Colorado Medicaid
Community Mental Health Services Program

FY 2012–2013 Site Review Report

for

Access Behavioral Care

April 2013

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

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Overview of FY 2012–2013 Compliance Monitoring Activities

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 Colorado's behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the ninth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2012–2013 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement.

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

This report documents results of the FY 2012–2013 site review activities for the review period—January 1, 2012, through December 31, 2012. 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 2011–2012 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 credentialing and recredentialing record reviews. 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 2012–2013 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the BHO's contract requirements, NCQA Credentialing and Recredentialing Standards and Guidelines, and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key 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 2012–2013 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient BHOs (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, NCQA Credentialing and Recredentialing Standards and Guidelines, and contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the 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 requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for enhancement for some elements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **Access Behavioral Care** (**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	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III Coordination and Continuity of Care	8	8	8	0	0	0	100%
IV Member Rights and Protections	5	5	5	0	0	0	100%
VIII Credentialing and Recredentialing	49	49	48	1	0	0	98%
X Quality Assessment and Performance Improvement	16	16	16	0	0	0	100%
Totals	**78**	**78**	**77**	**1**	**0**	**0**	**99%**

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

Table 1-2—Summary of Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing Record Review	80	70	70	0	10	100%
Recredentialing Record Review	80	62	62	0	18	100%
Totals	**160**	**132**	**132**	**0**	**28**	**100%**

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

Overall Summary of Performance

Colorado Access is a health plan with several lines of business, with **Access Behavioral Care** (**ABC**) being its behavioral health line of business. For the four standards reviewed by HSAG, **ABC** earned an overall compliance score of 99 percent. **ABC**'s strongest performances were in Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, and Standard X—Quality Assessment and Performance Improvement, all earning a compliance score of 100 percent. HSAG identified one required action in Standard VIII—Credentialing and Recredentialing, resulting in a score of 98 percent compliance for that standard. **ABC** demonstrated strong performance overall and an understanding of the federal health care regulations, the Colorado Medicaid Managed Care Contract, and NCQA Standards and Guidelines.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

Colorado Access maintained policies and performed care coordination activities for each of its lines of business, including **ABC**. Colorado Access' Care Coordination policy addressed service accessibility, continuity of care, and attention to individual needs for members with complex physical, mental, and cultural needs. The policy described the processes for member identification and assessment, development of the individual plan of care, provision of care coordination interventions, and monitoring and revision of the plan of care as needed or required. **ABC** provider communications outlined the required elements of the member mental health and individual needs assessment, as well as the required elements of the member treatment plan. **ABC** performed medical record audits to verify provider compliance with the assessment and treatment plan requirements. **ABC** demonstrated the Altruista case management software used to document all components of the member's care coordination record. **ABC** ensured that each member had a designated primary behavioral health provider who conducts a comprehensive mental health and individual needs assessment. In addition, Colorado Access performed comprehensive needs assessments on all members referred for care coordination. Although member signatures were obtained on treatment plans, **ABC** did not document member agreement in the case management record. HSAG recommended that **ABC** consider a mechanism to document the member's agreement with the care coordination plan in the Altruista case management file. Numerous policies and procedures addressed the confidentiality and security of member protected health information in the coordination of care and other **ABC** operations.

During the on-site interview, **ABC** presented a care coordination case for a 61-year-old female with a lengthy history of severe mental illness and multiple complex medical issues who was transitioning from a lengthy inpatient psychiatric hospitalization to a skilled nursing facility (SNF) for continued treatment. The case presentation demonstrated coordination with mental health providers, ancillary services, and wraparound service providers and demonstrated that the member had a primary mental health provider, a PCP, and an assigned care coordinator. Care management documentation demonstrated the development of an individual needs assessment and an individual treatment plan with measurable goals and interventions, and frequent care coordinator monitoring and follow-up with the member's caregiver (the SNF).

Summary of Strengths

Colorado Access had a well-defined care coordination program, with specialized care coordinators dedicated to support the **ABC** line of business and its members. **ABC** care management staff had a collaborative relationship with the primary mental health providers, such as the Mental Health Center of Denver (MHCD), and high-volume SNF providers, which enhanced the monitoring of and planning for services for members with complex cultural, mental health, and physical health needs. The Altruista case management software documented all of the components of the comprehensive care coordination process and allowed for integration of the treatment record from the mental health provider. **ABC** audited provider medical records to ensure provider compliance with the member assessment and treatment plan requirements.

Summary of Required Actions

There were no required actions for this standard.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

Colorado Access had numerous policies and procedures that included each of the member rights. Colorado Access employed numerous mechanisms to notify members of their rights (e.g., the member handbook, newsletters, and well-attended Member and Family Advisory Board [MFAB] meetings). Providers were notified of member rights and the requirement that providers take those rights into consideration through the provider manual. Colorado Access had processes for initial and ongoing training for its staff and providers, including cultural competency.

ABC may want to consider including brief member rights trainings as part of the provider overview training, or including topic-specific rights information in the provider bulletin periodically.

Summary of Strengths

Colorado Access had processes for ensuring that members and providers understand member rights. Colorado Access also provided periodic communication that reminded staff, members, and providers about member rights and the need to ensure these rights are taken into consideration at all times. Processes for ensuring member rights are taken into account were consistent across all lines of business. Colorado Access provided frequent training for staff and employees. Colorado Access had several mechanisms to engage providers in a partnership (e.g., a user-friendly Web site; frequent provider newsletters available electronically; and an impressive number of trainings delivered in person and/or via Webinar, publicized through its Web site).

Summary of Required Actions

There were no required actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

Colorado Access performed the credentialing and recredentialing processes for **ABC**, its behavioral health line of business. Colorado Access had a well-defined credentialing program that included NCQA-compliant policies, procedures, and practices. The policies and procedures delineated each type of practitioner subject to Colorado Access' credentialing processes, acceptable methods for primary source verification, and specific criteria required for acceptance into and continued participation in **ABC**'s provider network. HSAG found ample evidence that Colorado Access monitored and provided oversight of its delegates. On-site review of credentialing and recredentialing records demonstrated that primary source verification for credentialing and recredentialing was completed within the required time frames and that recredentialing was completed within the required 36-month time frame.

Summary of Strengths

Credentials Committee minutes were detailed and demonstrated the role of the medical director consistent with the Colorado Access policy. The minutes also evidenced that the committee reviewed files that did not initially meet the required criteria. The Credentials Committee also reviewed ongoing monitoring for sanction activity, quality of care issues, and delegates' reports of credentialing activities.

Practitioner credentialing and recredentialing files were comprehensive, neat, and very well organized, as were organizational provider records. Practitioner and provider records demonstrated Colorado Access' performance of all required credentialing and recredentialing activities.

Summary of Required Actions

While Colorado Access/**ABC** had numerous and appropriate methods to prevent discrimination during credentialing and recredentialing processes, there were no methods in place for monitoring to ensure nondiscriminatory credentialing practices, as required by NCQA. Colorado Access must develop processes for monitoring to ensure nondiscriminatory credentialing practices.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

Colorado Access has defined a comprehensive Quality Assessment and Performance Improvement (QAPI) program, applicable to all lines of business, which included monitoring of accessibility, provider availability, clinical practice guidelines, care management, Healthcare Effectiveness Data and Information Set (HEDIS®)[2-1] performance measures, member satisfaction, performance improvement projects (PIP), grievances and appeals, utilization, and medical record documentation. The **ABC** Quality Improvement (QI) Work Plan detailed the QI activities and performance benchmarks for the year. The QAPI Annual Evaluation report reviewed the achievement of program goals and objectives, the effectiveness of clinical and service quality initiatives, and performance outcomes for the year; and it included all of the elements specified in the requirements. The QI program is accountable to the Board of Directors through the Quality Improvement Committee (QIC) and the Medical Behavioral Quality Improvement Committee (MBQIC), whose members review information on the outcomes of QI monitoring and initiatives conducted by **ABC** staff. HSAG recommended that **ABC** consider increasing the formality and documentation of operational reviews of pertinent data and QI study findings. **ABC** demonstrated multiple mechanisms for monitoring quality and appropriateness of services, including over- and underutilization reports, member surveys, member grievances, and quality of care concerns. **ABC** demonstrated that it took corrective action for patterns of dissatisfaction or quality of care concerns (QOCCs). **ABC** reported only one substantiated QOCC, which was processed according to the requirements. However, HSAG recommended that **ABC** consider including a more detailed explanation of the originator's concern and how the concern was resolved in the acknowledgement and resolution letters.

ABC has adopted clinical practice guidelines (CPGs) which met the requirements for development, dissemination, and application to other **ABC** processes. **ABC** informed providers regarding how to access CPGs, but member communications did not clearly address clinical practice guidelines. HSAG recommended that **ABC** clarify where to find CPGs on the member Web site and develop a mechanism to inform members of the availability of CPGs and how to access them. Colorado Access had an integrated health information system which collects and processes member, provider, and service data from multiple databases to support the **ABC** QI program, including reporting of utilization of services, and grievance, appeal, and enrollment trends. **ABC** has implemented numerous mechanisms to validate the accuracy and completeness of data received from providers.

Summary of Strengths

ABC has experienced management staff to support the **ABC** line of business and QI programs. Colorado Access has defined one quality improvement program applicable to all lines of business, which enables **ABC** to be well resourced with QI policies, staff, systems, and committees. Colorado Access has invested in the development of high-functioning health information systems (HISs), which integrate data and produce reports to support QI monitoring activities and initiatives. **ABC** has designed the comprehensive, detailed, and well-formatted QAPI Annual Evaluation report,

[2-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

which addresses all of the required elements. MBQIC and QIC minutes included discussion and recommendations related to reported QI activities and outcomes.

Summary of Required Actions

There were no required actions for this standard.

Methodology

As a follow-up to the FY 2011–2012 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 2011–2012 compliance monitoring site review.

Summary of 2011–2012 Required Actions

As a result of the 2011–2012 site review, **ABC** was required to revise its 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 and the required time frame for filing an appeal or requesting a State fair hearing if requesting the continuation of previously authorized services.

Summary of Corrective Action/Document Review

ABC submitted its CAP to HSAG and the Department in March 2012. After requesting and receiving additional information regarding the details of the plan, HSAG and the Department determined that, if implemented as written, **ABC** would achieve full compliance. **ABC** submitted documents demonstrating that it had implemented the CAP to HSAG and the Department in July 2012. After careful review, HSAG and the Department determined **ABC** had successfully addressed all of the required actions.

Summary of Continued Required Actions

There were no required actions continued from the 2011–2012 site review process.

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living. Contract: II.E.1.g.1	**Documents Submitted:** • CCS305-Care Coordination 2-3-10 **Description of Process:** Colorado Access Care Coordination policy (CCS305) outlines our care coordination program. The CCS305 policy statement (page 2) reads: Through Care Coordination efforts, Colorado Access will develop and maintain means to identify, screen, assess and assist in the management of members with complex physical, mental, and cultural healthcare needs. Colorado Access' efforts will effectively coordinate care with multiple providers, human service agencies, and payers, on behalf of the member. The activities focus on coordinating provision of services, promoting and assuring service accessibility, with attention to the individual needs, continuity of care, comprehensive and coordinated service delivery, cultural competence and fiscal and professional accountability. This policy also details member identification for care coordination through methods such as: 1. Internal data sources such as condition specific profiles, emergency room visits reports, inpatient census reports, readmission reports and historical costs (p4); 2. Telephonic outreach and screening (p4); 3. Referrals from members, DCRs, Authorized Representative, or family members (p4); 4. Referrals from primary care, specialty care including mental health providers, schools, home health care or	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	ancillary service providers, human service agencies, the State, and other community agencies (p4); 5. Institutional providers (e.g., hospitals, skilled nursing, rehabilitation, residential, and sub-acute facilities) (p4); and 6. Referrals from other Colorado Access departments (Section II.A.1-6., page 4). In addition, the Facilitation of Care Coordination (Section III,A-C., pages 4-5) support this requirement.	
Findings: The Colorado Access Care Coordination policy (applicable to the ABC line of business) stated that care coordination focuses on promoting and ensuring service accessibility, continuity of care, and attention to individual needs for members with complex cultural, physical health, and mental health care needs. Methods included supporting members in reaching their optimal state of wellness and independent living within the community. The policy described the processes of member identification; assessments of member needs; sharing assessment of member needs with members/families, providers, and staff members; developing an individual plan of care; providing care coordination interventions; and monitoring and revising the plan of care, as needed.		
Required Actions: None.		
2. The Contractor has policies and procedures that address, and the Contractor provides for the coordination and provision of Covered Services in conjunction with: ◆ Any other MCO or PIHP. ◆ Other behavioral health care providers. ◆ Physical health care providers. ◆ Long term care providers. ◆ Waiver services providers. ◆ Pharmacists. ◆ County and State agencies. ◆ Other provider organizations that provide wraparound services.	**Documents Submitted:** • CCS305-Care Coordination • ABC Provider Manual 9/2011 • QM302-Review of Provider Medical Records • QM302 Attachment A. Chart Standards **Description of Process:** Colorado Access Care Coordination policy (CCS305) addresses the coordination of services with primary care as one of the specific care management interventions (Section III.C., pg 4-5). This section also outlines the process for care coordination with behavioral health care providers, physical health care providers,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ The Single Entry Point (SEP) care manager, as applicable. *42CFR438.208(b)(2)* Contract: II.E.1.g.1—3	long term care providers, waiver service providers, pharmacists, county and state agencies, and other organizations that may be providing wrap around services (p5). This is also addressed in the definition of care coordination (page 2). Coordination between ABC providers and a member's PCPs is a responsibility of our providers. This is explicitly stated in the Provider Manual (pages 26-29). In addition, Appendix A of the Provider Manual requires documentation of coordination with medical providers and other ancillary service providers (Assessment Standards #7-8, page 70). Documentation of active treatment must include documentation of continuity and coordination of care with the member's PCP and other ancillary service providers (#7, page 70). The Provider Manual also includes a web link to the sample PCP communication form (page 77). This form is available our website at http://www.coaccess.com/access-behavioral-care-provider-information. Clinical documentation standards in Appendix A are reviewed during provider chart audits. Colorado Access policy QM302 outlines the process for provider medical chart reviews to ensure providers are following these requirements.	

Findings:
The Care Coordination policy stated that one of the goals of care coordination was to coordinate medical and/or mental health care, community resources, and social supports for members with complex care needs. The policy defined care coordination as a collaborative process among Colorado Access and specified providers and agencies, as indicated. The policy specified that the individualized care coordination plan may include medical provider referrals, community resource and outside agency referrals, home and community-based services (HCBS), transportation, or wraparound benefits. The Access Behavioral Care (ABC) Provider Manual stated that providers are expected to coordinate care among the various caregivers and service providers involved with a member, and to incorporate those care coordination needs into an individualized service plan. The manual provided examples of other caregivers, including those specified in the requirement. The manual informed providers that ABC care managers are available to assist members with complex multisystem needs.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
During the on-site interview, ABC staff members presented a sample care coordination case for a 61-year-old female with a lengthy history of severe mental illness and other medical problems. The member was unable to live independently, was receiving complex medication management, and was transitioning from a lengthy inpatient psychiatric hospitalization to a skilled nursing facility (SNF) for continued treatment. The ABC care coordinator confirmed that the discharge plan from hospital to the SNF was well coordinated by the hospital and SNF staff. ABC staff stated that, due to the resources available in a nursing facility, the nursing facility would act as the member's caregiver, and the continuing care plan was primarily implemented through the SNF staff. ABC coordinated with the facility staff concerning the member's care plan. The case presentation demonstrated coordination of wraparound services and services with multiple behavioral health providers, ancillary service providers (laboratory, pharmacy), and the single entry point (SEP) case manager.		
Required Actions: None.		
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary (behavioral health) care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. *42CFR438.208(b)(1)* Contract: None	**Documents Submitted:** • CCS 305 Coordination of Care • FY13 Q1 Network Adequacy Report **Description of Process:** Colorado Access policy CCS 305 addresses Coordination of Care. Section I.B describes a goal of care coordination is "to ensure accessibility and timely coordination of the provision of covered services and continuity of care"(p3). Section I.C states to identify opportunities and establish individualized care plans based on needs assessment that will improve access to medical and/or mental health care, community resources and social supports for members with complex physical, mental and cultural healthcare needs"(p3). CCS 305 sections II and III describe the care coordination process. Care Coordination ensures that members who have an identified behavioral health have an appropriate primary behavioral provider. Colorado access also maintains an adequate network that ensures available access to primary behavioral health services (see FY13 Q1 Network Adequacy Report).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Network Adequacy Report stated that ABC maintains an adequate network of licensed mental health providers to ensure availability and accessibility of covered services for all members. The provider manual stated that the primary provider is responsible for providing services to members and for coordinating health care services with other providers or agencies. The manual stated that members may access a behavioral health provider either directly or by contacting ABC for assistance. The on-site care coordination case presentation demonstrated that the member had a primary mental health provider, primary care physician (PCP), and care coordinator.		
Required Actions: None.		
4. Contractor ensures that each member accessing services receives an individual mental health assessment and individual needs assessment. The mental health assessment addresses: ◆ Member demographics. ◆ Cultural and racial affiliations. ◆ Language and reading proficiency. ◆ Personal and family health history. ◆ Self-perceived health status to predict the member's likelihood of experiencing the most common mental illnesses. ◆ Personal health characteristics, including but not limited to: • Mental illness. • Alcohol consumption. • Substance use disorders. The individual needs assessment evaluates: ◆ Special transportation needs. ◆ Cultural and linguistic needs. *42CFR438.208(c)(2)* Contract: II.F.7	**Documents Submitted/Location Within Documents:** • ABC Provider Manual Jan 2010 • QM302-Review of Provider Medical Records • CCQC/50 claims audit results-available upon request • LSBI Audit Results-available upon request **Description of Process:** The ABC Provider Manual states that every member shall receive an individual intake and assessment (page 16). This is also mentioned in the section related to initial triage assessment (pages 34-35). The requirements for documentation of intake assessments are outlined in Appendix A (pages 69-72). The intake assessment for services is required to take place within the access standards referenced on page 11. In FY12 ABC's Medicaid Compliance program was updated to include a review of how medical record documentation was audited. Colorado Access policy QM302 describes the process of medical record reviews which has been in place since 1996. As part of the new compliance process Colorado Access audited three Mental Health Centers for compliance with Medicaid documentation standards to include mental health assessments. In addition, at the direction of the ABC Executive Director an audit was performed at Life Support Behavioral	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Institute on their medical record documentation after some inconsistent claims were observed. The ABC Provider Manual on page 68 describes in detail the clinical record documentation standards.	
Findings: The provider manual outlined the requirements for the initial intake assessment, required for all members, which included all of the required elements. The assessment elements were detailed in the medical record documentation requirements, for which ABC periodically audited medical records. The Review of Provider Medical Records policy outlined the procedures for medical record reviews to determine compliance with medical record standards. ABC provided a sample medical record audit tool, which was used to verify all of the required assessment elements, including transportation, cultural, and linguistic needs. The Care Coordination policy required an assessment of individual member needs for all members referred to care management. The on-site care coordination case presentation demonstrated the performance of a comprehensive mental health and individual needs assessment by the mental health provider. The provider assessment was integrated into the Altruista case management system, which also included an assessment of the members' care coordination needs performed by the ABC care coordinator.		
Required Actions: None.		
5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: II.F.7.g	**Documents Submitted:** • CCS 305-Care Coordination • Provider Manual p35 **Process Description:** Colorado Access Care Managers, Service Coordinators, and Peer Specialists routinely communicate their activities to providers and others involved in the member's care. This activity is implicit in the definition of Care Coordination (CCS305, page 2). One of the stated goals of our care coordination program is to "to facilitate communication and coordination among providers, caregivers, and stakeholders" (CCS305, I.G, pg 3). "To create efficiencies by decreasing the duplication of services" is another stated goal of the program (CCS305, I.H, pg 3). In addition, it is expected that care	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	coordination interventions are "non-duplicative (CCS305, Section I.H., page 3 and III.C.2, pgs 4-5) and collaborative. The ABC Provider Manual also refers to Special Populations and their access to care coordination (p35).	
Findings: The ABC Provider Manual specified that one of the medical record documentation requirements was the release of information form to allow sharing of member information with the member's PCP. The Care Coordination policy stated that one of the care coordination objectives was to decrease the duplication of services. The policy stated that care coordinators will communicate with family, providers, and staff members to share assessment findings and develop a plan of care in a non-duplicative collaborated manner. During the on-site interview, staff stated that while seeking services that are appropriate to meeting the special health care needs of a member, ABC communicates the assessment of specific member needs with providers and organizations. During transition of the member into or out of the plan, ABC coordinates with other managed care organizations and initiates single case agreements, as needed, to ensure continuity of care for members with special health care needs. Staff stated that, upon request, ABC will send a printed copy of the care coordination plan to other providers participating in the member's health care but generally limits communication of the member's needs to the information pertinent to a particular service provider.		
Required Actions: None.		
6. Each member has an individualized service plan (treatment plan/care plan) that includes: ◆ Measurable goals. ◆ Strategies to achieve the stated goals. ◆ Mechanism for monitoring and revising the service plan as appropriate. The service plan is developed by the member, the member's designated client representative (DCR) and the provider/treatment team and is signed by the member. (If a member chooses not to sign his/her service plan, documentation shall be provided in the member's medical record stating the member's reason for not signing the plan.)	**Documents Submitted:** • ABC Provider Manual Jan 2010QM302-Review of Provider Medical Records • LSBI Audit Results-Available upon request. • ABC Compliance Plan **Description of Process:** The ABC Provider Manual states that each member receiving treatment shall have an appropriate ISP (pages 14, 16, 20, 28, 38, 55, 71-72). Compliance with this requirement is audited during routine random medical record reviews as required per Colorado Access Review of Provider Medical Records (QM302). At the direction of the ABC Executive Director, an audit of medical	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Service planning shall take place annually or if there is a change in the member's level of functioning and care needs. *42CFR438.208(c)(3)* Contract: II.F.9	records was completed for Life Support Behavioral Health Institute. In FY12 ABC's Medicaid Compliance Program was updated to include 50 claim audits of three Mental Health Centers. The initial focus of the compliance program focused on high volume providers.	

Findings:

The provider manual informed providers of the requirement that they work with the member to develop an individualized service plan that includes individualized, measurable goals based on assessed member needs, services provided to attain the goals, and member and family participation and agreement with the treatment plan (evidenced by the member's and family's signatures). The manual stated the plan must be reviewed and updated at least every six months. ABC submitted evidence that ABC audits provider medical records for compliance with all of the elements specified in the requirement. The Care Coordination policy stated that the care coordinator will develop an individualized care plan, based on the assessment of member needs, with member, family, and provider involvement. The policy stated that the care plan would include time-specific goals and interventions, and must be monitored for progress and revised as necessary. During the on-site interview, staff demonstrated that the care coordination assessment and care plan are maintained electronically in the Altruista case management software, which does not provide for clear documentation of the member's agreement to the plan. HSAG recommended that ABC consider a mechanism to clearly document the member's agreement to the care coordination plan in the case management file.

The on-site care coordination presentation demonstrated the development of a treatment plan based on the provider's assessment of member needs and included member-specific, measurable goals and planned interventions. The record contained the member's signed agreement to the plan and demonstrated extensive interaction with the member. Staff stated that provider follow-up and progress notes were maintained in the Mental Health Center of Denver (MHCD) electronic record, which is accessible by ABC. The ABC care management plan also documented frequent follow-up with the caregiver (SNF staff) to monitor the progress of the patient and ensure that the member's care coordination needs were being met.

Required Actions:

None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. In all other operations as well the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: II.E.1.g.1, VII.S	• HIP201-Protection of Health Information • HIP204-Security of Electronic Protected Health Information • CCS305-Care Coordination pg6 • ABC Provider Manual Jan 2010 **Description of Process:** The sharing of member information for the purposes of continuity and coordination of care is handled in accordance with State and Federal laws and regulations outlined in Colorado Access Protection of Health Information policy (HIP201). In addition, Colorado Access Security of Electronic Protected Health Information policy (HIP204) outlines the policies for sharing electronic health information. Colorado Access Care Coordination policy (CCS305) states care coordination will work to ensure that member confidentiality is maintained, in accordance with 45 CFR Parts 160 and 164 and other applicable law and regulation, at all times when collaborating with both internal and external parties, as well as assuring that all confidential member information is maintained in an orderly fashion within the member's file (Section III.C.6., page 5). The ABC Provider Manual (pages 16-17) outlines member privacy requirements. These requirements are checked during random provider chart audits. These policies and procedures pertain to all activities undertaken by Colorado Access staff.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Protection of Health Information policy stated that all employees, providers, Board of Directors, and other entities affiliated with Colorado Access may not use or disclose member protected health information (PHI) except for treatment, payment, and operations; and they must obtain the member's written consent for other uses. The policy outlined processes for ensuring that member privacy is maintained, including confidentiality agreements, provider and vendor contract requirements, staff and provider training, limited access to PHI based on the need to know for specific job functions, and		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
verification of identity and authority of persons receiving PHI. The policy outlined, in detail, the circumstances in which written member authorization is or is not required to use or disclose PHI and described the procedures for processing breaches of PHI security. The Security of Electronic Protected Health Information policy described the roles and responsibilities of various staff for maintaining electronic and physical security of PHI. The policy stated that Colorado Access evaluates security policies and procedures for compliance with HIPAA and other legal requirements at least annually. The Care Coordination policy stated that care coordinators will ensure that confidentiality of member information is maintained at all times when collaborating with other parties, as well as within the member file. The provider manual and provider contract required providers to maintain confidentiality of member information in compliance with HIPAA and other regulations. The provider manual described the responsibility of the provider to obtain a written release of information from the member to allow communication of specific information with the member's PCP. ABC monitors for compliance with the release of information requirement via provider medical record audits.		
Required Actions: None.		
8. The Contractor may require nursing facility residents who are able to travel to a service delivery site to receive their mental health services at a service delivery site. The Contractor shall arrange for transportation for the member between the nursing facility and the service delivery site, but shall not be responsible for the cost of transportation. However, the Contractor shall provide medically necessary mental health services on-site in the nursing facility if transportation cannot be arranged. Contract: II.E.3	**Documents Submitted:** • CCS 413- Access and Availability for Members Residing in Nursing Facilities/Assisted Living Facilities **Description of Process:** CCS413 Section I states, "Colorado Access will arrange for the provision of medically necessary covered mental health services for members who are residents of nursing facilities/assisted living facilities and who cannot reasonably travel to a service delivery site for their services." Section I.A further states that Colorado Access will identify providers that are willing to travel and provide mental health services in the nursing facility (p2). CCS413 Section II describes the process for arranging for services for residents of nursing facilities and assist in arranging for transportation to the mental health services delivery site (p2).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Access and Availability for Members Residing in Nursing Facilities policy stated that ABC will arrange transportation for nursing facility residents to receive mental health services at ABC service delivery sites. If the member is not reasonably able to travel, the Colorado Access utilization management coordinator will arrange for the provision of mental health services on-site at the nursing facility. The on-site care coordination case presentation confirmed the delivery of mental health services on-site at the member's nursing facility by MHCD providers. Staff stated that ABC has also assigned peer specialists to designated nursing facilities to assist members with transition to the facility. The case presentation also demonstrated that member transportation needs were assessed and transportation was provided by the nursing facility, as needed.		
Required Actions: None.		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	8
			Total Score ÷ Total Applicable			=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: II.F.3.a	**Documentation:** CS212-Member Rights and Responsibilities, Section I (pg 2) **Process Description:** CS212 states that Colorado Access will establish and maintain written policies and procedures for treating members in a manner that is consistent with federal and state law, rules and regulations, and contract requirements (Section I, pg 2).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: ABC had several polices in place that addressed member rights and protections in accordance with federal health care requirements. ABC's Member Rights and Responsibilities policy described how member rights and responsibilities are communicated to providers, members, and ABC employees. ABC's Nondiscrimination policy defined the behavioral health organization's (BHO's) responsibility to protect member rights and to take necessary action to address any allegations of discrimination. In addition, ABC's Protection of Member Individually Identifiable Health Information policy described the BHO's role in protecting member confidentiality, including safeguarding members' PHI.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: II.F.3.a	**Documentation:** • CS212 Member Rights and Responsibilities, Sections III-V (pg 2 • Provider Manual, Section IV (pgs 18-19, 55) • Corporate Compliance Training _122612 • Quarterly Grievance and Appeals Reports Q1-4 **Process Description:** CS212 section III states that "Colorado Access will communicate member rights and responsibilities to members, Colorado Access employees and providers according to applicable federal and state laws, rules and regulations and contract requirements. 3 Distribution channels include, but are not limited to, member handbooks, provider manuals, new provider orientation, provider and member bulletins, company website, newsletters, member	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	complaint and appeal procedures, the Notice of Privacy Practices, and Evidence of Coverage documents.4" (p2) CS212 section IV also states that "Colorado Access provider contracts require provider compliance with all applicable federal and state laws, their implementing regulations, and Colorado Access policies and procedures, including member rights as identified herein and the requirement to take those rights into account when providing services to members" (p2). In addition, member rights are posted on the Colorado Access website at http://www.coaccess.com/your-rights-and-responsibilities. Providers are informed within the Provider Manual that Members have certain rights that they must be aware of (pgs 18-19, 55). Policy CS212 is included in the annual online Corporate Compliance training that all staff are required to pass annually. See slide 50 of the Corporate Compliance Training. Training results are available upon request. Quarterly grievance and appeals report track concerns related to member rights and are addressed.	

Findings:
The list of member rights was posted on the ABC Web site (obtainable from both the member and provider tabs) and was included in ABC's Member and Family Handbook (the member handbook). The ABC Provider Manual described the role of the Office of Member and Family Affairs (OMFA) and provider responsibilities related to member rights, provided discussion on specific rights such as participation in treatment planning, and referred providers to the Web site and to the Member and Family Handbook for a complete list of rights. The provider manual also contained telephone numbers for the State ombudsman for Medicaid managed care and for the ABC OMFA. ABC provided grievances and appeals reports for two quarters of the review period (January–March and April–June) that illustrated the BHO had the capability to track and trend grievances related to member rights and protections, and

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
that ABC followed up with members to strive for satisfactory resolution. There were no grievances filed in the area of member rights for the two quarters reviewed. Compliance training addressed member rights related to HIPAA regulations. During the on-site interview, ABC staff reported that internal staff members were required to attend orientation at the time of hire. New hire orientation included information about member rights. Staff members were also required to participate in annual compliance training that includes member rights information. Customer service staff members attend additional annual training regarding member rights and complete a related quiz each year. The schedule for provider training was available on the Web site. Staff members reported that Cultural Competency training for providers was scheduled as needed or requested. ABC may want to consider including brief member rights trainings as part of the provider overview training, or including topic-specific rights information in the provider bulletin periodically.		
Required Actions: None.		
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment, and the right to a second opinion. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210).	**Documentation:** • Member Handbook, Member Rights and Responsibilities (pgs 19-22) • 3rd Qtr 20011 Part Newsletter • 2nd Qtr 2012 Part Newsletter • 3rd Qtr 2012Part Newsletter • Provider Manual • Quarterly Grievance and Appeals Reports Q1-4 **Process Description:** Each new Member receives a new member packet mailing, including the ABC Member Handbook. This handbook outlines their rights (pgs 19-22). Specific requirements noted in the left hand column are addressed in the Member Handbook on (pgs 19-22). On a regular basis, the ABC Partnership Newsletter also reminds our Members that they have rights afforded to them. The 3rd quarter 2011, 2nd and 3rd quarter 2012 reminded Members how to access the Ombudsman for Medicaid Managed Care. We ensure these rights through the monitoring of member grievances related to member rights. See Grievance and Appeals reports for FY12.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Additional member rights, include 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, legislative bodies, or the media without the Contractor causing any adverse effects upon the provision of Covered Services. *42CFR438.100(b)(2) and (3)* Contract: II.F.1, II.F.4.j.3		
Findings: ABC's member handbook, distributed to each member at the time of enrollment, included the list of member rights, inclusive of those required in 42CFR438.100(b)(2)&(3). The provider manual addressed member rights and referred the provider to the Web site for the list of specific rights. Member rights were also posted on the ABC Web site and available through links from both the provider and members pages. The rights list found on the Web site also included each right as required at 42CFR438.100. Every member newsletter included information about the Medicaid ombudsman on the front page. ABC monitored grievance data quarterly for trends or patterns related to member rights to help ensure that member rights were upheld. Staff stated that grievance data review included grievances processed by Colorado Access/ABC staff as well as by the MHCD (ABC's delegate for grievance processing). During the on-site interview, ABC staff members indicated that personnel from OMFA were responsible for distributing member materials related to member rights, facilitating the Member and Family Advisory Board (MFAB) meetings, and advocating on behalf of members as needed. Staff reported that the MFAB meetings typically have more than 200 members in attendance and ABC staff members encourage members to express opinions and provide feedback to ABC during these meetings.		
Required Actions: None.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: II.F.1.h	**Documentation:** • Member Handbook, Member Rights and Responsibilities (pgs 19-22, bullets 32 and 33) • Provider Manual, Section X (pg 57) **Process Description:** ABC Members have the right to file a grievance about their care without retaliation. Member rights listed on our website, within the Member Handbook (p 21), and in the Provider Manual states that this is a Member right (p57). The ABC Member Handbook informs Members that they are free to: • Express an opinion about Access Behavioral Care's services to state agencies, legislative bodies, or the media without your services being affected (p21). • Exercise your rights without any change in the way Access Behavioral Care or our providers treat you (p21). ABC ensures that Members are free to exercise their rights without retaliation by monitoring issues that may arise through the grievance process, see grievance and appeal reports FY12 Q1-4.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The list of member rights included in the member handbook and posted on the ABC Web site identified the member's right to express an opinion about care received without the member's services being affected. The handbook and Web site also stated that members could exercise their rights without fear of retaliation. The ABC Provider Manual required providers to ensure that members felt free to express their concerns without fear of adverse consequences. In addition, ABC's Nondiscrimination policy stated that the BHO will not tolerate retaliation of any kind. The ABC annual member letter included a statement of member rights as a reminder. The Web site and the member handbook included a grievance form for members to use. ABC staff reported that each MFAB meeting included a discussion of the role of ABC's customer service staff and a brief reminder of each of the avenues members may use to provide feedback to ABC (during board meetings, in person, by telephone).		
Required Actions: None.		

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: VII.T	**Documentation:** • ADM205-Nondiscrimnination **Process Description:** Colorado Access policy ADM205 outlines our nondiscrimination policy and adherence to applicable Stated and Federal laws specifically in section V (pg 3).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Nondiscrimination policy mandated compliance with all State and federal laws and prohibited discrimination based on race, color, national origin, sex, religion, creed, sexual orientation, age, or mental or physical disability. The Protection of Member Individually Identifiable Health Information policy addressed the protection of member privacy and confidentiality, including safeguarding member PHI. In addition, ABC included the requirement to comply with federal and State laws in both the ABC Provider Manual and in provider contracts.		
Required Actions: None.		

Results for Standard IV—Member Rights and Protections							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	5	**Total Score**		=	5

Total Score ÷ Total Applicable	=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. NCQA CR1	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, All • CR302-Office Site Visit for Provider Credentialing, All • CMP206-Sanction, Exclusion, Prohibited Affiliation, and Opt-Out Screening, All • CR307- Credentialing and Recredentialing Provider Review Classification, All • CR312-Provider Rights, All • CR213-Adverse Actions and Hearing and Appeals Process for Providers, All • CR318-Ongoing Monitoring of Provider Sanctions, Grievances, and Occurrences of Adverse Actions, All • PNS202-Selection and Retention of Providers, All • ADM223 Delegation, All **Process Description:** Credentialing functions are the responsibility of the Director of Provider Contracting. Credentialing staff consist of the Manager of Contract Systems and a Credentialing Program Coordinator. 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 ☐ Not Applicable
Findings: Colorado Access performed the credentialing and recredentialing processes for ABC, its behavioral health line of business. The Practitioner Credentialing and Recredentialing policy provided an overview of Colorado Access' credentialing and recredentialing processes, referring to other pertinent policies for specific details. Processes reviewed on-site were consistent with the policies and provided evidence of Colorado Access' well-defined credentialing and recredentialing processes.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Required Actions: None.		
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, and or licensed professional counselors.) *42CFR438.214(a)* NCQA CR1—Element A1	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section I (pg3) • Credentialing Committee Minutes (available onsite for review) **Process Description:** Colorado Access policy CR301 outlines the company's credentialing practices. Practitioners are credentialed following current NCQA standards. The policies listed in Requirement #1 support the credentialing and recredentialing process. Colorado Access uses the CDPHE Colorado Health Care Professional Credential Application. This common State approved application specifies the types of practitioners to be credentialed. CR301, Section I, specifies the types of practitioners credentialed by Colorado Access (p 3-4).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described each type of practitioner subject to Colorado Access' credentialing processes. Practitioners credentialed and recredentialed by Colorado Access/ABC included medical doctors, doctors of osteopathy, podiatrists, chiropractors, doctors of dental science, psychologists, psychiatrists, social workers, nurses, and counseling professionals (including family therapists and licensed professional counselors). The ABC provider directory provided evidence that Colorado Access maintained a robust selection of practitioners that included licensed clinical social workers, licensed professional counselors, marriage and family therapists, psychologists, as well as other independent behavioral health practitioners.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.B. The verification sources used. NCQA CR1—Element A2	**Documentation Submitted:** • 1. CR301-Provider Credentialing and Recredentialing, Section XV (pgs 11-15) **Process Description:** The CR301 section noted above specifies the verification sources used for credentialing and recredentialing. If requested, credentialing staff can produce examples of practitioner credentialing file applications as evidence of the verification sources used.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the acceptable primary sources used for verifying licensure, education and training, Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certification, board certification, and malpractice coverage.		
Required Actions: None.		
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section VIII, pgs. 6-7 • CR307-Credentialing and Recredentialing Provider Review Classification, All • Provider Manual (pg 59) **Process Description:** CR301, Section VIII (p6-7) and CR307 outline the criteria used for Credentialing (p59-60). If requested, credentialing staff can produce examples of practitioner credentialing file applications as evidence of the criteria used.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the criteria for network participation, which applied to all practitioners under the scope of Colorado Access' credentialing program. The Credentialing/Recredentialing Practitioner Review Classification and Credentials Committee		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Determination Process policy (Practitioner Review Classification policy) described the specific criteria for files meeting the standard for clean files and those that are submitted to the Colorado Access Credentials Committee for review. The ABC Provider Manual informed providers of the criteria for participation and continued participation in ABC's provider network.		
Required Actions: None.		
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documentation Submitted:** • CR307-Credentialing and Recredentialing Provider Review Classification, All • CR301-Provider Credentialing and Recredentialing, Section IX (pgs 7-8), and Section XVI (pg 15-16) **Process Description:** Colorado Access policy CR307 outlines the process for making credentialing and recredentialing decisions. CR301 also speaks generally to the credentialing decision making process. If requested, credentialing staff can produce Credentialing Committee minutes as evidence of the decision making process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the Colorado Access Credentials Committee and its processes for reviewing practitioner applications and making credentialing and recredentialing decisions. The Practitioner Review Classification policy described the process and criteria for files that may go directly to the medical director for review.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section VIII (pg 6) **Process Description:** CR301 specifies how records are maintained by credentialing staff (p6). Credentialing files are maintained using the Apogee Managed Care Credentialing System (Morrisey Associates, Inc.). Prior to November 2009, we used the MSO product from Morrisey. Apogee software is a web-based comprehensive membership management system. During the site review, Credentialing staff can demonstrate this product if requested. Reviewers are welcome to visit the credentialing area where physical files are stored.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the process for the credentialing program coordinator to review credentialing files for completeness and timeliness and for forwarding the file to the chief medical officer or the associate medical director for review. The Practitioner Review Classification policy described which files may be reviewed by the chief medical officer or the associate medical director physician designee, and which files are sent to the Credentials Committee for review. The policy stated that the Credentials Committee may also review any file designated as "meeting criteria." The Credentials Committee meeting minutes provided evidence that the Credentials Committee reviewed credentialing and recredentialing files as well as the list of providers who were approved by the medical director when providers met, without exception, all of the credentialing criteria.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Sections VI (pg 5), VIII (pg 6-7) • Provider Manual (pg 62) **Process Description:** The process for delegating credentialing and recredentialing is specified in CR301 sections VI (pg 5) and VIII (p6-7). Currently, Colorado Access delegates credentialing and recredentialing to three entities: Denver Health, National Jewish, and University Physicians. These agreements are included in the "Delegation Agreements" folder. All three include ABC credentialed providers. The delegation of credentialing is also mentioned in the Provider Manual (pg 62).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: ABC staff members reported that ABC delegated credentialing to Denver Health and Hospital Authority, National Jewish Health, and University Physicians, Incorporated, for those providers. Colorado Access staff stated that each delegate maintained a network of physicians who had an independent relationship with Colorado Access for provision of services to ABC members. The Practitioner Credentialing and Recredentialing policy described the processes for the delegation, which included completion of a predelegation audit and Colorado Access' approval of the delegated entity's credentialing policies and procedures as well as subsequent oversight processes.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section III (pgs 4-5) • Provider Manual (pg 60) **Process Description:** The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner is specified in CR301 section III (p4-5). The ABC Provider Manual also describes non-discrimination on page 60. If requested, the Credentials Committee signatures on the Non-Discrimination Acknowledgment can be made available during the site review.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Practitioner Credentialing and Recredentialing policy stated that Colorado Access does not make credentialing and recredentialing decisions based solely on ethnic/national identity, gender, age, sexual orientation, type of practice, or types of patients the practitioner may specialize in treating. The policy also stated that Colorado Access will not discriminate—in terms of participation, reimbursement, or indemnification—against any health care professional who is acting within the scope of his or her license or certification under State law solely on the basis of that license or certification. In addition, the policy described the Credentials Committee process and described how the committee, the chief medical officer, and the associate medical director designee applied the criteria in the credentialing policies to each case prepared and reviewed for credentialing and recredentialing. The policy stated that all participating Credentials Committee members signed an acknowledgment form stating that they do not discriminate when making credentialing and recredentialing decisions. Signed nondiscrimination forms for committee members were reviewed on-site. The Provider Manual informed providers of ABC's policy not to discriminate during the credentialing and recredentialing processes. During the on-site interview, ABC staff reported that if complaints were received, the medical director would review the case. While Colorado Access/ABC had appropriate methods to prevent discrimination, there were no methods in place for periodic monitoring to ensure nondiscriminatory credentialing practices, as required by NCQA.

Required Actions:

Colorado Access must develop processes for monitoring to ensure nondiscriminatory credentialing practices.

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, Section II.B (pg 3) • Provider Manual (pg 60) **Process Description:** Colorado Access policy CR301 states, "Practitioners have the right to review the information submitted in support of the credentialing application; be notified during the credentialing process if information obtained varies substantially from practitioner's information; correct any erroneous information submitted as a part of the credentialing process; and be informed, upon request, of the status of their credentialing or recredentialing application (Section V, pg 5)." Colorado Access policy CR312 details the rights afforded practitioners in the credentialing process (Section II.B, pg 3). The ABC Provider Manual on page 60 states; "Practitioners have the right to review the information submitted in support of the credentialing application, to be notified during the credentialing process if information obtained varies substantially from practitioner's information, correct any erroneous information submitted as a part of the credentialing process, and be informed, upon request, of the status of their credentialing or recredentialing application."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The Practitioner Credentialing and Recredentialing policy stated that if an application contained information that varied substantially from the information acquired during the credentialing process, the practitioner would be given the opportunity to correct the information and/or explain the discrepancy. Providers were notified in the credentialing application that they would be notified if information received during the credentialing process varied from the

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
information provided by the applicant and that the applicant had the right to correct any erroneous information. The Practitioner Rights policy stated that such notification would occur in writing using a standard form.		
Required Actions: None.		
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section XVII (pg 16) **Process Description:** Colorado Access policy CR301 states, "Providers undergoing initial credentialing are notified in writing within ten (10) business days of the Senior Medical Director weekly reviews and Credentials Committee decisions." (Section XVII).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy stated that practitioners undergoing initial credentialing are notified in writing within 60 calendar days of the committee's credentialing decision. On-site review of credentialing and recredentialing files demonstrated that notification was typically provided within the same week of the decision.		
Required Actions: None.		
2.J. The medical director's or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	• CR301-Provider Credentialing and Recredentialing, Section IV (pg 5) and IX (pgs 7-8). **Process Description:** Colorado Access policy CR301 requires Medical Director responsibility for the credentialing program (Section IV p5 and IX p7-8 and). Credentialing Committee minutes (available during site review) are evidence that the Chief Medical Officer, or other Associate Medical Director designee, chairs the committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Practitioner Credentialing and Recredentialing policy stated that the chief medical officer or the associate medical director designee is responsible for clinical aspects of the credentialing program and serves as chair of the Credentials Committee. The policy also stated that the chief medical officer or the associate medical director (designee) is authorized to approve practitioners for participation who meet criteria. The Credentials Committee meeting minutes reviewed on-site provided evidence of the medical director's involvement and participation in the committee. During the on-site interview, ABC staff confirmed that the credentialing date for clean files is the medical director sign-off date and for the files reviewed by the Credentials Committee, it is the committee date.		
Required Actions: None.		
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section VII (pg 6) **Process Description:** Colorado Access policy CR301 (Sections noted above) specifies the process for ensuring the confidentiality of all credentialing information (p6). Confidentiality statements signed by the Credentials Committee can be produced upon request during the site review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the processes and procedures used for ensuring the confidentiality of information obtained during the credentialing and recredentialing processes. Processes included signed confidentiality statements by staff with access to credentialing and recredentialing materials, locked file cabinets for storage of hard copy files, shredding of copied materials, and password protection security of electronic files.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section XVIII (pg 16-17) **Process Description:** Colorado Access policy CR301 specifies the process for listing practitioner information in provider directories. CR301 Section XVIII states; "Colorado Access verifies that the information pertaining to credentialed providers that is contained in member materials including provider directories is consistent with the information obtained during credentialing by conducting audits, at least annually. Examples of elements audited may include verification of the provider's name, education, training, certification, and specialty (p16)."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described annual audits for accuracy of the provider directory information. Colorado Access staff stated that the claims system was used to query provider contact information, which was verified against the information contained in the credentialing database. Staff also stated that the online searchable database is updated within days of a change to the database. Hard copies used for mailings are printed annually by the vendor used for eligibility mailings.		
Required Actions: None.		
2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request. NCQA CR1—Element B1	• CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, All • Colorado Health Care Professional Credentials Application (#12, pg 23) • Provider Manual (pg 60)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	Process Description: Colorado Access policy CR301 states, "Providers have the right to review the information submitted in support of the credentialing application. Providers will be notified during the credentialing process if information obtained varies substantially from provider's information. Providers have the right to correct any erroneous information submitted as a part of the credentialing process, provide missing information during the verification process, and be informed, upon request, of the status of their credentialing or recredentialing application." (Section V). Colorado Access policy CR312 specifies the process practitioners need to follow to obtain information related to their credentialing application. The CO Health Care Professional Credentials Application used by Colorado Access informs practitioners of their right to review information submitted in support of their application (p23). Practitioners are also informed of this right within the Provider Manual (pg 60).	
Findings: The Practitioner Credentialing and Recredentialing policy included the provision that practitioner applicants have the right to review information submitted in support of their credentialing/recredentialing application. The Practitioner Rights policy described Colorado Access' processes for allowing practitioners to access their information. Providers were informed of this right in the credentialing application and in the provider manual.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, Section II (pg 3) • Colorado Health Care Professional Credentials Application (pg. 23) • Provider Manual (pg 60) **Process Description:** Colorado Access policy CR301 states, "Practitioners have the right to … correct any erroneous information submitted as a part of the credentialing process" (Section V, pg5). Colorado Access policy CR312 specifies the process practitioner's should follow to request that information within their application be corrected (Section II, pg 3).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy included the provision that practitioners have the right to correct any erroneous information obtained during the credentialing/recredentialing process. The Practitioner Rights policy described Colorado Access' processes for correcting erroneous information. The policy included the link to find a correction form online.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
2.O. The right of practitioners, upon request, to receive the status of their application. NCQA CR1—Element B3	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section V (pg 5) • CR312-Provider Rights, Section III (pg 3) • Colorado Health Care Professional Credentials Application (#12, pg 23) • Provider Manual (pg 60) **Process Description:** Colorado Access policy CR301 states, "Practitioners have the right to … be informed, upon request, of the status of their credentialing or recredentialing application" (Section V, pg 5). Colorado Access policy CR312 specifies the process practitioner's should follow to request the status of their application (Section III, pg 3). Practitioners are informed of this right within the CO Health Care Professional Credentials Application (#12, pg 23). The Provider Manual also informs providers of this right (pg 60).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy included the practitioner's right to receive the status of his/her credentialing application, upon request. The Practitioner Rights policy described Colorado Access' processes for informing practitioners of their application status, upon request. Providers were notified of this right in the credentialing application and in the provider manual.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
2.P. The right of applicants to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	**Documentation Submitted:** • CR312-Provider Rights, Section IV (pg 3) • Colorado Health Care Professional Credentials Application • (Schedule A, pgs 22-23) • Provider Manual (pg 60) **Process Description:** Colorado Access policy CR312 states, "Practitioners are notified of these rights by the Provider Manual and on Schedule A of the Colorado Health Professional Credentials Application" (Section IV, pg 4). Practitioners are notified of their rights when they sign Schedule A of the CO Health Care Professional Credentials Application. Providers are also notified of their rights within the Provider Manual (pg 60). This document is readily available on our website at http://www.coaccess.com/access-behavioral-care-provider-information	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Rights policy stated that providers are notified of their rights via the provider manual and in the credentialing application. The credentialing application and the provider manual included each of the applicant rights.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR9—Element A	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section XI (pg 9) • CR318-Ongoing Monitoring of Provider Sanctions, Grievances, and Occurrences of Adverse Events, All **Process Description:** Colorado Access policy CR301 states, "Colorado Access conducts ongoing monitoring of practitioners contracted to participate in the Colorado Access networks that fall within the scope of credentialing activities and will take appropriate action based on the findings. The ongoing monitoring activities conducted between recredentialing cycles will include Medicare and Medicaid sanctions or exclusions, practitioners who opt-out of Medicare, Colorado State licensing sanctions or limitations on licensure, and practitioner-specific member grievances, and occurrences of adverse events " (Section XI p9) . Colorado Access policy CR318 outlines the specific monitoring activities referred to in CR301, Section XI. • On a monthly basis, credentialing staff check 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). • Member quality of care concerns of 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 Section I.E-G. The summary report prepared by Quality Management will be available upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Practitioner Credentialing and Recredentialing policy stated that ongoing monitoring activities between credentialing cycles included review for Medicare/Medicaid sanctions and Colorado State licensure sanctions, review of practitioner-specific member grievances, and review of occurrences of adverse events. The Ongoing Monitoring of Sanctions, Grievances, and Occurrences of Adverse Events policy (Ongoing Monitoring policy) stated that monitoring for State and Medicare/Medicaid sanctions occurred monthly. The Ongoing Monitoring policy also stated that if a provider had been disciplined, Colorado Access monitored compliance with the corrective actions. The Investigation of Potential Clinical Quality of Care Grievances and Referrals policy described the processes for peer review and Colorado Access' response when practitioners were determined to have quality-of-care issues. The Sanction Monitoring Report, which was presented each month to the Credentials Committee, provided evidence that the BHO regularly monitored practitioner sanctions, licensure issues, Office of Inspector General (OIG) sanctions, and other adverse events for practitioners in the network and presented the information to the Credentials Committee for review. On-site review of the Credentials Committee meeting minutes provided evidence that the Sanction Monitoring Report was presented to and reviewed by the committee. On-site, ABC provided evidence of the monthly search for sanctions using the appropriate online databases and crosscheck to determine if ABC providers were on the list.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR10—Element A1	**Documentation Submitted:** • CR213-Adverse Actions and Hearing and Appeals Process for Providers, All • CR318-Ongoing Monitoring of Providers Sanctions, Grievances, and Occurrences of Adverse Events, Section III (pgs 4-5) **Process Description:** Colorado Access policy CR213 outlines the action available to ABC if a provider does not meet quality standards. Colorado Access policy CR318 also outlines the actions available to the credentialing committee (Section III, pgs 4-5).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Adverse Actions and Hearing and Appeal Process for Practitioners policy (Adverse Actions policy) described the range of actions available to Colorado Access in response to an administrative action or a peer review action taken against a practitioner. Actions included imposition of a corrective action plan (CAP) or reduction, suspension, or termination of the practitioner's network participation. The Credentials Committee meeting minutes provided evidence that the committee pended or denied credentialing to providers who did not meet the credentialing criteria for quality reasons.		
Required Actions: None.		
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR10—Element A2 and B	**Documentation Submitted:** • CR213-Adverse Actions and Hearing and Appeals Process for Providers, Section IV (pg 7-8) **Process Description:** Colorado Access policy CR213 specifies the procedures to be followed when Colorado Access takes an action against a practitioner for quality reasons (Section IV, pgs 7-8).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Adverse Actions policy described Colorado Access' processes for reporting adverse actions to the appropriate agency, including the applicable State licensing board, the National Practitioners Data Bank (NPDB), and the Healthcare Integrity and Protection Data Bank (HIPDB), as applicable. Colorado Access staff stated that medical director approval is obtained prior to notification of authorities.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Required Actions: None.		
2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR10—Element A3and C	**Documentation Submitted:** • CR213-Adverse Actions and Hearing and Appeals Process for Providers, Section II (pg 5) and Attachment C (pgs 10-16) • Provider Manual (pg 61) **Process Description:** CR213 Section I.A states, "For actions involving quality of care, professional competence and/or conduct, the Provider will be notified by certified mail within five (5) business days of the decision set forth in Section II below. (p5)" CR213 Section II.C describes the minimum contents of the written notice (5-6). CR213 Section II.C indicates as part of the written notification that a practitioner can request a hearing within 30 days of written notice. CR213 Section II.E states that practitioner has 30 days to request a hearing (p6). CR213 Attachment D states that practitioner can be represented by an attorney or any person of the practitioner's choice (p30). CR213 Attachment A III.F&G describe how a hearing panel and hearing officer are appointed (p13). CR213 Section III.D states; "The Appeal Panel may render its decision orally at the close of the Appeal Hearing. Within thirty	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	(30) calendar days after rendering an oral decision, or within thirty (30) calendar days after the close of the Appeal Hearing if no oral decision has been rendered, the Appeal Hearing Panel shall issue a decision which shall be accompanied by a written report that contains findings of fact and conclusions that articulate the connection between the evidence produced at the Appeal Hearing and the decision rendered. The written decision and report shall be delivered to Colorado Access and the Provider within ten (10) business days."	
Findings: The Adverse Actions policy described the practitioner appeal and hearing processes. Practitioners were notified of the appeal and hearing process in the provider manual.		
Required Actions: None.		
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	**Documentation Submitted:** • CR213-Adverse Actions and Hearing and Appeals Process for Providers, Attachment A (pg 11) • Provider Manual, Section XI (pg 62) **Process Description:** Practitioners are notified of the appeal process in the Practitioner Termination for Professional Review Action letter (CR213, Attachment A p11). Practitioners are also made aware of the credentialing appeal process within the Provider Manual (pg 62)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Adverse Actions policy included a template letter that informed practitioners of the actions Colorado Access took, the reasons for the actions, and the practitioner's right to request a hearing.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section IX (pgs 7-8) • Credentialing Committee Roster 2012 **Process Description:** Colorado Access policy CR301 designates the existence of a credentialing committee (Section IX, pgs 7-8). This committee consists of participating network providers from all Colorado Access lines of business. The credentialing committee roster is included.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy described the Colorado Access Credentials Committee and its responsibilities. The Credentials Committee roster listed the committee's membership, which consisted of a range of practicing physicians including a psychologist and medical doctors from several disciplines.		
Required Actions: None.		
4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds. ◆ Medical director or equally qualified individual review and approval of clean files. NCQA CR2—Element B	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section IX (pgs 7-8) • CR307-Credentialing and Recredentialing Provider Review Classification, Section I.B.1- 2 (pg 3) **Process Description:** Colorado Access policy CR301 stipulates that the credentialing committee will review, at a minimum, the status of practitioners who do not meet established credentialing criteria (Section IX, pg 7). Colorado Access policy CR307 specifies the process for reviewing practitioners who do not meet minimum standards and for review and approval of files by the Medical Director (Section I.B.1-2, pgs 2-3).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Practitioner Review Classification policy described the criteria for applicants who met the criteria for clean files that may be reviewed by the chief medical officer, and for those files that must be reviewed by the committee. The Credentials Committee meeting minutes provided evidence that the Credentials Committee reviewed all files that did not cleanly meet the credentialing criteria.		
Required Actions: None.		
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR3—Elements A and B	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section VIII (pgs 6-7) and XIV (pgs 10-15) **Process Description:** Colorado Access policy CR301 outlines the use of primary source verification and the deadlines for this verification to occur (Sections VIII, pgs 6-7 and XIV, pgs 9-13).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Practitioner Credentialing and Recredentialing policy described the processes for primary source verification and for the time limits for verifying each element at the primary sources, all of which were NCQA-compliant.		
Required Actions: None.		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil). ◆ The correctness and completeness of the application. NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section X (pgs 8-9) • Colorado Health Care Professional Credentials Application (pgs 19-21, 24-26) **Process Description:** Colorado Access policy CR301 requires that all credentialing and recredentialing applications must include a current and signed attestation that includes the bullets listed to the left (Section X, pg 9). The CO Health Care Professional Credentials Application requires practitioners to attest to these requirements (pgs 19-21, 24-26).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy stated that Colorado Access requires all practitioners to complete the Colorado Health Care Professional Credentials Application. The application included each of the required attestations. On-site review of 10 credentialing and 10 recredentialing files provided evidence that each file contained a completed and signed application and attestation from the provider.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR5—Element A NCQA CR7—Element D	**Documentation Submitted:** • CR301-Practitioner Credentialing and Recredentialing, Section XI (pg 9), XIV.A (pg 10), XV.H (pg 14) **Process Description:** Colorado Access policy CR301 requires that Colorado Access receive information on practitioner sanction before making a credentialing decision. This includes State and CMS sanctions. See specific sections noted above.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing policy stated that in support of credentialing or recredentialing applications, State licensure sanctions and Medicare/Medicare sanctions are researched using the required databases. On-site review of credentialing and recredentialing files confirmed review for sanctions at credentialing and recredentialing.		
Required Actions: None.		
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR6—Element A	**Documentation Submitted:** • CR301-Provider Credentialing and Recredentialing, Section VIII (pg 7), XV.I (pg 15) • CR302-Office Site Visit for Providers Credentialing, All • Provider Manual (pg 61) **Process Description:** Colorado Access policy CR301specifies that a site visit will occur if a complaint is received related to the physical accessibility, appearance, or adequacy of waiting room or examining room space. If a site visit is required, Colorado Access policy CR302 outlines the process for practitioner site visits. Section II.A outlines what items will be assessed in a site visit (p2-3).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	Practitioner site review guidelines are also noted in the Provider Manual (pg 61).	
Findings: The Office Site Visit for Provider Credentialing policy delineated Colorado Access' criteria for office site visits. The policy stated that an office site assessment will assess physical appearance, physical accessibility, appointment availability, and the adequacy of waiting room and exam/treatment room space. The policy also stated that the office site visit included assessment of medical record-keeping practices, including practices for confidentiality, file organization, and documentation. The site visit form, attached to the policy, included the specific requirements for each standard, which included a review for all of the NCQA standards. Providers were informed of the site review standards via the provider manual. During the on-site interview, ABC staff members reported that there had been no site visits based on office site quality during the review period.		
Required Actions: None.		
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Monitoring member complaints for all practitioner sites at least every six months. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B	**Documentation Submitted:** • CR302-Office Site Visit for Provider Credentialing, All **Process Description:** Colorado Access policy CR302 outlines the process for practitioners site visits based on a member complaint. CR302 Section I describes how Colorado Access will conduct site visits when member complaints are received (p2). CR302 Section V.A&B describes actions that will be taken to improve offices that do not meet thresholds (p3). Section V.A also indicates that follow up site visits will occur every six months until the office meets the threshold (p3). Section VI describes how follow up visits are documented (p3).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Office Site Visit for Practitioner Credentialing policy included the process for determining office sites that require an office site visit. The policy contained the provision that two or more complaints or one Level 3 complaint (safety issue as defined by the Occupational Safety and Health Administration [OSHA]) in a 12-month period would trigger a site visit. The Colorado Access thresholds for what triggers a site visit were compliant with NCQA guidelines. The Office Site Visit for Practitioner Credentialing policy also stated that if an office did not meet Colorado Access' threshold for acceptability, a CAP would be developed and a follow-up site visit would be scheduled every six months until the performance standards were met. The Colorado Access Investigation of Potential Clinical and Quality of Care (QOC) Grievances and Referrals policy described Colorado Access' process for referring Level 3 complaints to the Credentials Committee for review and follow-up. The policy also stated that if the circumstances of the QOC incident precluded waiting for the next scheduled Credentials Committee meeting, the quality management department would notify the appropriate Colorado Access medical director or physician designee for immediate action. The policy also described the actions Colorado Access would take for a Level 3 incident (most serious), which included requesting a CAP from the involved provider or practitioner or termination of the provider.		
Required Actions: None.		
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit = 180 calendar days). NCQA CR7—Elements A and B NCQA CR8— Element A	**Documents Submitted/Location Within Documents:** • CR301-Provider Credentialing and Recredentialing, Section IX (pg 8) Section VIII (pgs 6), Section XIV (pgs 11) • Provider Manual (pg 28) **Process Description:** Colorado Access policy CR301 specifies that practitioners are recredentialed at least every 36 months (Section IX, pg 8). This policy also outlines the information the recredentialing process must include (Section VIII, pgs 6 and XIV, pg 11).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Practitioner Credentialing and Recredentialing policy stated that practitioners were recredentialed every 36 months and described the verification criteria required for recredentialing, which met NCQA requirements. Providers were informed in the provider manual that recredentialing occurred every three years. The recredentialing files reviewed on-site provided evidence that the above information was validated at the primary source, and that recredentialing occurred every three years.		
Required Actions: None.		
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies. NCQA CR11—Element A1	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4) • Credentials Committee Roster 2012 **Process Description:** Colorado Access policy CR305 outlines the process for the initial and ongoing assessment of organizational providers. The Organizational Provider Credentialing meets monthly and is staffed by Colorado Access clinical staff (see Credentialing Committee Roster 2012). Minutes will be available for review during the site visit. CR305 specifies that Colorado Access will ensure all organizational providers are in good standing with State and Federal regulatory bodies (Section IV, pg 4-5).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Credentialing policy included the procedures for assessment of organizational providers with which ABC contracts. The procedures included the process for obtaining applicable State licenses or certifications, and evidence of eligibility to participate in federal health care programs, as evidenced by the federal OIG database query. Review of five organizational provider records on-site demonstrated that ABC followed its procedures regarding assessment of organizational provider files.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4), Section V (Pgs 7) • Provider Manual (pgs 28-29) **Process Description:** Colorado Access policy CR305 specifies that Colorado Access confirms that each organizational provider has been reviewed and approved by an accrediting body (Section IV and V, pgs 4-9).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Credentialing policy included the process for obtaining a copy of any applicable accreditation certificates when contracting with and assessing organizational providers. The on-site review of organizational provider files provided evidence that the BHO collected accreditation information and certificates from organizational providers that were accredited.		
Required Actions: None.		
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status. NCQA CR11—Element A3	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section VII.E (pg 12) **Process Description:** Colorado Access policy CR305 specifies that Colorado Access will conduct an on-site assessment is the organization does not have accreditation status (Section VII.E, pg 12).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Credentialing policy stated that nonaccredited facilities were subject to an on-site assessment by Colorado Access. Colorado Access provided an on-site assessment form for use for non-accredited facilities not surveyed by the Division of Behavioral Health (DBH) or Colorado Department of Public Health and Environment (CDPHE).		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section II (pg 3), and VII.D (pg 11) **Process Description:** Colorado Access policy CR305 states, "Colorado Access conducts a pre-contractual assessment and re-assessment at least every three years. Reassessment includes confirmation that the organizational provider remains in good standing with State and Federal regulatory bodies. If not approved by an accrediting body, provisions for site review follow the same initial assessment procedures at reassessment (Section VII.D, pgs 11).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Credentialing policy contained the procedures for reassessing organizational providers every three years, which included verifying that the provider was in good standing with State and federal regulatory agencies and whether the provider was accredited, and performing site visits for organizations not accredited. On-site review of five organizational provider files demonstrated that providers were reassessed every three years.		
Required Actions: None.		
11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.) NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4), V (pgs 6), and VII. E (pg10) **Process Description:** • Colorado Access policy CR305 (Section IV) specifies the Criteria and Verification Requirements used to evaluate organizational providers during initial credentialing and recredentialing and the verification requirements associated with each follow.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	• In the case of non-accredited organizational provider(s), Colorado Access will utilize the CMS site survey conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Alcohol and Drug Abuse Division (ADAD) Site Inspection in lieu conducting a site visit. Colorado Access requires each organizational provider be accredited by one of the accreditation bodies listed in the CR 305 policy, Sct V. In lieu of accreditation, Colorado Access will accept the CMS site survey conducted by CDHPE, the DMH site review or the DBH Site Inspection Report, as applicable. If the organizational provider is not accredited by an entity recognized by Colorado Access or not subject to site reviews conducted by CMS, DMH or DBH, Colorado Access will perform a site visit.	
Findings: The Organizational Provider Credentialing policy listed numerous appropriate accrediting bodies ABC would accept. On-site review of organizational provider records included two facilities accredited by The Joint Commission.		
Required Actions: None.		
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4), V (pgs 7), and VII. E (pg 12) **Process Description:** Colorado Access policy CR305 specifies the selection process and assessment criteria for each type of nonaccredited organizational provider. • In the case of non-accredited organizational provider(s), Colorado Access will utilize the CMS site survey	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	conducted by the Colorado Department of Public Health and Environment (CDHPE), the DMH site review conducted on behalf of the Department of Human Services (DHS) or the Division of Behavioral Health (DBH) Site Inspection in lieu conducting a site visit. • If the organizational provider has not undergone a site visit by one of the above, Colorado Access will perform a site visit.	
Findings: The Facility Site Assessment form included a review of appointment availability, credentialing/recredentialing policies and practices, various aspects of clinical operations, safety policies and practices, office/site appearance, treatment record-keeping practices, confidentiality procedures, and medication safety practices. ABC had a specific form for each type of organizational provider.		
Required Actions: None.		
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section VII E (pg 12) **Process Description:** Colorado Access policy CR305 organizational site review survey procedures confirm that nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Organizational Provider Assessment policy stated that the site visit for nonaccredited facilities included a review of staff hiring and credentialing processes. Review of organizational provider files on-site demonstrated that ABC followed its policies for ensuring that nonaccredited facilities credential their practitioners.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section IV (pgs 4), V (pgs 7), and VII. E (pg 12) **Process Description:** Colorado Access policy CR305 outlines the requirements and terms for substituting a CMS or state review for the required site visit. The policy explains that if the organizational provider is not accredited or is accredited by an entity not recognized by Colorado Access, receipt of a copy of the report (survey), letter sent to the organizational provider from CMS, DMH or DBH that shows that the facility was reviewed and passed inspection.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of organizational provider files demonstrated that ABC obtained DBH and CDPHE survey reports for nonaccredited facilities surveyed by these State departments. Review of Credentials Committee meeting minutes demonstrated that the committee reviewed the applicable State survey during the organization's reassessment/recredentialing process.		
Required Actions: None.		
15. The Contractor's organizational provider assessment policies and process includes assessment of at least: ◆ Inpatient facilities. ◆ Residential facilities. ◆ Ambulatory facilities. NCQA CR11—Element B	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section I. A, B, C (pgs 2-3) **Process Description:** Per policy CR305 Colorado Access will conduct a pre-contractual credentialing of Physical and Behavioral health organizational providers for all lines of business. A full list is outlined in policy CR 305.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Organizational Provider Assessment policy stated that Colorado Access' organizational providers may include community mental health centers (CMHCs), hospitals, residential treatment facilities, rehabilitation facilities, and other types of facilities. The provider directory provided evidence that ABC contracted with inpatient facilities, residential treatment facilities, and ambulatory facilities. On-site record review included files for a hospital, a residential treatment center, an alcohol and drug rehabilitation facility, and two CMHCs.		
Required Actions: None.		
16. The Contractor has documentation that it has assessed contracted behavioral health care (organizational) providers. NCQA CR11—Element C	**Documents Submitted/Location Within Documents:** • CR305-Organizational Provider Credentialing, Section I. B (pg 2) **Process Description:** Colorado Access policy CR 305 outlines the list of medical and behavioral health providers for which pre-contractual credentialing will be performed on, for all lines of business. A full list is outlined in policy CR 305.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of organization-specific files demonstrated that ABC documented assessment and reassessment activities for organizational providers with which it contracts.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR12	**Documents Submitted/Location Within Documents:** • ADM223-Delegation, All • Executive Summaries for: (located in the Executive Summary and Audit Results uploaded folder) o Boulder Valley IPA o Denver Health and Hospital Authority o University Physician Inc o Northern Colorado IPA o National Jewish Health **Process Description:** Per policy ADM 223, Colorado Access will establish and maintain a pre-Delegation assessment process for Contractors with which Colorado Access desires Delegation and a process to accomplish Delegation oversight of Contractors awarded Delegation.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Delegation policy described ongoing monitoring and annual audit processes for oversight of delegates. ABC provided audit reports for each delegate that demonstrated that ABC conducted an on-site annual audit for each credentialing delegate. The Centura Health Audit was a predelegation audit completed in July 2012, and all others were annual audits, also completed within 2012. On-site review of Credentials Committee meeting minutes demonstrated that the committee reviewed periodic reports of credentialing activities from each delegate.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
18. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A	**Documents Submitted/Location Within Documents:** • Delegation Agreements for: (located in the Delegation Agreements uploaded folder) o Boulder Valley IPA o Denver Health and Hospital Authority o University Physicians Inc o Northern Colorado IPA o National Jewish Health o Centura Health • Delegation Agreement template (located in the Delegation Agreements uploaded folder) **Process Description:** • Each credentialing delegation agreement: o Is mutually agreed upon o Describes the responsibilities of the Contractor and the delegated entity o Describes the delegated activities o Requires at least semiannual reporting to the Contractor o Describes the process by which the Contractor evaluates the delegated entity's performance o Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: ABC provided signed Credentialing Delegation Agreements with the Northern Colorado Individual Practice Association (IPA), Centura Health, Denver Health and Hospital Authority, University Physicians Incorporated, Boulder Valley IPA, and National Jewish Health. The delegation agreements described delegated activities and responsibilities for both parties, and reporting requirements. The agreements also specified how Colorado Access will monitor the delegate's performance of credentialing activities. The agreement specified several reports required monthly or annually, as appropriate. The agreement also provided for remedies if the delegate's performance is not adequate.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Required Actions: None.		
19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B	**Documents Submitted/Location Within Documents:** • ADM223-Delegation, Section I.L (pg 4) • HIP203 Business Associate Agreement **Process Description:** Each Business Associate agreement includes: • Includes a list of allowed uses of PHI • Includes a description of delegate safeguards to protect the information (PHI) from inappropriate uses • Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards • Includes a stipulation that the delegate will provide individuals with access to their PHI • Includes a stipulation that the delegate will inform the Contractor if inappropriate use of the information (PHI) occur • Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Business Associate Agreement included the required HIPAA-compliant provisions. During the on-site interview, ABC staff confirmed that Colorado Access had a Business Associate Agreement with each delegate.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
20. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR12—Element C	**Documents Submitted/Location Within Documents:** • Delegation Agreement Template, Section B.2 (pg 4) • Delegation Agreements – located in the Delegation Agreements uploaded folder **Process Description:** The delegation agreement Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Each of the delegation agreements included the provision that Colorado Access retains the right to approve, suspend, and terminate individual practitioners and providers. During the on-site interview, staff members confirmed that ongoing monitoring for sanctions includes practitioners credentialed by delegates. In addition, the Credentials Committee reviewed credentialing reports by delegates. If sanctions or other concerns are discovered, the process would be to alert the delegate and begin appropriate ABC committee review procedures to determine the appropriate action.		
Required Actions: None.		
21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR12—Element D	**Documents Submitted/Location Within Documents:** • 2012 Centura Health Physician Group Pre-Delegation Documents **Process Description:** Colorado Access evaluated the delegate capacity, as identified in the uploaded pre-delegation documents, prior to signing the contract with Centura Health Physician Group.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: ABC provided the completed Pre-Delegation Audit report for Centura Health Group, completed in July 2012, and the delegation agreement signed in October 2012.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
22. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR12—Element E	**Documents Submitted/Location Within Documents:** • 2012 Boulder Valley IPA Audit Results • 2012 Denver Health and Hospital Authority Audit Results • 2012 University Physician Inc. Audit Results • 2012 Northern Colorado IPA Audit Results • 2012 National Jewish Health Audit Results **Process Description:** Colorado Access has performed an audit for each of above listed facilities, whose delegation agreements have been in the effect longer than 12 months. The audit results for each have been uploaded to the Executive Summary and Audit Results folder.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Audit reports submitted for each delegate demonstrated that Colorado Access' audit included a file review for compliance with NCQA standards.		
Required Actions: None.		
23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	**Documents Submitted/Location Within Documents:** • 2012 Boulder Valley IPA Audit Results • 2012 Denver Health and Hospital Authority Audit Results • 2012 University Physician Inc. Audit Results • 2012 Northern Colorado IPA Audit Results • 2012 National Jewish Health Audit Results **Process Description:** Colorado Access has performed an audit for each of above listed facilities, whose delegation agreements have been in the effect longer than 12 months. The annual evaluation performs a comparison of NCQA standards against those of Colorado	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Access. The audit results for each have been uploaded to the Executive Summary and Audit Results folder.	
Findings: Audit reports submitted for each delegate demonstrated that Colorado Access conducted a review of policies and procedures and reviewed for compliance with NCQA standards.		
Required Actions: None.		
24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR12—Element G	**Documents Submitted/Location Within Documents:** • Boulder Valley IPA • Denver Health and Hospital Authority • University Physician Inc • Northern Colorado IPA • National Jewish Health **Process Description:** Colorado Access Credentialing staff receives monthly report from each organization delegated credentialing. These reports can be produced during the site visit if requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Review of Credentials Committee meeting minutes demonstrated that ABC reviewed periodic reports of credentialing activities performed by each delegate. The frequency of reports varied based on the volume of credentialing activity, but all reports were produced at least semiannually.		
Required Actions: None.		
25. The Contractor identifies and follows up on opportunities for improvement, if applicable. NCQA CR12—Element H	**Documents Submitted/Location Within Documents:** • 2012 Boulder Valley IPA Audit Results • 2012 Denver Health and Hospital Authority Audit Results • 2012 University Physician Inc. Audit Results • 2012 Northern Colorado IPA Audit Results • 2012 National Jewish Health Audit Results	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Process Description: Colorado Access performs annual audits, per the audit results explanation any opportunities for improvement are identified and documented in the Recommendations for Improvement section as well as followed up on if applicable. Per the pre-delegation audit for Centura Health, the delegation recommendation was for Colorado Access to perform a 6-month delegation audit in order to assure the action plans listed in the audit results were implemented.	
Findings: The Centura pre-delegation audit report demonstrated that Colorado Access identified opportunities for improvement, and recommended corrective actions. Colorado Access accepted Centura for a six-month provisional period pending completion of corrective actions.		
Required Actions: None.		

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	48	X	1.00	=	48
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	49	**Total Score**		=	48

Total Score ÷ Total Applicable	=	98%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42CFR438.240(a)* Contract: II.H.1	**Documentation:** • CY12 COA QAPI Program Description • FY13 ABC Work Plan • FY12 ABC QAPI Annual Evaluation • CY12 MBQIC Agendas and Minutes • CY12 QIC Agenda and Minutes **Process Description:** The QAPI Program is described in the 2012 Colorado Access QAPI Program Description. The Annual ABC Work Plan outlines the QAPI Program deliverables. The Annual ABC QAPI Evaluation summarizes the QAPI activities completed each year. The key quality committees are the MBQIC and QIC that monitor quality program activities. (Minutes and agendas are available for review) The MBQIC, QIC and Board of Directors (BOD) annually approve the QAPI Program Description and Annual Evaluation.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Colorado Access Quality Improvement (QI) Program Description (applicable to all lines of business) defined the objectives and the organizational structure for the QI program. The Board of Directors has ultimate accountability for the program and delegates responsibility for oversight of the program to the corporate-wide Quality Improvement Committee (QIC). The Medical/Behavioral Quality Improvement Committee (MBQIC) is a provider subcommittee of the QIC responsible for recommending strategies to monitor and improve the clinical quality of health care delivered to members. The description stated that results of activities and measures are analyzed and addressed through the implementation of action plans to improve or correct identified problems. Program components included analysis of accessibility, provider availability, clinical practice guidelines, care management, Healthcare Effectiveness Data and Information Set (HEDIS) clinical performance measures, member satisfaction, performance improvement projects (PIPs), grievances and appeals, utilization management, medication utilization, member education, and medical record documentation. The description identified the behavioral health quality program manager as being responsible for ABC QAPI operations. The QI Program Description is updated and approved annually.

The ABC QI Work Plan documented the QI activities, metrics, and measurable goals (including benchmarks) for the year. ABC uses results of the annual evaluation of quality activities and ongoing performance objectives to revise the work plan annually. The ABC QAPI Annual Evaluation reviews

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
the achievement of program goals and objectives, the effectiveness of clinical and service quality initiatives, and performance outcomes for the year. The report included summary data findings, analysis of results, strategies and goals, and actions taken within each of the major focus areas of the QI program. Both the QIC meeting minutes and MBQIC meeting minutes documented review and approval of the Colorado Access QAPI program description, the ABC QAPI Annual Evaluation report, and the subsequent year's ABC QI Work Plan. Meeting minutes included detailed discussions and recommendations related to the outcomes of QI activities. During the on-site interview, staff stated that the review of detailed quality monitoring data was routinely performed by a number of management groups prior to reporting the outcomes to the MBQIC and QIC committees. Staff stated that these reviews are inherent to business operations and, as such, are not formally documented. HSAG recommended that ABC consider increasing the formality of the reviews and documentation of pertinent findings to substantiate the performance of ongoing monitoring of QI data.		
Required Actions: None.		
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: II.H.2.n	**Documentation:** • 2012 COA QAPI Program Description (p 13, 18) • FY13 ABC Work Plan (p 5) • FY12 ABC QAPI Annual Evaluation (p 4-5, 33-36) • 2012-2013 UM Program Description • ABC Dashboard Updated 2012 (Medical Trends) • 2012 ABC Average Daily Census Trending Graphs • Provider Manual (p 58-59) • FY13 Access to Care Plan (p 7-13) • CCS307-Utilization Review Determinations • CCS302-Medical Criteria for Utilization Review **Process Description:** The QAPI Program Description and the UM Program Description outline the philosophy of Colorado Access and ABC toward the monitoring of both the underutilization and overutilization of services. The QAPI program monitors utilization such as ER, inpatient and follow-up after inpatient care, at least annually, through	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	the QAPI program evaluation. Monthly and quarterly reports are reviewed by key stakeholders in the interim, and interventions are implemented as needed. Colorado Access views each member's utilization of services as an entire continuum of care. The overutilization of one level of service may be symptomatic of the underutilization of another level of service. Colorado Access endeavors to regularly monitor utilization of all levels of service and to analyze each of these components to identify opportunities for intervention at the both the member and provider level. Relevant UM policies include CCS307-Utilization Review Determinations and CCS302-Medical Criteria for Utilization Review. Provider responsibilities in regard to monitoring of service utilization are addressed in the ABC Provider Manual. The over utilization of services is primarily addressed through the prior authorization process. Providers must demonstrate ongoing medical necessity to receive an authorization for services. The appropriate medical information is submitted and reviewed by a Clinical Service Coordinator. The process is detailed in the policies referenced above. An example of this review process, along with the associated documentation can be provided during the on-site review.	
Findings: The QI Program Description and Utilization Management (UM) Program Description stated that potential over- and underutilization is managed through the UM Program, as well as the case management and disease management programs. ABC monitors utilization through trending reports (e.g., length of stay, inpatient days, ER visits, readmissions) and HEDIS measures (underutilization). The QI Annual Evaluation report included measures and analysis of utilization trends, and the QI work plan included performance goals related to specific utilization measures.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to all members. *42CFR438.240(b)(4)* Contract: II.H.2.m.6	**Documentation:** • 2012 COA QAPI Program Description (p 10-13) • FY13 ABC Work Plan • FY12 ABC QAPI Annual Evaluation (p 16-18, 20-21, 29-31) • 2012-2013 UM Program Description • Provider Bulletin August 2012: Coordination of care between providers for those with special needs • Provider Manual (Updated 9/2011), Special Populations (p 35), Special Population Standards (p74), and Quality Management (p 58-59) • ADM205-Nondiscrimination • ADM206-Culturally Sensitive Services for Diverse Populations • ADM207- Effective Communication with Limited English Proficient Persons and Sensory-Impaired/Speech-Impaired Persons • ABC Partnership Newsletters Q1 2012 - Peer Specialist Services information; Q2 2012 - Substance Abuse Services **Process Description:** ABC has various mechanisms for assessing the quality and appropriateness of care furnished to all members including those with special needs, as outlined in the QAPI Program Description and the ABC Work Plan. Results for all measures are reported in the ABC Annual QAPI Evaluation. The various communication mechanisms for both members and providers emphasize the importance of providing care and accessing care for those with special needs. The CFAB and OMFA structure provides another mechanism for consumers with special health care needs to have feedback mechanisms into the QI Program.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Colorado Access policies address services for Members with limited English proficiency or who are sensory or speech impaired (ADM207). Policy ADM206 addresses the delivery of culturally sensitive services for diverse populations. The purpose of policy ADM205 is to ensure that discrimination does not impair the ability of members to receive services. In April 2012, Julie Reiskin, Executive Director for the Colorado Cross Disability Coalition, conducted training for all Colorado Access employees. Training handouts are available to all COA staff on the intranet.	
Findings: The Colorado Access QI Program Description, the ABC QI Annual Evaluation, and the ABC QI Work Plan described numerous mechanisms for assessing the quality and appropriateness of care, including utilization management processes and use of clinical practice guidelines, trended performance (such as HEDIS), member satisfaction surveys, review of grievance and appeal data, review of quality of care concerns (QOCCs), clinical outcomes reporting, and PIPs. The provider manual informed providers that they are required to participate in the QI program, including providing medical records to ABC upon request and reporting claims and other specified data. The MBQIC and QIC regularly reviewed data and made recommendations for improvements designed to impact the quality and appropriateness of care and services.		
Required Actions: None.		
4. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual quality report describes: ◆ The Contractor's performance on the standard measures on which it is required to report. ◆ The results of each performance improvement project. ◆ The techniques used by the Contractor to improve its performance, effectiveness, and quality outcomes. ◆ Qualitative and quantitative impact the techniques had on quality.	**Documentation:** • 2012 COA QAPI Program Description, Section V.A (p 10-13) • FY13 ABC Work Plan (p 2-5, 12) • FY12 ABC QAPI Annual Evaluation (p 4-5, 11, 26-28, 32-37) • ABC PIP Coordination of Care – Behavioral/Medical • ABC PIP Coordination of Care - Psych ER and MH • FY2010-2011 Validation of PM • ABC Final Draft BHO 22 PM FY2011-2012	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ The overall impact and effectiveness of the quality assessment and improvement program. ◆ How past quality assessment and performance improvement activities will be used to target improvement for the next year. ◆ A description and organizational chart for each quality committee. *42CFR438.240(e)(2)* Contract: II.H.2.s.1 Exhibit R3	**Process Description:** The QAPI Program Description and Work Plan describe the scope specific activities monitored throughout the year including QI activities, metrics, goals, and reporting timeframes. The QAPI Program Description also describes the techniques used to improve performance. It contains an organizational chart for the various quality committees and describes the responsibilities of each committee. ABC has a process in place for evaluating the impact and effectiveness of the QAPI Program at least annually. The annual QAPI Evaluation includes a detailed description of the findings and an analysis of overall impact and effectiveness. It details activities targeted for improvement in the next fiscal year based on outcomes reported from the previous year. The QAPI Program Description describes the process by which the evaluation will be reviewed by the various committees including the cross functional QIC and external (member and provider) input from the MBQIC. The QAPI Program Description outlines how performance improvement projects and measurement are key components of the QAPI Program. The FY13 ABC Work Plan outlines specific performance measures, and it references identification of new performance improvement projects (PIPs) for the upcoming year. ABC recently retired two PIPs. The most recent submissions for each of the two PIPs are attached, as well as the most recent submission of the DRAFT BHO performance measures. The annual evaluation summarizes progress on both performance improvement projects and annual measures.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The ABC QAPI Annual Evaluation Report included a summary of the overall impact of the QI program, as documented through key performance indicators, a summary of key accomplishments for the year, and a summary of goals for the subsequent year. The report also detailed the data findings, analysis, and strategies for the coming year related to each of the major QI focus areas; and it incorporated results of PIPs, qualitative and quantitative information, and discussion of performance improvement techniques. The report discussed the role of the MBQIC in the oversight of QI performance throughout the year. The Colorado Access QAPI Program Description included the composition and organizational chart of Colorado Access QI Committees. The ABC QI Work Plan included the targeted improvement goals identified in the annual evaluation report from the previous year. The MBQIC and QIC meeting minutes documented review and analysis of the ABC QI Annual Evaluation report with discussion of findings.		
Required Actions: None.		
5. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated periodically as appropriate. *42CFR438.236(b)* Contract: II.H.2.h	**Documentation:** • 2012 COA QAPI Program Description (p 12) • FY13 ABC Work Plan (p 4) • FY12 ABC QAPI Annual Evaluation (p 28-29) • CY12 MBQIC Minutes: 11/06/12 and 3/01/11 • Guideline Track 2012-2013 • ADHD Guideline • Depression Guideline • Bipolar Treatment Guideline • Metabolic Monitoring Guideline • QM311 Clinical Practice Guidelines- p 2 I **Process Description:** QM311 outlines the Colorado Access Clinical Practice Guideline Policy and Procedure. Development of guidelines is based on reliable clinical evidence and consideration of member needs. This is also discussed in the QAPI Program Description and ABC QAPI Annual Evaluation. Guidelines are developed and approved by MBQIC which includes contracted health care professionals. Guidelines are updated and reviewed through the committee, as noted in the ABC Work Plan and MBQIC minutes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Clinical Practice Guidelines policy stated that Colorado Access would adopt clinical practice guidelines (CPGs) that meet all of the criteria outlined in the requirement. The ABC annual evaluation report and MBQIC meeting minutes documented review and adoption of the behavioral health guidelines. The ABC Provider Manual described the clinical guidelines development process and informed providers of the specific behavioral health guidelines that have been adopted. The manual informed providers that ABC requires that treatment fall within the generally accepted treatment standards as defined in published CPGs. During the on-site interview, staff stated that many of the ABC guidelines originated from HealthTeamWorks, which publishes guidelines based on nationally recognized standards. An ABC provider subcommittee reviews the proposed guidelines prior to approval by the MBQIC. Staff stated that ABC adopts CPGs primarily for reference by providers in the delivery of care to members.		
Required Actions: None.		
6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. *42CFR438.236(c)* Contract: II.H.2.h.2	**Documentation:** • 2012 COA QAPI Program Description p (p 10-11) • FY13 ABC Work Plan (p 4) • FY12 ABC QAPI Annual Evaluation p (p 28-29) • MBQIC Minutes: 11/06/12 and 3/01/11 • ABC Provider Bulletin June 2012Guidelines • Provider Manual (p 20) • ABC website: member- o www.coaccess.com/health-and-wellness • ABC website: Provider- o www.coaccess.com/practice-guidelines • QM311 Clinical Practice Guidelines- p 3 V **Process Description:** ABC disseminates guideline availability to providers through the provider bulletin, MBQIC committee, and posting of guidelines on the COA website. Guidelines are available upon request to any	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	interested person including providers, members or potential members. Communication of availability is noted on the member website. This information is available at no cost.	
Findings: The Clinical Practice Guidelines policy stated that guidelines were disseminated to providers through the Colorado Access Web site, to members upon request, and to the public at no cost. The Preventive Health Services policy stated that Colorado Access develops and maintains preventive services guidelines based on nationally accepted standards and that guidelines are available to providers and members at no cost. The ABC Provider Manual informed providers of the specific CPGs adopted by ABC, provided the Web site address to access the CPGs, and stated that providers would be notified of new CPGs through the ABC Provider Bulletin. Although a list of CPGs was available on the ABC member Web site, the CPGs were not easily identified; and it took navigating through several links to obtain them. During the on-site interview, ABC staff acknowledged that accessing CPGs on the member Web site was not easy, and that the ABC Member Handbook did not address CPGs. HSAG recommended that ABC clarify the availability of CPGs on the member Web site and develop a mechanism to inform members of the availability of CPGs and how to access them.		
Required Actions: None.		
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: II.H.2.h.3	**Documentation:** • 2012 COA QAPI Program Description (p 10-11) • 2012-2013 UM Program Description • Provider Manual (p 33-38). Also see the following sections: *Summary of Provider Responsibilities (p 14) *Authorizations (p 33) *QM Provider Responsibilities (p 59) • ABC Member Handbook, Criteria (Guidelines) for Services (p 5-6) • QM311 Clinical Practice Guidelines-p 3 VI • QM308 Preventive Health Services-p 2-3 I.C and V • CCS307 Utilization Review Determinations • CCS 302 Medical Criteria for Utilization Review p 3 I A **Process Description:** QM 311 and 308 outline that decisions for UM and coverage of services are consistent with practice guidelines. CCS 302 and CCS	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	307 describes the process for utilization management and coverage of services. The MBQIC reviews and approves UM criteria which is discussed in the UM Program Description. UM criteria (currently Interqual copyrighted by McKesson Health Solutions) are based on standardized national guidelines for care and UM.	
Findings: The Clinical Practice Guidelines policy stated that Colorado Access will ensure that decisions regarding utilization management, member education, covered services, and other areas to which the CPGs apply are consistent with adopted CPGs. ABC submitted policies that confirmed UM decisions are based on InterQual guidelines. During the on-site interview, staff stated that CPGs are used to educate providers and as a reference for case management decisions. CPGs also provide the basis for member education regarding disease management. Staff stated that QI staff, the medical director, and line of business managers review CPGs to ensure consistency with other operational decisions, and submit recommendations to the MBQIC during the annual guideline approval process. Staff stated that InterQual utilization management guidelines are based on information from nationally recognized sources as were the CPGs.		
Required Actions: None.		
8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: II.H.2.q.2	**Documentation:** • 2012 COA QAPI Program Description (p 10) • FY12 ABC Annual QAPI Evaluation (p 21-25) • FY13, Q1 Appeals Report • FY13, Q1 Grievance Report • 2012 ABC Average Daily Census Trending Graphs • Monthly Membership Summary November 2012 • ISCAT – CO BHO CY11-12 • IT data flow **Process Description:** ABC has a robust information system that collects and integrates data in the data warehouse and various other systems. (See IT data flow) IT and the Decision Support Departments can report and analyze data, as needed, to support the administration of the program as	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	demonstrated in the Annual QAPI evaluation and other reports referenced in this section. The ISCAT and audit process provide further detail on the IS capabilities of ABC. In addition, Coordinated Clinical Services, Appeals and Grievances, and Customer Service Departments document in the Altruista Guiding Care tool. This is a member centric tool that allows users to document review determinations, care management activities, customer service calls, and appeal activity and provides reporting capability and data analysis.	
Findings: The IT Data Flow diagram provided an overview of multiple source systems for collecting and processing data related to claims from multiple external providers (e.g., laboratory, pharmacy), eligibility, customer services, credentialing, case management, and authorizations. All data were integrated and maintained in the Enterprise Database, which provided reporting and electronic output to the Colorado Access Web site, operating departments, the Department, and other external recipients. Reporting can be customized online or through programmed routine reports. ABC submitted numerous examples of reports used in the QAPI program that demonstrated integration of health information system (HIS) information.		
Required Actions: None.		
9. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and dis-enrollments for other than loss of Medicaid eligibility. *42CFR438.242(a)* Contract: II.H.2.q.2	**Documentation:** • 2012 COA QAPI Program Description (p 11-15) • FY13 ABC Work Plan • FY12 ABC Annual QAPI Evaluation • FY13 Q1 Appeals Reporting • FY13 Q1 Grievance Reporting • 2012 ABC Average Daily Census Trending Graphs • Monthly Membership Summary November 2012 **Process Description:** ABC's health information system provides information on utilization, grievances and appeals, membership, and dis-enrollments.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	IT and the Decision Support Departments can create ad hoc reports, as needed, to support the administration of the program as outlined in the Work Plan and as demonstrated in the ABC Annual QAPI evaluation and other reports referenced in this section.	
Findings: Staff stated that the Altruista Guiding Care software is an integrated component of the system-wide HIS and is used to document authorizations, grievances and appeals, care coordination, and other member-centric information. This system also has reporting and data analysis capabilities. Staff stated that ABC uses routine HIS reports as well as ad-hoc queries to monitor QI; and staff submitted examples of HIS reports related to utilization of services (dashboard report), grievances, appeals, and enrollment trends. During the on-site interview, staff stated that disenrollment data from the State do not provide adequate information related to reasons for termination, but that member complaints leading to disenrollment are tracked through the customer service database. Staff stated that the requirement for mandatory enrollment of members in the BHO minimizes disenrollment for reasons other than eligibility.		
Required Actions: None.		
10. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: None	**Documentation:** • 2012 COA QAPI Program Description (p10-13) • FY13 ABC Work Plan • FY12 ABC Annual QAPI Evaluation (p 12-16) • Monthly Membership Summary November 2012 • ABC FY13, Q1 Network Adequacy Report • 2012 ABC Average Daily Census Trending Graphs **Process Description:** Data is collected on member and provider characteristics and services as outlined in the QAPI Program Description and Work Plan and summarized in the Annual Evaluation. For example, evidence of specific data collection on member characteristics can be seen in the membership report, provider characteristics in the Network Adequacy Report and services furnished in the Average Daily Census Report.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: ABC submitted examples of reports that demonstrated collection of data related to member characteristics, provider characteristics, and services furnished to members. During the on-site interview, staff explained that ABC collected data on member characteristics from claims and enrollment databases, with updates from the customer service, care management, and utilization management systems. ABC collects provider characteristics through the provider contracting and credentialing databases, and provider information is integrated into the claims payment system. ABC collected data on services provided to members primarily through the claims database, supplemented by case management data, reports from the State regarding use of State hospital bed days, and Statewide Data Analytics Contractor (SDAC) data for members enrolled in the Regional Care Collaborative Organization (RCCO).		
Required Actions: None.		
11. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys. ◆ Anecdotal information. ◆ Grievance and appeals data. Contract: II.H.2.m.1	• **Documentation:**2012 ABC ECHO Survey • FY12 ABC Annual QAPI Evaluation (p 21-25) • FY13 Q1 Appeals Reporting • FY13 Q1 Grievance Reporting • OMFA Member Comment Form Desktop Procedure • Member Comment Form **Process Description:** Colorado Access monitors member perceptions of accessibility and adequacy of services through a variety of mechanisms including the annual ABC ECHO member satisfaction survey, grievance and appeals data (reported quarterly and annually), and anecdotal information from members and family members at the quarterly Member & Family Advisory Board (MFAB) meetings. Members are encouraged to complete and submit Member Comment Forms at the MFAB meetings. (See OMFA Member Comment Form Desktop Procedure) Upon receipt and review of these forms by the Director of the Office of Member and Family Affairs (OMFA), these forms are then logged in a database and routed to the appropriate COA Department for follow-up with members, as needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The ABC Experience of Care and Health Outcomes (ECHO) Survey report, a Consumer Assessment of Healthcare Providers and Systems (CAHPS) product, included trended results, analysis, and recommended actions related to member satisfaction with mental health and chemical dependency services. The member comment form and procedure documented the process for tracking anecdotal member satisfaction information. The Quarterly Grievance Monitoring report included trended data by type of grievance (access, quality, customer service) for each Colorado Access line of business. The Annual QI Evaluation report included summary results of the ECHO, Mental Health Statistics Improvement Program (MHSIP), and Youth Services Survey for Families (YSS-F) surveys; member grievances; and QOCC investigations. All are used to monitor member perceptions of access, appropriateness, and quality of services.		
Required Actions: None.		
12. The Contractor monitors member perceptions of well-being and functional status as well as accessibility and adequacy of services provided by the Contractor by reviewing the results of the statewide Mental Health Statistics Improvement Program (MHSIP), the Youth Services Surveys (YSS), and the Youth Services Surveys for Families (YSS-F). Contract: II.H.2.m.2	**Documentation:** • 2012 ABC ECHO Survey • FY2010-2011 Validation of Performance Measures, Appendix E (MHSIP and YSS-F) **Process Description:** The ECHO survey is conducted annually to assess member perceptions related to accessibility and adequacy of services, and member well-being/functional status. ABC takes action when trends in satisfaction or dissatisfaction are identified. The MHSIP and YSS-F survey results are reviewed by ABC as supplementary data for members receiving services through the mental health centers. Results for the FY11-12 MHSIP, YSS and YSS-F surveys have not yet been received by ABC.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Performance Measures report and the ABC Annual QAPI Evaluation report included the results of the MHSIP and YSS-F surveys. The annual report included analysis and recommendations related to the results of each survey. During on-site interviews, staff stated that the survey data are reviewed by operations management; and any relevant findings are reported to the QIC. Staff stated that the MHSIP, YSS-F, and YSS surveys have limited value because they survey only members who receive services from the mental health centers, not all BHO members. ABC has evolved toward the use of other surveys (e.g., ECHO) to monitor members' perceptions of services.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
13. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. Contract: II.H.2.m.5	**Documentation:** 1. 2012 COA QAPI Program Description (p 10-13) 2. ADM 203 Member Grievance Process (p 3 I A 3) 3. 2012 ABC ECHO Survey 4. FY13 Q1 Grievance Report **Process Description:** Colorado Access develops corrective actions plans when a pattern of complaint or statistically significant dissatisfaction is identified as outlined in the QAPI Program Description scope. ADM 203 discusses the grievance process including resolution of serious complaints and quarterly monitoring to detect patterns. ABC did not develop any corrective action plans in FY11-12, as no significant levels of dissatisfaction were detected. All complaints were investigated, and no CAPs were required during the year.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Colorado Access QI Program Description stated that results of member satisfaction and grievance measures are analyzed and addressed with staff, members, and providers, as applicable; and action plans are implemented to improve or correct identified problems. The sample Quarterly Grievance Monitoring report tracked grievances by type (access, quality of service, financial), and included analysis of the reasons for the grievances. Staff stated that the overall number of grievances remains below the threshold for corrective action. The ECHO member satisfaction survey report indicated two possible opportunities for improvement, which were being evaluated through more focused study activities. Staff reported that no CAPs for member dissatisfaction were necessary during the audit year.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
14. The Contractor investigates, analyzes, tracks, and trends quality of care (QOC) concerns. (Client complaints about care are not quality of care concerns under this section and should be processed as grievances, unless the Department instructs otherwise.) Contract: II.H.2.o	**Documentation:** FY12 ABC Annual QAPI Evaluation (p 23-24) **QM 201 –** Investigation of Potential Clinical Quality of Care Grievances and Concerns **Process Description:** ABC investigates all potential quality of care concerns and has a detailed process outlined in QM 201. This policy outlines the procedures, processes and timeframes that must be followed to thoroughly investigate concerns, along with the follow up actions that are required. ABC tracks and analyzes QOC concerns with annual documentation and reporting in the QAPI Evaluation. The QAPI Evaluation is reviewed annually in all Quality Committees including QIC, MBQIC, and by the Board of Directors.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Investigation of Potential Clinical Quality of Care Grievances and Concerns policy stated that all QOCCs identified through member grievances or referred from providers/staff are investigated by the ABC medical director and documented in the data system. The policy detailed the procedures for processing the QOCC, including quarterly reporting of QOCC trends to the compliance and credentialing committees. The Annual QI Evaluation report stated that there was only one substantiated QOCC identified during the reporting year, which was investigated and resolved. The number of QOCCs was under the specified goal, and having so few QOCCs met the benchmark. During the on-site interview, staff stated that the majority of potential QOCCs are referred by internal staff rather than members, and most concerns were determined to be unsubstantiated after investigation.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
15. When a quality of care concern is raised, the Contractor : ◆ Sends an acknowledgement letter to the originator of the concern. ◆ Investigates the QOC issue(s). ◆ Conducts follow-up with the member to determine if the immediate health care needs are being met. ◆ Sends a resolution letter to the originator of the QOC concern, which contains: • Sufficient detail to foster an understanding of the resolution. • Description of how the member's health care needs have been met. • A contact name and telephone number to call for assistance or to express any unresolved concerns. Contract: II.H.2.	**Documentation:** **QM 201 –** Investigation of Potential Clinical Quality of Care Grievances and Concerns **Process Description:** ABC follows each required step outlined in QM201 to ensure that all potential quality of care concerns are thoroughly investigated with necessary acknowledgement and notification to the originator of the concern. There was one QOC concern raised in FY2011-12, and all necessary actions were taken including acknowledgement letter sent, investigation of issues raised, follow up with member to ensure that health care needs were met, resolution letter sent.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Investigation of Potential Clinical Quality of Care Grievances and Concerns policy outlined the procedures for disposition of an identified QOCC, including an acknowledgement letter, investigation, follow-up with the member, and a resolution letter, specifically as outlined in the requirement. During the on-site interview, staff provided sample acknowledgement and resolution letters, and provided documentation of an investigation of a QOCC. HSAG recommended that ABC consider including a more detailed explanation of the originator's concern and how the concern was resolved in the acknowledgement and resolution letters, according to the criteria outlined in the requirement.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
16. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* Contract: II.H.2.q.1	**Documentation:** • ABC CO 2011-12 BHO 411 Report (Claims Validation) • ABC Claim Encounter Flat File Requirements • FY12 ABC Annual QAPI Evaluation (p 25-26) • ABC Nov 2012 IBNR Report • ABC Nov 2012 IBNR Notes • Decision Support ABC Flat and 837 Encounter File QA Review Process • ABC Provider Manual • ABC Provider Website http://www.coaccess.com/access-behavioral-care-provider-information • CLM301-Timing Filing and Prompt Payment of Claims • IT Data Flow **Process Description:** ABC ensures that data received from its providers is accurate and complete through a variety of data quality checks and processes. The timeliness and accuracy of data is monitored through quarterly Claims timeliness and accuracy reporting. The ABC Provider Manual provides education on billing/submission guidelines to address timeliness (timely filing), required fields on claim forms, and only accepting standard claim forms or HIPAA compliant EDI files. Screening for data completeness, logic and consistency and collecting service information in standardized formats is outlined in the ABC Claims Validation Report, the ABC Flat File Requirements, the DS Encounter Data QA Process and the ISCAT.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The Colorado Access QAPI Program Description stated that Colorado Access is committed to ensuring the reliability and integrity of data used in the QAPI Program through internal and external audit processes including data entry, flow, and accuracy audits; delegated vendor audits; the HEDIS audit; and the Information Systems Capabilities Assessment Tool (ISCAT). In addition, Colorado Access performs claims validation studies to compare

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
submitted claims to provider medical record documentation, with results reported to the MBQIC, QIC, and involved physicians. The Claims Validation Report contained the results of an external audit performed to determine the accuracy of claims information. The ISCAT documented that ABC received all claims and encounter data in standardized formats. The PowerSTEPP claims transaction system applies edits to each claim for accuracy and completeness, and notifies providers to correct errors prior to submission to the Department. The Timely Filing and Prompt Payment of Claims policy defined the time frames for timely submission of claims by ABC providers. The provider manual and the ABC provider Web site detailed provider responsibilities for timely filing of claims, use of standardized claims forms, and accuracy of coding and completion of fields in the claim form.		
Required Actions: None.		

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	16	**Total Score**		=	16

Total Score ÷ Total Applicable	=	100%

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Access Behavioral Care

Review Period:	January 1, 2012—December 31, 2012	**HSAG Reviewer:**	Barbara McConnell
Date of Review:	February 13, 2013	**Participating Plan Staff Member:**	Jennifer Rogers

SAMPLE	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**	
Provider ID#																				
Provider Type (MD, PhD, NP, PA, MSW, etc.)	LCSW		LPC		LPC		LCSW		LCSW		LMFT		LPC		LPC		LPC		PhD	
Application Date	3/2/12		6/28/11		9/13/12		5/23/12		4/14/11		2/21/12		1/3/12		4/5/12		6/16/11		6/6/11	
Specialty	Social Work		Counselor		Counselor		Social Work		Social Work		Therapist		Counselor		Counselor		Counselor		Psychology	
Credentialing Date (Committee/Medical Director Approval Date)	5/24/12		7/28/11		9/21/12		7/1/12		7/28/11		3/30/12		2/9/12		5/1/12		6/30/11		6/9/11	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	NA		NA		NA		NA		NA		NA		NA		NA		NA		NA	
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)	X		X		X		X		X		X		X		X		X		X	
♦ Work history	X		X		X		X		X		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	**7**		**7**		**7**		**7**		**7**		**7**		**7**		**7**		**7**		**7**	
Point Score	**7**		**7**		**7**		**7**		**7**		**7**		**7**		**7**		**7**		**7**	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	

Total Record Review Score					**Total Applicable: 70**	**Total Point Score: 70**	**Total Percentage: 100%**
Notes:							

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Access Behavioral Care

Review Period:	January 1, 2012—December 31, 2012	**HSAG Reviewer:**	Rachel Henrichs
Date of Review:	February 13, 2013	**Participating Plan Staff Member:**	Jennifer Rogers

SAMPLE	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**	
Provider ID#																				
Provider Type (MD, PhD, NP, PA, MSW, etc.)	LCSW		LCSW		LPC		LPC		LPC		LPC		LPC		LPC		PhD		PhD	
Application/Attestation Date	10/5/10		4/17/12		11/21/12		1/10/11				2/22/12				3/28/11		6/1/12		9/20/11	
Specialty	Social Work		Social Work		Counselor		Counselor				Counselor				Counselor		Psychology		Psychology	
Last Credentialing/Recredentialing Date	12/19/07		7/22/09		3/31/10		6/3/08				7/22/09				8/27/08		10/16/09		02/25/09	
Recredentialing Date (Committee/Medical Director Approval Date)	12/2/10		6/14/12		1/17/13		4/21/11				6/21/12				6/30/11		8/9/12		12/29/11	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X				X				X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	NA		NA		NA		NA				NA				NA		NA		NA	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	NA		NA		NA		NA				NA				NA		NA		NA	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X				X				X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X				X				X		X		X	
♦ Signed application and attestation	X		X		X		X				X				X		X		X	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X				X				X		X		X	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X		X		X		X				X				X		X		X	
Applicable Elements	**6**		**6**		**6**		**6**				**6**				**6**		**6**		**6**	
Point Score	**6**		**6**		**6**		**6**				**6**				**6**		**6**		**6**	
Percentage Score	**100%**		**100%**		**100%**		**100%**				**100%**				**100%**		**100%**		**100%**	

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Access Behavioral Care

OVERSAMPLE	1		2		3		4		5											
Provider ID#																				
Provider Type (MD, PhD, NP, PA, MSW, etc.)	MD		LMFT																	
Application/Attestation Date	8/11/10		3/21/11																	
Specialty	Psychiatry		Therapist																	
Last Credentialing/Recredentialing Date	10/31/07		7/14/08																	
Recredentialing Date (Committee/Medical Director Approval Date)	10/21/10		6/7/11																	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**										
Recredentialing Verification The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X																	
♦ A valid DEA or CDS certificate (if applicable)	X		NA																	
♦ Credentials (i.e., verified board certification only if the practitioner states on the recredentialing application that there is new board certification since last credentialing/recredentialing date)	X		NA																	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X																	
♦ Verification that the provider has not been excluded from federal participation	X		X																	
♦ Signed application and attestation	X		X																	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X																	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X		X																	
Applicable Elements	**8**		**6**																	
Point Score	**8**		**6**																	
Percentage Score	**100%**		**100%**																	
Total Record Review Score									**Total Applicable: 62**				**Total Point Score: 62**				**Total Percentage: 100%**			

Notes: Records 5 and 7 were initial credentialing records. Recredentialing was not yet due.

Appendix C. Site Review Participants for Access Behavioral Care

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

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
ABC Participants	**Title**
Carrie Bandell	Director of Quality Management
Robert Bremer	Executive Director, ABC
Laura Coleman	Director of Clinical Services
Rodonda DeLoach	Health Coach
Rich Duncan	Manager of ABC Care Management
Sandy Gahagan	Care Manager II
Bethany Himes	Executive Director, CHP+
John Kickhaefer	Operations Manager, ABC
Suzanne Kinney	Behavioral Health Quality Program Manager
Claudine McDonald	Director, Office of Member and Family Affairs
Suzanne Nelson	Care Manager II
Marina Osovskaya	CHP+ Program Specialist
Irina Pomirchy	CHP+ Senior Program Manager
Jennifer Rogers	Manager, Credentialing Program
Robin Walker	Care Manager II
Department Observers	**Title**
Teresa Craig	Contract Manager
Alan Kislowitz	Health Plan Manager
Russell Kennedy	Quality Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2012–2013 for Access Behavioral Care

If applicable, the BHO 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 2012–2013 Corrective Action Plan *for* ABC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
Standard VIII—Credentialing and Recredentialing 2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes).	While Colorado Access/ABC had appropriate methods to prevent discrimination, there were no methods in place for periodic monitoring to ensure nondiscriminatory credentialing practices, as required by NCQA. Colorado Access must develop processes for monitoring to ensure nondiscriminatory credentialing practices.				

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 2012–2013 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 BBA Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tools, 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 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 BHO's 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.)
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 2012–2013 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 Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2012–2013 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.