontracted services. ◆ Provides for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. ◆ Requires the subcontractor and any other	0910National Jewish - 2009 Delegation Agreement ◆ ProtoCall - 2009 Executed Delegation Agreement UPI - 2009 Amended Restated Delegation Agreement **Description:** ABC delegation agreements: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor: o UPI, NJH, Denver Health (Section A.3, A.10) o MHCD, DST, ProtoCall (Section A.5) o MCS (Attachment A, II, Attachment C, A.5) ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate o UPI, NJH (Section B.7, C.1) o MHCD , DST, (Section B.4, C.1) o Denver Health (Section B.6, C.1) o MCS (Section 6.b, Attachment A, II, Attachment B, IV.B) o DST (C.3) ◆ Specifies that the subcontract shall comply with the standards specified in the Contractor's agreement with the Department o MCS (Attachment C) o MHCD (page 1, A.2) o UPI, NJH, Denver Health (page 1) o DST (page 1)	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
subrecipients to notify the Department when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. *42CFR438.230(b)(2)* *Contract: II.B.2, Exhibit S—III.B–M*	♦ Requires at least semi-annual reporting of progress and findings to the Contractor o UPI, NJH, Denver Health (Section A.10) o MHCD, DST, ProtoCall (Section A.5) o MCS (Attachment A, II, Attachment C, A.5)DST (A.5) ♦ Describes the process which the Contractor will use to evaluate the subcontractor's performance o MCS (Attachment C, A.1-A.9, B.1-B.4) o MHCD (A.1-A.11, B.1-B.7) o UPI, NJH (A.1-A.12, B.1-B.10) o Denver Health (A.1-A.13, B.1-B.9) o DST (A.1-A.8, B.1-B.5) ♦ If the subcontractor will perform utilization management, the agreement provides that the compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services (reference 42CFR438.12(e). o ABC does not delegate any UM functions. ♦ Includes a provision that the subcontractor shall maintain complete files of all records, documents, communications, and other materials which pertain to the operation of the subcontract or to the delivery of services under the subcontract sufficient to disclose fully the nature and extent of services/goods provided to each member and to document all activities and services under the agreement. o MCS (Attachment A, V., Attachment C, A.7,	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
	C.3) o MHCD (A.10) o UPI, NJH (A.11) o Denver Health (A.11, A.13) o DST (A.6) ♦ Includes provisions permitting duly authorized agents of the Department, State and federal government to access the subcontractors premises, during normal business hours to inspect, audit, monitor, or otherwise evaluate the quality, appropriateness, timeliness, or any other aspect of the subcontractors performance of subcontracted services. o MCS Amendment No 1 o MHCD Delegation Agreement Sept 1, 2010, Section A.10, pg 3-4 o UPI Provider Agreement Section E.2, pg 12 o NJH Facility Provider Agreement July 1, 2011 Section F.2, pg 10. Note that the Delegation Agreement references the Facility Provider Agreement o Denver Health Facility Provider Agreement Jan 1, 2004, Section E.2 o DST Amendment No 1 (9-29-11), Section A.9, pg 3 ♦ Provides for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. o MCS Amendment No 1 o MHCD Delegation Agreement Sept 1, 2010,	

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Section A.10, pg 3-4 o UPI Provider Agreement (8-1-05), Section E.2, pg 12 o NJH Facility Provider Agreement July 1, 20011 Section F.2, pg 10. Note that the Delegation Agreement references the Facility Provider Agreement o Denver Health Facility Provider Agreement Jan 1, 2004, Section E.2 o DST Amendment No 1 (9-29-11), Section A.10, pg 3 ♦ Requires the subcontractor and any other subrecipients to notify the Department when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. o Metro Crisis Services (Service Agreement, Section 32.) o MHCD Provider Agreement Jan 1, 2011, Section B.20, pg 6 o UPI Amendment No 5 (9-28-11), Section G.7 o NJH Facility Provider Agreement July 1, 2011, Section B.20, pg 7 o Denver Health Amendment No 1, Section A.14 o DST Amendment No 1 (9-29-11), Section A.11, pg 3	
Findings: All required provisions for delegation agreements were present in either the delegation agreement, the provider agreement with that delegate, or in the subsequent amendments.		
Required Actions: None.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
8. The Contractor provides a description of the grievance, appeal and fair hearing procedures, approved by the Department, and time frames to all Subcontractors at the time the subcontractor enters into a contract with the Contractor. The description includes: ◆ The member's right to file grievances and appeals. ◆ The requirements and time frames for filing grievances and appeals. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers that the member can use to file a grievance or an appeal by telephone. ◆ The member's right to a State fair hearing for appeals: • The method to obtain a State fair hearing • The rules that govern representation at the hearing ◆ The fact that, when requested by the member: • Benefits will continue if the member files an appeal or a request for a State fair hearing within the time frames specified for filing. • The member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the member. *Contract: II.B.2, Exhibit S–V*	**Documents:** ♦ MCS Delegate Grievance and Appeals Notification Letter ♦ MCS Notification Receipt ♦ DST Delegate Grievance and Appeals Notification Letter ♦ DST Notification Receipt **Description:** ABC had not been providing this at agreement execution information to subcontractors who are not also providers. The delegate notification letter was mailed to DST and MCS in September to satisfy this requirement. This information has already been provided to UPI, Denver Health, National Jewish, and MHCD through their provider agreements which refer them the Provider Manual and Member Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: A complete description of the member grievance system was included in the provider manual. All but one of ABC's delegates (DST) were also service providers and as such had access to ABCs provider manual via ABC's Web site. During the on-site interview, ABC staff members reported that providers receive a welcome letter at the time of contracting, directing the provider to access the provider manual. Notification to DST regarding ABC's grievance and appeals process was sent separately and directly to DST. MCS also received the grievance and appeal information separately with a link to ABC's Web site included.		
Required Actions: None.		

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	8	**Total Score**		=	8

Total Score ÷ Total Applicable	=	100%

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Access Behavioral Care

Review Period:	January 1, 2011–September 30, 2011
Date of Review:	November 1, 2011–November 2, 2011
Reviewer:	Barbara McConnell, MBA, OTR
Participating BHO Staff Member:	Stephanie Dohrman

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
1	******	12/10/10	12/13/10	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	1/4/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments: This resolution time frame was extended. ABC sent the extension letter on December 12, 2010 (nine working days). The extension allows 14 additional calendar days for resolution. ABC met the required time frames. The diagnosis was Pervasive Developmental Disorder (PDD). PDD was not a covered service. ABC conducted an evaluation, as required, to determine whether a co-occurring mental health diagnosis existed.												
2	******	5/20/11	5/21/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	6/3/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments: This resolution time frame was extended. ABC sent the extension letter on June 2, 2011 (nine working days). ABC met the required time frames.												
3	******	5/23/11	5/25/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	5/31/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
4	******	6/3/11	6/3/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	6/6/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
5	******	6/14/11	6/14/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	6/17/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
6	******	6/14/11	6/15/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☒ N☐	Y☒ N☐	6/29/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments: This resolution time frame was extended. Although this appeal was processed as an expedited appeal and a written acknowledgement letter was not required, an acknowledgement letter was sent within 24 hours of the receipt of the appeal.												
7	******	7/13/11	7/14/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☒ N☐	Y☒ N☐	7/18/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments: Although this appeal was processed as an expedited appeal and a written acknowledgement letter was not required, an acknowledgement letter was sent within 24 hours of the receipt of the appeal.												
8	******	8/8/11	8/9/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	8/10/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Access Behavioral Care

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
9	******	8/19/11	8/19/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☒ N☐	Y☒ N☐	8/26/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments: This resolution time frame was extended. ABC sent the extension letter on August 23, 2011 (two working days). ABC met the required time frames. Although this appeal was processed as an expedited appeal and a written acknowledgement letter was not required, an acknowledgement letter was sent within 24 hours of the receipt of the appeal.												
# Applicable Elements				9	9	9				9	9	9
# Compliant Elements				9	9	9				9	9	9
Percent Compliant				100%	100%	100%				100%	100%	100%

Note: M = Met, N = Not met, U = Unknown, Y = Yes, N = No

Total # Applicable Elements	**54**
Total # Compliant Elements	**54**
Total Percent Compliant	**100%**

Appendix C. Site Review Participants for Access Behavioral Care

Table C-1 lists the participants in the FY 2011–2012 site review of **ABC**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Katherine Bartilotta, BSN	Project Manager
ABC Participants	**Title**
Rob Bremer	Executive Director
Laura Coleman	Director, Clinical Services
Stephanie Dohrman	Grievance and Appeal Manager
Mary H Fischer	Senior Manager Claims/Appeals
Reyna Garcia	Senior Director, Customer Service and Claims
John Kiekhaefer	Operations Manager
Suzanne Kinney	Behavioral Health Quality Program Manager
Claudine McDonald	Director, Office of Member and Family Affairs
Brenda Mientka	Compliance Manager
Travis Perez	Provider Network Systems Analyst
Jennifer Rogers	Manager, Credentialing Program
Gary Smith	Director Provider Network Services
Michelle Tomsche	Program Director, BHI
Department Observers	**Title**
Russell Kennedy	Quality Compliance Specialist
Jerry Ware	Quality Compliance Specialist
Marceil Case (via telephone)	Behavioral Health Specialist

Appendix D. Corrective Action Plan Process for FY 2011–2012 for Access Behavioral Care

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

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	If applicable, the 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 to HSAG and the Department. The BHO will submit the CAP using the template provided. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the 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**
	Following review of the CAP, the Department or HSAG 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. ◆ 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 CAP, the BHO should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

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

The template for the CAP follows.

Table D-2—FY 2011–2012 Corrective Action Plan *for* ABC		
Standard V: Member Information		
Requirement	**Findings**	**Required Actions**
Requirement 13: The member information materials sent following enrollment also include the following information regarding the grievance, appeal, and fair hearing procedures: ♦ The right to file grievances and appeals. ♦ The requirements and time frames for filing a grievance or appeal (including oral filing). ♦ The right to a State fair hearing: ▪ The method for obtaining a State fair hearing, and the rules that govern representation at the State fair hearing. ♦ The availability of assistance in the filing process. ♦ 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 time frames specified for filing, and the service authorization has not expired. ▪ The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ♦ The right that providers may file an appeal on behalf of the member with the member's written consent.	The member handbook depicted the time frame for requesting a State fair hearing as 20 calendar days. Under the continuation of services section the timely filing for appeals when requesting the continuation of previously authorized services was, "Within 10 calendar days from the date on the letter saying what action ABC has taken or intends to take, or before the authorization ends, whichever is less time." During the on-site interview ABC staff members stated that member handbook changes regarding the time frame for requesting a State fair hearing were in process and the member page of ABC's Web site had been modified to reflect this correction. Staff members stated that future mailings of new member packets would reflect the change. Staff members stated that the description of the appeals process in the notice of action letter had also already been corrected.	ABC must revise the member handbook and other member communications to specify the accurate time frames for requesting a State fair hearing for appeals related to a new request for services (30 days from the date of the notice of action). The handbook must also accurately reflect the required time frame for filing an appeal or requesting a State fair hearing if requesting the continuation of previously authorized services (within 10 days from date of the notice of action or before the effective date of the termination or change in services, whichever is later).
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* ABC
Standard V: Member Information
Training Required:
Monitoring and Follow-up Planned:
Documents to be Submitted as Evidence of Completion:

Table D-3—FY 2011–2012 Corrective Action Plan *for* ABC		
Standard VI: Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 20: A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action.	The Appeal Process policy included the provision that members may request a State fair hearing at any time during the appeal, but not later than 30 calendar days from the date of the notice of action, and that members need not exhaust ABC's appeal process prior to requesting a State fair hearing. Members were incorrectly informed in the Appeal Information attachment (attached to notices of action and appeal resolution letters) of the previous 20-calendar-day time frame for requesting a State fair hearing. Members were informed in the member handbook that they may request a State fair hearing instead of using ABC's internal appeal process, at any time during the ABC appeal, or if not happy with ABC's decision on the appeal. (See the Member Information standard, requirement 13 for scoring specific to the member handbook information about State fair hearing request time frames.)	ABC must review member communication used during the appeal process to ensure that members receive current information regarding the time frame for requesting a State fair hearing.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-3—FY 2011–2012 Corrective Action Plan *for* ABC		
Standard VI: Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 22: The Contractor provides for continuation of benefits while the BHO-level appeal and the State fair hearing are pending if: ♦ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action. ▪ The intended effective date of the proposed action. ♦ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ♦ The services were ordered by an authorized provider. ♦ The original period covered by the original authorization has not expired. ♦ The member requests extension of benefits.	The Member Appeal Process policy included the provision for continuation of benefits in the appeal section and the State fair hearing section of the policy. The provision for timely filing was accurate in the appeals section (within 10 calendar days, or before the effective date of the intended action, whichever is later); however, in the State fair hearing section of the policy, the time frame was depicted as 30 days. (See the Member Information standard, requirement 13 for scoring specific to the member handbook information about continuation of benefits.)	ABC must revise its applicable policies to accurately reflect the timely filing requirement for appeals and State fair hearings when continuation of benefits (services) is requested.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Activities for Access Behavioral Care

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
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 dates 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 other review activities. ◆ HSAG staff attended Behavioral Health Quality Improvement Committee (BQUIC) meetings to discuss the FY 2011–2012 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the BHOs were prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the federal Medicaid managed care regulations (the BBA) and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tool, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific managed care regulations or contract requirements. ◆ HSAG considered the Department's responses when determining compliance and analyzing findings.
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 review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the "evidence as submitted by the BHO" section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 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 and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.) ◆ HSAG reviewed additional documents requested as a result of the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with BHO staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2011–2012 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 required of the BHO to achieve full compliance with federal Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2011–2012 Site Review Report. ◆ HSAG submitted the site review report to the BHO and the Department for review and comment. ◆ HSAG incorporated the BHO's and Department's comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.