FY 2015–2016 Site Review Report

for

Access Behavioral Care—Denver and Access Behavioral Care—Northeast

February 2016

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

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1. Executive Summary
for Access Behavioral Care

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 federal healthcare regulations and managed care contract requirements. The Department of Health Care Policy & 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 report documents results of the FY 2015–2016 site review activities for the review period of January 1, 2015, through December 31, 2015, for both **Access Behavioral Care—Denver** (**ABC-D**) and **Access Behavioral Care—Northeast** (**ABC-NE**). This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the four standard areas reviewed this year. Section 2 contains graphical representation of results for all 10 standards across two three-year cycles as well as trending of required actions. Section 3 describes the background and methodology used for the 2015–2016 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2014–2015 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the 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 plan process the BHO will be required to complete for FY 2015–2016 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. Colorado Access operates both **ABC-D** and **ABC-NE** lines of business according to corporate-wide processes for the standards reviewed in 2015—2016; therefore, the score is for **ABC** as a whole. (There is no differentiation for **ABC-D** and **ABC-NE**). HSAG documented findings and assigned required actions to any requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal healthcare regulations. At the request of the Department, HSAG designated select contract requirements within the Coordination and Continuity of Care standard as *Information Only* elements. These requirements were not scored. HSAG gathered information during on-site interviews regarding the BHO's implementation of these requirements. Detailed findings for each of these elements were outlined in the Compliance Monitoring Tool and are summarized below in Standard III—Continuity and Coordination of Care.

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

Table 1-1—Summary of ABC-D 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	10	10	7	3	0	0	70%
IV Member Rights and Protections	6	6	5	0	1	0	83%
VIII Credentialing and Recredentialing	46	45	42	3	0	1	93%
X Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
Totals	**76**	**75**	**68**	**6**	**1**	**1**	**91%**

Table 1-2 presents the scores for **ABC-D** for the credentialing and recredentialing record reviews. Details of the findings for the record review are in Appendix B—Record Review Tool.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	90	80	80	0	10	100%
Recredentialing	90	70	70	0	20	100%
Totals	**180**	**150**	**150**	**0**	**30**	**100%**

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

Table 1-3—Summary of ABC-NE 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	10	10	7	3	0	0	70%
IV Member Rights and Protections	6	6	5	0	1	0	83%
VIII Credentialing and Recredentialing	46	45	42	3	0	1	93%
X Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
Totals	**76**	**75**	**68**	**6**	**1**	**1**	**91%**

Table 1-4 presents the scores for **ABC-NE** for the credentialing and recredentialing record reviews. Details of the findings for the record review are in Appendix B—Record Review Tool.

Table 1-4—Summary of ABC-NE Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing	90	81	81	0	9	100%
Recredentialing	90	70	70	0	20	100%
Totals	**180**	**151**	**151**	**0**	**29**	**100%**

Standard III—Coordination and Continuity of Care

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

ABC had policies, procedures, and resources in place to address coordination and continuity of care for members. **ABC** behavioral health providers were responsible for coordinating a member's care with the member's primary care provider (PCP). Community mental health centers' (CMHCs') care management staff assisted with coordinating services. **ABC** designated care management staff to assist with assessment and coordination of needed services for members with complex behavioral, physical, and social needs, including coordination with community providers and external agencies. **ABC** encouraged its providers to refer members with complex care coordination needs to **ABC** and also identified members using claims-based data and assessment information. Care management activities are facilitated through shared information systems accessible by care managers across Colorado Access' various programs and product lines. **ABC** ensured members an ongoing source of behavioral healthcare by offering an openly accessible network of providers (i.e., no referrals or authorizations required), informing members how to access the network, and offering assistance in connecting members with behavioral health medical homes. **ABC** did not require referrals for access to specialist services and arranged for services out-of-network, as necessary, through single-case provider agreements. The **ABC** provider manual charged providers with the responsibility of contacting the member's PCP to obtain results of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screenings, documenting results in the member assessment, and referring members to a PCP when EPSDT screening is needed but has not yet been performed. The provider manual informed providers that "any service necessary to treat healthcare needs identified through EPSDT screening must be provided through Medicaid, even if the identified service is not a covered service of the Medicaid plan." The Colorado Access care coordination policy stated that care coordinators will assist with arranging EPSDT-related services not covered by the plan.

ABC-D and **ABC-NE** are two of Colorado Access' lines of business that provide care management services to members. Others include three Regional Care Coordination Organizations (RCCOs) for regions in northeast Colorado, Denver, and the surrounding metropolitan area; the single entry point (SEP) for Denver; and the Child Health Plan Plus (CHP+) health maintenance organization (HMO) and State Managed Care Network (SMCN). Most of the geographic regions for these lines of business overlap. During 2015, Colorado Access developed and began implementing an enterprise-wide reorganization of care management services into teams that cross all product lines, rather than assigning staff to support individual product lines and programs. Colorado Access designed this strategy to eliminate duplication of care coordination activities and to make most efficient use of the expertise available within various lines of business through a multidisciplinary team approach. In addition, Colorado Access configured teams to provide support and programs for categories of members with special healthcare needs, such as members residing in long-term care facilities, members transitioning from inpatient mental health facilities or the criminal justice system, foster children, and pregnant women. **ABC** also began co-locating care management staff at community-

based provider settings (e.g., Denver Health Medical Center and the Colorado Mental Health Institute at Fort Logan) which serve a large number of members. Staff stated that on-site engagement with members being discharged from psychiatric inpatient or emergency services has been successful and will be expanded to University of Colorado Hospital in the near future. During on-site interviews, staff characterized care coordination processes as being in a continual state of evolution and estimated that the complete organizational transformation of care coordination within Colorado Access may require two to three years.

ABC also continued to assign behavioral healthcare coordinators to support the CMHC care managers with complex members.

- **ABC-D** care managers partner with **ABC-D**'s major provider, Mental Health Center of Denver (MHCD), on a number of specialized programs and to coordinate priority access for referrals to MHCD. **ABC-D** care managers also support providers and members receiving services in the extended provider network (approximately 50 percent of **ABC-D** members).
- **ABC-NE** had three behavioral healthcare coordinators assigned to support non-CMHC providers and CMHCs with complex members. Staff members stated that the regional SEP care managers participate with **ABC** and RCCO care managers in local "hot-spotter" care planning meetings.

During on-site interviews, **ABC** presented several case studies that demonstrated collaborative efforts among **ABC**, RCCO, CMHC, and SEP care managers to arrange services for members with complex needs, including coordination with home and community-based services (HCBS), long-term care services, and the departments of human services (DHS).

Other information provided during on-site interviews applicable to *Information Only* elements included:

- The redesigned care coordination program will include a team dedicated to developing care plans and coordinate services, including a behavioral health component, as necessary for all pregnant women, for one year post-partum.
- **ABC** regional directors continued to work with DHSs to develop mechanisms for access to mental health services for children in DHS custody. As a component of the enterprise-wide reorganization of care managers, Colorado Access located community-based care managers at The Children's Hospital and Denver Health Medical Center (Denver Health has a targeted clinic that specializes in care of foster children) to engage with and coordinate services for children and families with mental health service needs.
- **ABC-D**, in partnership with MHCD and the Colorado Mental Health Institute at Fort Logan, developed a coordinated process for discharge of members from Fort Logan. **ABC-D** and MHCD care managers meet on-site with Fort Logan staff prior to member discharge to coordinate and schedule needed services and follow-up appointments at MHCD. Staff stated that Fort Logan staff provided positive feedback regarding the transition team process.
- Also in partnership with MHCD, **ABC-D** had a well-defined long-standing process for providing behavioral health services to members residing in 16 long-term care facilities. **ABC-D** was beginning to evaluate the effectiveness of current services provided to members in long-term care facilities. In addition, **ABC** has been working with the Colorado Access RCCOs and a

collaboration of skilled nursing facilities (SNFs) to explore gaps in care and resolve identified issues.

- Colorado Access was facilitating and participating in collaborative work sessions with a variety of agencies to better understand the processes and identify barriers and solutions to transitioning members from correctional facilities to community providers and support services. Colorado Access dedicated a staff member to focus on outreach and organize initiatives with the Department of Corrections (DOC) and county jail systems. Colorado Access identified both successes and barriers in these initiatives. Each program requires significant time and energy for understanding the complexity of the system and building sustaining partnerships.
- Colorado Access' operation of its Medicare line of business and its experience providing services for the Medicare-Medicaid Program (MMP) members in its RCCO lines of business, enhanced **ABC**'s ability to make referrals and coordinate benefits with Medicare providers for dual-eligible members.
- While Colorado Access implemented many of the pilot programs for categories of members with specialized needs in the **ADC-D r**egion, the **ABC-NE** care coordinators were working with coordinators from RCCO Region 2, area CMHCs, SEPs, DHSs, and community agencies to replicate successful program initiatives in **ABC-NE**.
- The Department requested that HSAG have an on-site discussion with each BHO regarding the plan's application of the expanded definition of medical necessity for EPSDT services. Staff members stated that **ABC** does not require prior authorization for covered services and that PCPs would either provide services or refer other EPSDT-related services to the appropriate community providers or programs. Therefore, **ABC** would not be aware of or review EPSDT services for medical necessity.

Summary of Findings Resulting in Opportunities for Improvement

Care coordination policies primarily described the goals, objectives, and intent of integrated care management and collaboration with external providers and entities and included very little description of specific procedures and accountabilities. The policies minimally addressed requirements related to sharing member needs assessments with other healthcare plans and outreach to multiple external agencies and organizations to coordinate care. HSAG cautioned that Colorado Access' reorganization of its internal care coordination resources should not minimize the development of processes to coordinate with external entities and recommends that Colorado Access enhance efforts to define mechanisms to do so. Staff stated that as the organizational transition of care coordination becomes better defined and/or as specialized programs being developed and pilot tested are completed, Colorado Access intends to define more specific policies and procedures. HSAG recommends that **ABC**/Colorado Access proceed as expeditiously as possible to detail care coordination policies and procedures and delineate accountabilities for care coordination. HSAG also recommends that Colorado Access expedite the internal care coordination transformation process to prevent inadequate, confusing, inefficient, or incomplete implementation of the reorganization plan.

While the development of care coordination activities related to members with complex needs is in place and being enhanced, **ABC** is required to provide care coordination services—including needs assessments, sharing of information with other providers and health plans, and coordinating services

with external agencies and organizations—for all members. Therefore, for members who may not be referred to **ABC** care management, providers need to be familiar with and implement these activities. HSAG recommends that **ABC** enhance communication of all care coordination requirements at the provider level and develop mechanisms to periodically evaluate whether providers are either performing these services effectively or referring members to **ABC** for care coordination, as appropriate.

ABC employed medical record chart audits as the mechanism for ensuring that providers meet requirements to coordinate services for members or to refer members with complex needs to **ABC** care management. However, chart audit criteria did not include documentation of coordinating with other providers, agencies, or community service referrals. In addition, **ABC** audited only 10 total medical records in 2015. Therefore, HSAG recommends that **ABC**/Colorado Access define a more effective mechanism for oversight of provider performance of required care coordination activities.

Staff stated that the requirement to arrange needed EPSDT services for members is difficult for BHO providers and/or **ABC** staff to operationalize because the physical health PCP is likely more knowledgeable about whether the needed service is EPSDT-related and is primarily responsible for arranging any needed services. Staff stated that **ABC** has been seeking clarification from the Department regarding how to effectively operationalize EPSDT requirements within the BHO; therefore, **ABC** had not identified specific mechanisms for BHO providers or staff to identify and take action on EPSDT-related services not covered by the BHO (e.g., HCBS). HSAG acknowledges that operationalizing EPSDT service requirements through the behavioral health provider system is complicated and recommends that **ABC**, alone or through a collaboration of BHOs, continue to work with the Department to clarify expectations and identify implementable procedures. **ABC** should also consider providing training focused on EPSDT requirements and how to assist members with obtaining needed services covered by Medicaid but not the BHO.

Despite ongoing efforts and activities to develop mechanisms for transitioning members being released from correctional facilities into necessary healthcare services, most initiatives remain in the discussion, development, and pre-implementation stages. HSAG encouraged Colorado Access to move as expeditiously as possible from planning to implementing programs.

Summary of Required Actions

The provider manual informed providers of their responsibility to perform an initial and ongoing member assessment and defined the components of the assessment. However, the monitoring mechanism employed—medical record audits—was inadequate to ensure that each member accessing services receives an individual assessment with the defined components. The audit did not include cultural and linguistic needs and was applied to an inadequate sample of member records—i.e., two records per five providers annually. **ABC** must enhance the scope of monitoring providers to ensure that members have a comprehensive service plan that addresses the elements outlined in the requirement.

Similarly, the provider manual communicated the provider's responsibility for developing an individualized service plan and specified all elements outlined in the requirement. The medical record audit tool incorporated monitoring of all required elements of the treatment plan. However,

the medical record audit was performed on a number of records (10 total records annually) inadequate to be a valid representation of the overall performance of the health plan. In addition, the medical record audit was performed by **ABC-D** only. **ABC** must enhance the process and scope of monitoring providers to ensure that members accessing services receive an intake assessment with the required components.

Although the provider manual requires BHO providers to obtain results of EPSDT screenings from the member's PCP and to refer the member to the PCP for any EPSDT screenings not performed, the provider manual did not inform providers of their responsibility to provide referral assistance for EPSDT-related treatment not covered by the BHO. The provider manual also did not instruct providers on how to obtain assistance in making referrals for non-covered EPSDT services (e.g., referring the member to Colorado Access care management, Healthy Communities, or the Office of Clinical Services). During on-site interviews, staff members stated that Colorado Access had no additional provider training regarding referral for EPSDT services and no mechanism to monitor providers for compliance with EPSDT care coordination requirements. **ABC** must enhance its procedures and provider communications to more specifically address requirements for providing referral assistance for treatment and services not covered by the BHO but found to be needed as a result of conditions disclosed during EPSDT screening and diagnosis. Procedures should include referring members to the **ABC** care coordination staff, Healthy Communities, or the Office of Clinical Services.

Standard IV—Member Rights and Protections

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

The Colorado Access policies and procedures related to member rights and protections were applicable to all lines of business, including **ABC-D** and **ABC-NE**. The Member Rights and Responsibilities policy affirmed Colorado Access's commitment to ensuring the rights of its members. The Nondiscrimination, Problem Reporting and Non-Retaliation, and Member Disability Rights Request and Complaint Resolution policies provided guidance to staff members on how to report suspected and alleged rights violations and described the process for investigating such reports. The Nondiscrimination policy identified the department responsible for developing and implementing training and education for staff, providers, and members with regard to member rights.

All **ABC** customer service staff members participated in member rights training within the review period and were provided with a laminated list of member rights to be posted at their desks. All new providers were offered an introductory webinar training that included a review of member rights and how to report suspected and alleged rights violations. A list of member rights and instructions on how to report alleged rights violations were also included in the provider manual, which was accessible through the website along with the webinar training. Additionally, **ABC** published and distributed member rights posters to be displayed in all service locations. **ABC-D** and **ABC-NE**

included information about member rights in newsletters, annual mailings, on the website, and in both **ABC-D** and **ABC-NE** member handbooks. **ABC** further ensured that members and providers are aware of member rights by requiring that its providers give each member a copy of the member rights and keep a signed acknowledgment form in the medical record.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to member rights and protections.

Summary of Required Actions

Rather than list the specific member rights, Policy CS212—Member Rights and Responsibilities referenced a specific section of the Colorado Code of Regulations (CCR) and the contract between **ABC** and the Department. While this mechanism of reference is acceptable, the section of CCR referenced in the policy was incorrect and the contract routing number was outdated. Colorado Access must revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights.

Standard VIII—Credentialing and Recredentialing

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

The Colorado Access policies and procedures related to credentialing and recredentialing providers and organizations were applicable to all lines of business, including **ABC-D** and **ABC-NE**. The policies were well-written, comprehensive, and compliant with National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines. During on-site interviews, credentialing staff members displayed extensive knowledge of NCQA requirements and Colorado Access policies and appeared confident discussing the processes and procedures used.

HSAG encountered various scenarios during on-site record reviews that demonstrated staff were credentialing and recredentialing providers in a manner consistent with the written procedures. Credentialing and recredentialing files included an application printed from the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing Datasource (or an application that the provider mailed to Colorado Access) and documentation that demonstrated staff verified licensure, DEA or CDS certification (as applicable), board certification status, education and training, work history, and current malpractice insurance. Files also included documentation demonstrating that Colorado Access queried the National Practitioner Data Bank (NPDB) for history of professional liability claims and to ensure that the provider had not been excluded from federal participation. HSAG also found evidence that staff regularly followed up with providers to collect, as needed, additional information such as explanation for gaps in work history.

Colorado Access delegated credentialing and recredentialing to several of its contracted organizations. The delegation agreements described the activities, responsibilities, and reporting requirements as well as remedies available to Colorado Access should the delegate fall short of its obligations. Colorado Access retained the right to approve, suspend, or terminate providers approved by any of its delegated entities. HSAG reviewed annual audit findings for each delegated entity and found evidence that Colorado Access required corrective actions when necessary and followed up as appropriate.

HSAG reviewed credentialing committee meeting minutes that confirmed the credentialing committee met regularly, reviewed all credentialing and recredentialing files from Colorado Access and from delegates, and made appropriate determinations.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Access credentialing staff members indicated that the company was in the process of consolidating the various policies and procedures related to credentialing and recredentialing into one document. HSAG suggested that Colorado Access could further strengthen its practice to ensure nondiscrimination by including a process to have a committee other than the credentialing committee review all denied provider applications.

Summary of Required Actions

Colorado Access' policies and procedures required confirmation at least every three years that contracted organizations are in good standing with both State and federal regulatory agencies. On-site record review demonstrated that Colorado Access implemented this policy; however, two of the organizations had not been recredentialed within the three-year time frame. Colorado Access must develop and employ a process to ensure that organizations with which it contracts are recredentialed at least every three years.

The Organizational Provider Credentialing policy and procedure included the criteria used to assess unaccredited organizational providers, which included staff hiring and credentialing processes. On-site record review demonstrated that Colorado Access collected the organization's policies and procedures related to staff hiring and credentialing; however, some policies collected were not compliant with Colorado Access' credentialing standards. Colorado Access must ensure that unaccredited organizations with which it contracts credential practitioners in a manner consistent with Colorado Access's own policies, procedures, and standards.

The Organizational Provider Credentialing policy and procedure described the circumstances under which Colorado Access could substitute a CMS or State quality review in lieu of a site visit; however, the policy did not specify that Colorado Access would confirm that the survey conducted by CMS or the State meets its own quality assessment criteria or standards. HSAG did not find evidence in the records reviewed that Colorado Access confirmed the content of the CMS or State review. Some CMS and State reviews included with the records reviewed indicated the need for corrective action; however, Colorado Access did not document confirmation that the corrective actions had been completed. Furthermore, one of the State site reviews documented in the record as being used in lieu of a site visit was more than three years old at the time of the credentialing

decision. Colorado Access must specify in its policies that it will confirm that CMS and State quality reviews used in lieu of Colorado Access site visits include all criteria and standards identified in Colorado Access' policy. Colorado Access must ensure that CMS and State quality reviews used are no more than three years old at the time of the credentialing decision; and if the CMS or State quality review required that the organization complete any corrective actions, Colorado Access must document that the organization completed those corrective actions.

Standard X—Quality Assessment and Performance Improvement

The following sections summarize findings applicable to both **ABC-D** and **ABC-NE**. Any notable differences in compliance between the lines of business have been identified.

Summary of Strengths and Findings as Evidence of Compliance

Colorado Access' Quality Assessment and Performance Improvement (QAPI) program was applicable to all lines of business. The program description stated that quality monitoring encompasses access and availability; utilization management; member satisfaction; clinical outcomes/performance measures; performance improvement projects (PIPs); and evaluation of internal operational performance, practice guidelines, and care management. The program evaluates quality for the combined businesses of Colorado Access, as well as by product line, by provider and by categories of members. Colorado Access used a variety of data from existing systems (e.g., claims/encounters, grievances and appeals, performance measures) for ongoing and periodic monitoring of services provided to members. **ABC** staff provided reports demonstrating that its information systems can integrate data from multiple sources and produce reports for tracking, analysis, and profiling of quality performance within a variety of categories.

Colorado Access has a multi-layered committee and oversight structure for the analysis of quality data and outcomes. The Quality Management (QM) Department conducts in-depth internal analysis of quality data, studies, and indicators and works with providers and the Executive Management Team regarding improvements required. Each administrative director for each product line has ongoing access to reports from claims-based data and special dashboard reports of defined performance indicators (e.g., emergency room [ER] visits or hospital readmission rates). The administrative management representatives from all lines of business met monthly to review quality performance of Colorado Access programs and providers. Colorado Access reported outcomes of internal analysis and actions taken or recommended to the Quality Improvement Committee (QIC) (accountable to the Board of Directors). The QIC also received input from the Quality and Performance Advisory Committee (QPAC), the Pharmacy and Therapeutics Committee, the Member and Family Advisory Boards, and the Credentials Committee. All activities were reported to the QIC through a well-designed and comprehensive annual report, which presented an overview and summary data from all quality activities performed throughout the year. At the time of review, Colorado Access had recently reorganized and replaced management staff in the Quality Management Department. Quality management staff described a number of improvements in quality management processes, monitoring activities, and reports that it planned to implement in the future.

Summary of Findings Resulting in Opportunities for Improvement

Colorado Access' operational staff was responsible for analyzing quality data and providing reports with conclusions and recommendations to improve quality performance. QIC meeting minutes, as well as the reports provided to the QIC, were documented at a high level with limited findings and recommendations reported. In addition, the annual quality reports for **ABC-D** and **ABC-NE** included limited evaluation of the effectiveness of the QAPI program per requirement 42CFR438.240(e). HSAG recommends that Colorado Access maintain a mechanism for documenting the results/conclusions of ongoing staff analysis activities in order to ensure a comprehensive and continuous stream of information (i.e., data, findings, conclusions, recommendations) regarding quality monitoring and improvements. HSAG also recommends that Colorado Access enhance the QAPI annual report and/or QIC meeting minutes to include an expanded statement of the committee's determination of the effectiveness of **ABC** QAPI program.

During the on-site interview, staff demonstrated that Colorado Access has and uses a multitude of data to track and evaluate its quality performance. Staff also stated that while they can analyze and profile data at the provider level, data are primarily shared with providers by "exception"—i.e., when data indicates a variance from the norm. HSAG recommends that **ABC** develop a provider profile/report card that compares provider-specific data across multiple quality measures and share the report card with individual providers periodically. This process may stimulate providers to investigate or self-initiate quality improvement activities and could expand the scope of the quality program to regularly engage providers in quality monitoring.

Although **ABC** developed clinical practice guidelines for prominent behavioral health conditions, staff stated that Colorado Access has only informal mechanisms for ensuring that the guidelines are applied in internal processes (i.e., utilization management [UM] decisions, member education programs) and no definitive expectations regarding providers' use of the guidelines. Staff stated that, going forward, QM plans to publish practice guidelines in provider bulletins. Staff stated that Colorado Access enforces compliance with guidelines primarily by "exception," such as when a grievance, quality of care concern, or other practice is identified that may be in conflict with practice guidelines. HSAG recommends that Colorado Access enhance procedures to define accountabilities (e.g., UM medical directors, medical education staff) for confirming consistency with practice guidelines and/or define a more formal process—e.g., comparing the adopted guideline to other organizational materials during annual review of each guideline—for ensuring that covered services, UM decisions, and member education materials are consistent with adopted practice guidelines.

While practice guidelines were accessible to providers and members on the Colorado Access website, HSAG noted that the member handbook did not inform members of the availability of guidelines. During on-site interviews, staff stated the Colorado Access is considering developing or purchasing clinical guidelines written in member-friendly terms for distribution to members. HSAG also recommends that Colorado Access inform members of the availability of practice guidelines and how to access them.

Policy QM201 detailed the procedures for investigating and documenting quality of care concerns (QOCs) from members, providers, or staff members, and included specified time frames for resolution. The policy included time frames for accepting and resolving QOCs from members

according to the required time frames for processing grievances. During on-site interviews, staff confirmed that QOCs are not processed as grievances but accepted from members at any time and processed using the QOC procedures. HSAG recommends that Colorado Access revise and clarify this policy to disassociate the QOC process from the member grievance process—i.e., QOCs are accepted from members at any time, are not necessarily associated with an "incident," and do not have to be processed within the time frames required for processing grievances.

Summary of Required Actions

HSAG required no corrective actions for this standard.

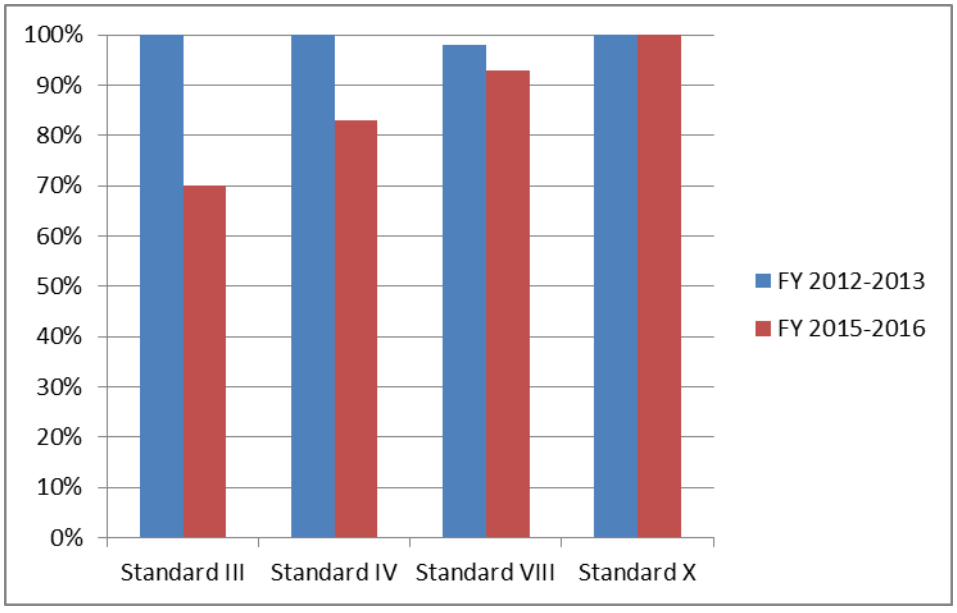
Comparison of Results

This is the second year of the **ABC-NE** contract with the Department. Therefore, prior results are limited. HSAG included information for **ABC-NE** where applicable.

Comparison of FY 2012–2013 Results to FY 2015–2016 Results

Figure 2-1 shows **ABC-D**'s scores from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **ABC-D**'s contract with the State may have changed, and may have contributed to performance changes.

Figure 2-1—Comparison of FY 2012–2013 Results to FY 2015–2016 Results for ABC-D

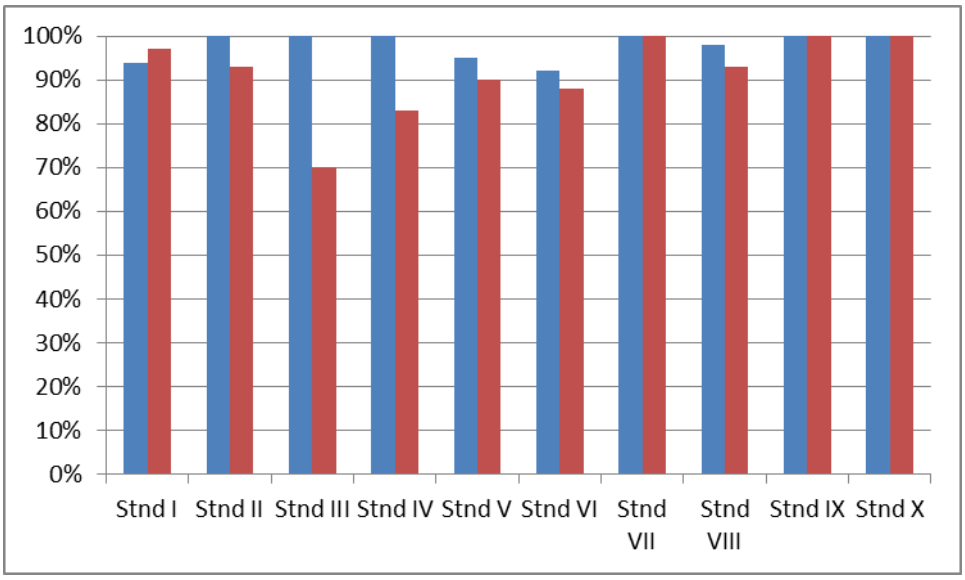


This is the first year that HSAG reviewed Standard III, Standard IV, Standard VIII, and Standard X for **ABC-NE**; therefore, comparison to prior results is not available.

Review of Compliance Scores for All Standards

Figure 2-2 shows **ABC-D**'s scores for all standards reviewed over the last two three-year cycles of compliance monitoring. Table 2-1 shows which standards were reviewed each year. The figure compares the score for each standard across two review periods and may be an indicator of overall improvement.

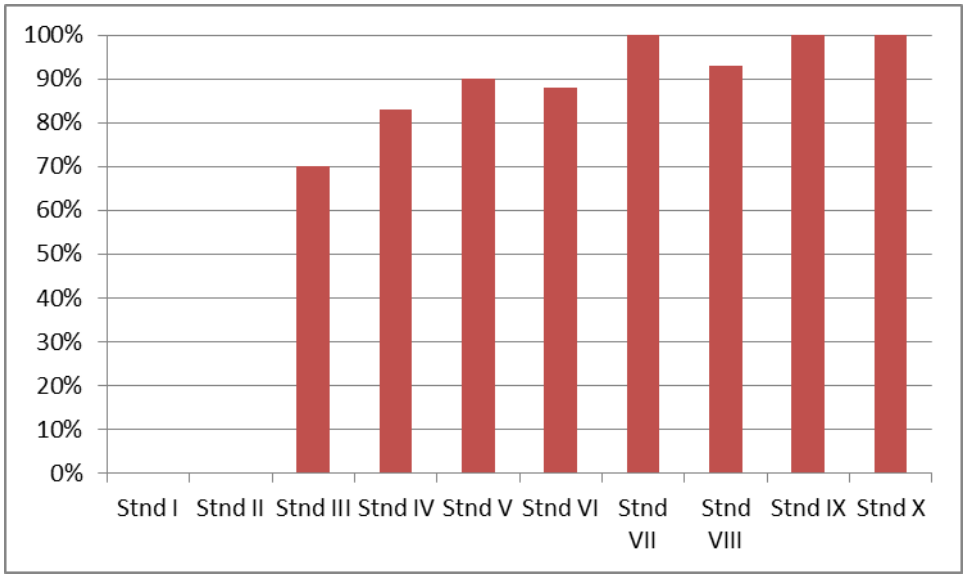
Figure 2-2—ABC-D's Compliance Scores for All Standards



Note: Results shown in blue are from FY 2010–2011, FY 2011–2012, and FY 2012–2013. Results shown in red are from FY 2013–2014, FY 2014–2015, and FY 2015–2016.

Figure 2-3 shows **ABC-NE**'s scores for all standards reviewed in FY 2014– 2015 and FY 2015– 2016.

Figure 2-3—ABC-NE's Compliance Scores for All Standards



Note: Results shown are from FY 2014–2015 and FY 2015–2016.

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

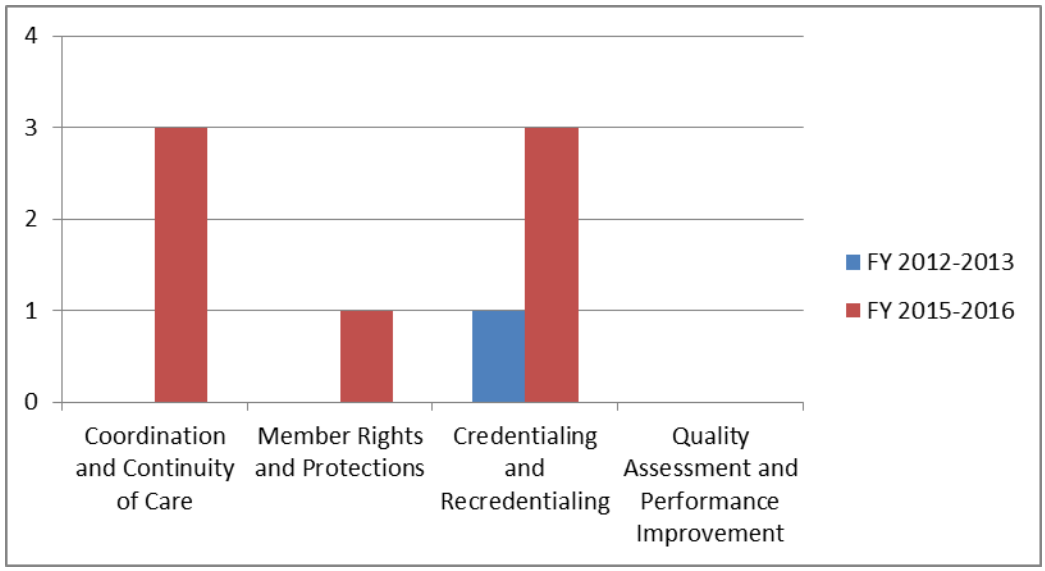
Table 2-1—List of Standards by Review Year

Standard	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
I—Coverage and Authorization of Services	X			X		
II—Access and Availability	X			X		
III—Coordination and Continuity of Care			X			X
IV—Member Rights and Protections			X			X
V—Member Information		X			X	
VI—Grievance System		X			X	
VII—Provider Participation and Program Integrity		X			X	
VIII—Credentialing and Recredentialing			X			X
IX—Subcontracts and Delegation		X			X	
X—Quality Assessment and Performance Improvement			X			X

Trending the Number of Required Actions

Figure 2-4 shows the number of requirements with required actions from **ABC-D**'s FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X were previously reviewed) compared to the results from this year's review. Although the federal requirements did not change for the standards, **ABC-D**'s contract with the State changed and may have contributed to performance changes.

Figure 2-4—Number of FY 2012–2013 and FY 2015–2016 Required Actions per Standard for ABC-D



Note: **ABC-D** had no required actions for Coordination and Continuity of Care, Member Rights and Protections, or Quality Assessment and Performance Improvement resulting from the FY 2012–2013 site review. **ABC-D** also had no required actions for Quality Assessment and Performance Improvement resulting from the FY 2015–2016 site review.

This is the first year that HSAG reviewed Standard III, Standard IV, Standard VIII, and Standard X for **ABC-NE**; therefore, trending of required actions is not available.

Trending the Percentage of Required Actions

Figure 2-5 shows **ABC-D**'s percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards, as indicated in Table 2-1 above.

Figure 2-5—Percentage of ABC-D's Required Actions—All Standards Reviewed

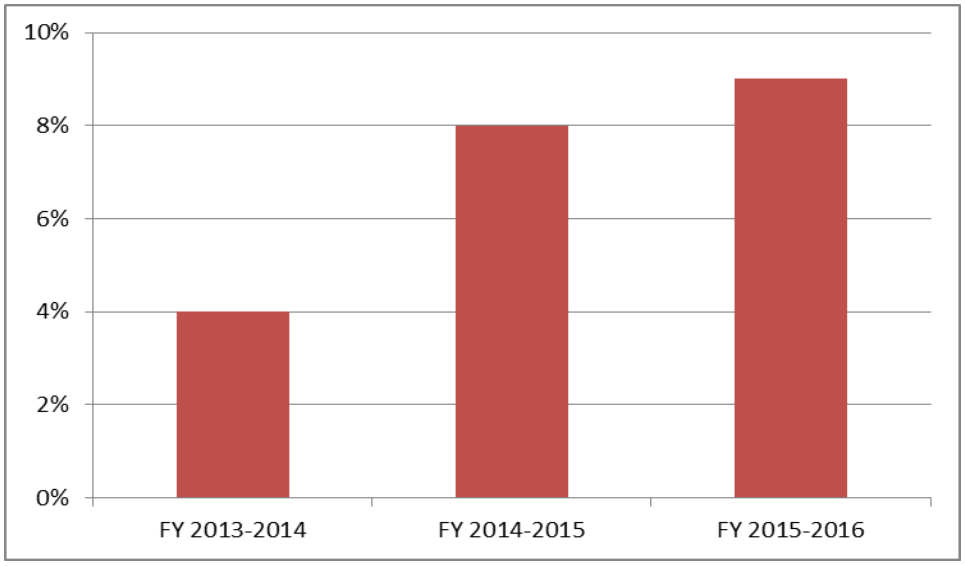
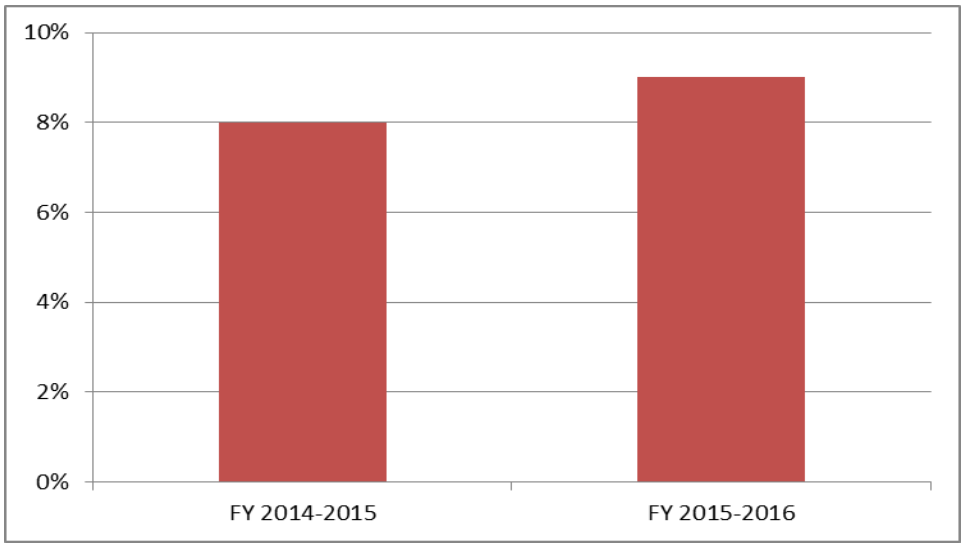


Figure 2-6 shows **ABC-NE**'s percentage of requirements that resulted in required actions over the past two years of compliance monitoring. Each year represents the results for review of different standards, as indicated in Table 2-1.

Figure 2-6—Percentage of ABC-NE's Required Actions—All Standards Reviewed



Overview of FY 2015–2016 Compliance Monitoring Activities

For the fiscal year (FY) 2015–2016 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of records, documents, and materials provided on-site; and on-site interviews of key BHO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to BHO credentialing and recredentialing. HSAG documented detailed findings in the Compliance Monitoring tool for any requirement receiving a score *Partially Met* or *Not Met*.

A sample of the BHO's administrative records related to Medicaid credentialing and recredentialing were also reviewed to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements, effective July 2015. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all of the BHO's credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG reviewed a sample of 10 credentialing records and 10 recredentialing records each from **ABC-D** and **ABC-NE**, to the extent possible. For the record review, the health plan received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The four standards chosen for the FY 2015–2016 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in

subsequent years: 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.

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

4. Follow-up on Prior Year's Corrective Action Plan

for **Access Behavioral Care**

FY 2014–2015 Corrective Action Methodology

As a follow-up to the FY 2014–2015 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 it successfully completed each of the required actions. HSAG and the Department continued to work with **ABC-D and ABC-NE** until they completed all required actions from the FY 2014–2015 compliance monitoring site review.

Summary of 2014–2015 Required Actions

As a result of the FY 2014–2015 site reviews, **ABC-D** and **ABC-NE** were required to address two elements in Standard V—Member Information and three elements in Standard VI—Grievance System. For Standard V, both plans were required to determine appropriate language to inform members of the Child Mental Health Treatment Act (CMHTA) and to update member materials to include this language. **ABC-D** and **ABC-NE** were also required to ensure that providers understand their responsibilities to provide members with information delineated in Exhibit A—2.6.8.4 of its contract with the Department and that providers have the required information available and accessible to members.

For Standard VI, **ABC-D** and **ABC-NE** were required to do the following:

- Ensure that appeal resolution letters are written in language easy for a member to understand and include an adequate explanation of results of the grievance process so that the member will understand that the grievance was actually resolved.
- Revise policies and procedures and related member communications, including the member handbooks, to accurately describe the time frames related to requesting continuation of previously authorized services during an appeal and/or State fair hearing.
- Provide grievance and appeal information, as specified in the requirement, to providers and subcontractors at the time they enter into a contract.

Summary of Corrective Action/Document Review

ABC-D and **ABC-NE** submitted its CAP to HSAG and the Department in April 2015. HSAG and the Department reviewed the proposed plan of correction and approved it as written. **ABC-D** and **ABC-NE** began submitting documents that demonstrated implementation of the plan in July 2015.

HSAG and the Department reviewed documents submitted by **ABC-D** and **ABC-NE** to demonstrate implementation of the plan at several intervals between July and October 2015 and determined in November 2015 that **ABC-D** and **ABC-NE** had successfully completed all corrective actions.

Summary of Continued Required Actions

ABC-D and **ABC-NE** had no required actions continued from FY 2014–2015.

Appendix A. Compliance Monitoring Tool for Access Behavioral Care

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has written policies and procedures that address the timely coordination of the provision of covered services to its members, service accessibility, attention to individual needs, and continuity of care to promote maintenance of health and maximize independent living. Contract: Exhibit A—2.4.2.1.1.1.–2.4.2.1.1.4	Documentation: • CCS 305- Care Coordination (pg 2) • CCS 306- Delivering Continuity and Transition of Care for Members • CCS 310- Access to Primary and Specialty Care Description: In addition, the Facilitation of Care Coordination (section III A-C) supports this requirement.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 healthcare providers. ◆ Physical healthcare providers. ◆ Long-term care providers. ◆ Waiver services providers. ◆ Pharmacists. ◆ County and State agencies. ◆ Public health agencies. ◆ Organizations that provide wraparound services. *42CFR438.208(b)(2)* Contract: Exhibit A—2.4.2.1.1.5; 2.4.2.2.1.3	Documentation: • CCS305- Care Coordination • ABC Provider Manual (page 19, 93-94, 88) • QM302- Review of Provider Medical Records • QM302- Attachment A. Chart Standards Description : 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, 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 (page 19). In addition, Appendix A of the Provider Manual requires documentation of coordination with medical providers and other ancillary service providers (93-94) Documentation of Active Treatment is in the Provider manual on page 88	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	http://www.coaccess.com/documents/ProviderManual.pdf • The Provider Manual also includes a web link to the sample PCP communication form (page 93). This form is available on 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.	
2.A. The Contractor develops specialized treatment and service plans for female members for one year postpartum to ensure that the behavioral and physical needs of the mother and child are being met. Contract: Exhibit A—2.4.2.4.2.6.1	Description: Targeted "high risk" pregnancies are outreached by the prenatal care manager. In that outreach we attempt to complete a comprehensive assessment, care plan, ongoing coordination of care to include referrals for behavioral health care if indicated, and an Edinburgh Postnatal Depression Scale with follow up referrals and coordination of care as indicated. If necessary, a referral would then be made to either the child or adult "intake" clinician with the ABC Care Management team.	Information Only

Findings:
Colorado Access was in the process of restructuring and integrating care coordination activities for members across all lines of business. The redesign will include a team of care coordinators dedicated to services for pregnant women. Although the existing program (described in the Evidence column above) targets pregnant women identified as having a high-risk pregnancy, the future program team will address services and a care plan, with a behavioral health component, as necessary, for all pregnant women. Staff stated that it is most likely that women at risk for postpartum depression will be identified at a child health visit and then referred to behavioral health providers and the care coordination team. The Care Coordination policy stated that care coordination interventions included specialized treatment and service plans for one year postpartum, including assisting with EPSDT services.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
2.B. The Contractor coordinates with the member's medical health providers to facilitate the delivery of health services, and makes reasonable efforts to assist individuals to obtain necessary medical treatment. If a member is unable to arrange for supportive services necessary to obtain medical care due to her/his behavioral health disorders, the Contractor will arrange for supportive services whenever possible. Contract: Exhibit A—2.4.2.2.2	• Example is available upon site review at HSAG's request. • CCS305- Care Coordination • All ABC care managers are required to go through RCCO Program training to include: Transition Program (Member program details, Care Plans, Care Coordination, Use of local programs, HNA, and RCCO onboarding. This enables both the behavioral health staff and the RCCO staff to understand each other's workflows and work collaboratively together.	Information Only
Findings: In preparation for restructuring the care coordination activities across all lines of business, Colorado Access cross trained its BHO and Regional Care Collaborative Organization (RCCO) care coordinators to work as collaborative teams to meet member needs. During the on-site interview, ABC provided case studies of members with complex needs and demonstrated collaboration among behavioral and medical providers. In addition, ABC described a community-based care management initiative at Denver Health (DH) Medical Center that provides on-site interventions for members with complex needs presenting at Denver Health emergency and inpatient psychiatric units. Case presentations included a member with significant medical needs, social needs, and a major mental health disorder who was assisted by a team of care coordinators from ABC, Mental Health Center of Denver (MHCD), and the single entry point (SEP) that arranged for stabilization of medical and behavioral needs in a long-term care facility, obtained peer specialist support, and arranged transportation to mental health appointments. Other case presentations focused on the interaction between the behavioral health and RCCO care coordinators to assist members with co-occurring behavioral and physical health needs.		
2.C. The Contractor provides for care coordination and continuity of care for special populations and complex members, including those who are involved in multiple systems and those who have multiple needs, such as: ◆ Members residing in long-term care/nursing facilities. ◆ Dually or multiply eligible members. ◆ Dually or multi-diagnosed members. ◆ Members involved with the correctional system. ◆ Child/Youth members in out-of-home placements, foster care, and subsidized adoptions.	Documentation: • CCS305-Care Coordination • CCS306- Delivering Continuity and Transition of Care for Members (page 2-3, and II.) Description: • As stated in CCS305 members in special populations or have complex needs are identified through many mechanisms as stated in CCS305-Care Coordination section II. Members, DCRs, providers can all make referrals for care coordination. Additionally members and/or providers are outreached based on utilization reports.	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Members transitioning from Colorado Mental Health Institutes (Ft. Logan and Pueblo) and hospitals. ◆ Members receiving wraparound services under an HCBS waiver. Contract: Exhibit A—2.4.2.4.1; 2.4.2.4.2; 2.4.2.2.1.1	• Colorado Access' Care Management is in the process of transforming into an enterprise or companywide program designed around special health care needs. Functional teams are being created to be able to meet special or complex health care needs as populations or specific needs are identified. Since COA has the BHO, RCCO and SEP contracts in Denver information specific to members needs for coordination can easily be shared and used to effectively meet the members' needs across multiple special needs or diagnosis with an emphasis on a person centered experience. o One such team is a team made up of SEP, Behavioral Health and AMES staff who work with members at Ft. Logan. This functional team is able to work with members to gain eligibility, assessment and access to waiver services, long-term care, nursing homes or other community resources in order to transition from Ft. Logan. • Progress is being made in collaboration with the other BHO's, RCCO's, DOC and other stakeholders who serve criminally involved members to ensure continuity of care for these members (see 2F below for detailed information). • Colorado Access staff are also working with DDHS to create communication points and workflows for children in DDHS custody placed in foster care. • Colorado Access is also deploying Care Managers into community settings. Currently Care Managers are placed in the Denver Health Psychiatric Emergency and the Denver Health Psychiatric IP units. Having face to face contact with members for the purposes of discharge planning and coordination are showing promising results in decreasing average length of stay and decreasing readmissions.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: As described preceding, Colorado Access was transitioning its care coordination services into teams of coordinators that address special healthcare needs or specific groups of members such as foster care children, members institutionalized in state hospitals, pregnant women, members transitioning from correctional facilities, members with frequent visits to DH emergency room (ER) and psychiatric units, members in long-term care facilities, and others. In addition, ABC assigned care coordinators to support members with other complex behavioral health needs and who work with other members of the internal care management staff (RCCO and SEP coordinators) to meet members' holistic needs. Staff estimated that the program transformation may require two to three years to complete. (Review of programs for some of these specialized groups is detailed in other requirements.) While many of the pilot programs have been implemented in the ADC-D region, the ABC-NE care coordinators are working with coordinators from RCCO Region 2 as well as area community mental health centers (CMHCs), SEPs, departments of human services (DHS), and community agencies to replicate successful program initiatives. During the on-site interview, staff presented a case study of a member with multiple mental health, physical health, and social needs that demonstrated collaboration among behavioral health, RCCO, and community support coordinators and providers to meet the member's needs. ABC encourages providers to refer all members with complex or special healthcare needs to the Colorado Access/ABC care management staff. ABC also identifies members with high-risk diagnoses or needs through claims data, including high use of ER or inpatient services.		
2.D. The Contractor ensures that providers (primarily Community Mental Health Centers) communicate with and coordinate services with the Single Entry Point (SEP) care manager for each member who participates in the Waiver for Persons with Mental Illness (HCBS-MI) or Waiver for the Elderly, Blind, or Disabled (HCBS-EBD). The Contractor also coordinates with assisted living residences (ALRs) or other supported community living arrangements in which HCBS waiver recipients live. Contract: Exhibit A— 2.4.2.2.1.2	Description: A portion of the ABC care managers training involves the software used by the ALTSS (Access long term support solutions). This software contains chart notes from the ALTSS case managers. The ALTSS case managers can also access Alturista which is where ABC care managers document. Both teams notify each other when there is a shared member. This ensures we are not duplicating services. • Colorado Access' Care Management is in the process of transforming into an enterprise or companywide program designed around special health care needs. Functional teams are being created to be able to meet special or complex health care needs as populations or specific needs are identified. Since COA has the BHO, RCCO and SEP contracts in Denver information specific to members needs for coordination can easily be shared and used to effectively meet the members' needs across multiple special needs or diagnosis with an emphasis on a person centered experience. o One such team is a team made up of SEP, Behavioral Health and	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	AMES staff who work with members at Ft. Logan. This functional team is able to work with members to gain eligibility, assessment and access to waiver services, long-term care, nursing homes or other community resources in order to transition from Ft. Logan. • Progress is being made in collaboration with the other BHO's, RCCO's, DOC and other stakeholders who serve criminally involved members to ensure continuity of care for these members (see 2F below for detailed information). • Colorado Access staff are also working with DDHS to create communication points and workflows for children in DDHS custody placed in foster care. • Colorado Access is also deploying Care Managers into community settings. Currently Care Managers are placed in the Denver Health Psychiatric Emergency and the Denver Health Psychiatric IP units. Having fact to face contact with members for the purposes of discharge planning and coordination are showing promising results in decreasing average length of stay and decreasing readmissions.	
Findings: As previously stated, ABC care coordinators collaborate with RCCOs, SEPs, and others in ABC-D and ABC-NE regions to arrange home and community-based services (HCBS) and other long-term support services. In the Denver region, the SEP is operated by Colorado Access, which enables ready access by all Colorado Access care coordinators to shared care coordination files. In ABC-NE, ABC care managers meet with SEP care managers who attend the community-based hot-spotter care planning meetings. Staff stated that relationships between ABC and RCCO care managers and the SEPs in the northeast region have progressed positively during 2015.		
2.E. The Contractor coordinates with county departments of human/social services in regard to children and youth in out-of-home placements (including kinship care, foster care, and subsidized adoptions) to: ◆ Ensure that children who have had a positive screen for trauma receive a formal follow-up trauma assessment and trauma-informed covered services (if indicated).	Description: • Colorado Access is working with the different county DHS agencies to develop points of contact when children served by DHS need a behavioral health service. The goal is to create MOUs to establish formal communication points and workflows. • In the NE region this trauma waiver has only been started in Larimer and Weld counties. When a DHS caseworker has a positive	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Coordinate behavioral health referrals and services with county case workers, and initiate/maintain contact with case workers on an ongoing basis regarding child/adolescent members as well as adult members who have child welfare-involved children in their care. ◆ Ensure that therapists and case managers coordinate with county case workers regarding significant events which include, but are not limited to, discharge from treatment, significant clinical decompensation, and no-shows. The provider network includes clinical staff who are familiar with the unique needs of child welfare members, are able to provide psycho-educational as well as practical therapeutic interventions, and know of and refer families to community resources. The Contractor identifies a person within its organization who can serve as a main point of contact for the county departments of human/social services. Contract: Exhibit A—2.5.11.5; 2.4.2.4.2.7.1	TRAILS, they send a notification to the SummitStone or Northrange for further trauma assessment and treatment to take place. If the CMHC cannot provide the service they coordinate with the BHO to find an appropriate provider in the BHO network. • Colorado Access frequently reviews requests from county departments of child welfare to add specialty providers to our provider network with specialties related to children in their custody. o The current network has numerous providers with specialties related to trauma, attachment disorder and other specialties commonly needed by kids in the child welfare system. • For Colorado Access the Behavioral Health Clinical Director and the ABC Northeast Executive Director are the main contacts for the county departments of human/social services.	

Findings:
ABC-D and ABC-NE directors serve as the point of contact with DHSs in their regions. Directors continued to work with DHS to develop mechanisms for access to needed mental health services for children in DHS custody. As a component of enterprise-wide reorganization of care managers, Colorado Access located community-based care managers at The Children's Hospital and DH Medical Center to engage with and coordinate services for children and families with mental health service needs. Staff reported that these on-site teams have been very successful; and Colorado Access expects to expand this process to other entities where a significant number of members, including foster children, may be receiving services. At the time of the site review, Colorado Access was working to expand on-site care management to University of Colorado Hospital clinics.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
2.F. The Contractor collaborates with agencies responsible for the administration of jails, prisons, and juvenile detention facilities to coordinate the discharge and transition of incarcerated adult and child/youth members. The Contractor: ◆ Ensures members receive medically necessary initial services after release from correctional facilities and provides the continuation of medication management and other behavioral healthcare services prior to community reentry and continually thereafter. ◆ Designates a staff person as the single point of contact for working with correctional facilities that may release incarcerated or detained members into the Contractor's service area. ◆ Collaborates with correctional facilities to obtain medical records or information for members who are released into the region, as necessary for treatment of behavioral health conditions. ◆ Works with the Department on initiatives, including Medicaid eligibility issues, related to members involved or previously involved with the State correctional system. ◆ Proposes (to the Department) innovative strategies, such as the use of technology, communication protocols, and coordination techniques with the courts, parole officers, police officers, correctional facilities, and other individuals needed to meet these requirements. Contract: Exhibit A—2.4.2.4.2.5	Description: A collaboration between all BHO's has been established in partnership with BHI, with the goal of coordinating one process for the continuity of care for criminally involved members with high behavioral health needs from all systems (i.e. DOC, jails, community corrections, probation, parole, and juvenile justice). This collaborative group has designated a single point of contact for each BHO to coordinate the discharge and transition of this population from all systems and has identified two objectives thus far that need to be accomplished to meet contractual deliverables: 1) Identification of discharging members and; 2) Reporting to HCPF through the post-correctional data report. The BHO collaborative has convened several meetings that included representatives from HCPF, the Director of Prisons, DOC, TASC, and other stakeholders. More recently, the RCCO's have also been included in these discussions to identify high physical needs members, as well as those with high behavioral health needs. This larger group has identified several considerations in moving a process forward to ensure continuity of care: • Complying with HIPPA when there is data exchanged. • Ensuring members have been attributed to the correct BHO and/or RCCO. • Development of a universal referral form that could be used to identify and transmit pertinent medical information between facility and BHO. As of June 2015, the State agreed to provide data to the BHO's on individual DOC members prior to release. As the State works through barriers to releasing this data, the contractual requirement of a data report that would track these members post release has been put on hold.	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	In the interim, Colorado Access continues to work with the other BHO's to find alternative and creative ways to connect care management services to these members prior to release, with the goal of helping establish a medical home and avoid any interruption in needed BH treatment/services. The BHO collaborative group has connected with the newly formed DOC re-entry pods to develop a process to connect the appropriate BHO with its member prior to release. The group is exploring the possibility of using BAA's or MOU's with the DOC to obtain medical records or information for members who are released into our region. Other activities that have taken place include a meeting with the head of Community Corrections, Glen Tapia and a follow-up presentation to Denver and Colorado Springs regional case managers for the clinical programs to educate and establish connections between Community Corrections and the BHO's when barriers to continuity of care arise upon release. Progress has also been made in connecting the BHO's to the various jail systems, which presents challenges as the processes differ from county to county. Thus far, two groups identified have been identified: 1) Members coming out of institutes (Pueblo-IMD Transitions Team) going into the jails 2) High mental health utilizers within the jails The BHO collaborative presented to the Colorado Jail Association in September and Sheriffs' Association in October. Connections were made with the mental health clinicians/contacts within the jails and counties who were having difficulties in getting people registered for Medicaid were identified and work will begin to address these barriers to enrollment.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Several questions have arisen from these outreach opportunities and work will continue to: • Identify if there are additional mental health programing services other than JBBS in each county jail? • Who can identify mental health clients within each jail? • How does each jail transition inmates into the community? • Does anyone follow inmates after release? • Can data be received from the jails and what needs to be in place in order to be HIPPA compliant? • What are the barriers to connecting those leaving jails to needed services? Outreach has recently been initiated with Juvenile Justice with a meeting being planned with the Foote Detention Facility to get more information re: services provided once youth are released. Also, Colorado Access participates on the DCP Board and will continue to make connections and collaborate with those serving the juvenile population. Colorado Access is engaged and at the planning table for two projects in collaboration with MHCD, the City and County of Denver, and the Corporation for Supportive Housing that benefit criminally involved members and potential members. First, the front end user group was established by the Denver Crime Prevention and Control Commission to target individuals identified as those who have the highest number of General Session court cases in Denver County. Those identified also had high rates of homelessness and utilized high-cost health settings inappropriately. This original FEU program helped identify who these individuals are and then offered wraparound services and housing first, with the goal of reducing system costs and improving client outcomes. The next iteration of the FEU group project is the Social Impact Bond project. With the SIB, those high cost/high utilizer criminal justice	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	involved individuals are similarly being identified and provided with housing and wraparound services. The main difference with the SIB is the funding mechanism (using private dollars to fund the services that Medicaid does not currently cover). In addition to the SIB, the FEU group is being targeted through the City's new Behavioral Health Solutions Center, which is in development. Colorado Access will continue to be engaged with and support both of these projects. Colorado Access participates on several community collaborations involving criminally involved members including the Community Justice Reform Coalition's ACA/CJ Stakeholder Meetings; RISE-Privately funded organization that restores competency housed out of Arapahoe County Jail; and National Organization of Counties-Stepping Up Initiative-blue print project to reduce the number of mentally ill people in jails. The BHO collaborative will be meeting with Correct Care Solutions in November to discuss ways to work together to leverage their connections to released inmates in connecting them to needed services. Finally, Colorado Access and BHI are collaborating with TASC to leverage the relationships already established between TASC and members releasing from criminal justice. The goal is to develop a process with TASC to create stronger and more immediate connections between released offenders and the physical and behavioral health services they need and now qualify for under Medicaid.	
Findings: Colorado Access was actively facilitating and participating in collaborative work sessions with a variety of agencies to better understand the processes and to identify barriers and solutions to transitioning members from correctional facilities to community providers and support services, as described in the "Evidence as Submitted by BHO" section above. Colorado Access hired a staff member dedicated to organizing program initiatives, conducting outreach activities with representatives of the corrections systems, and developing plans for implementation. Progress made in 2015 included:		

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Requirement	**Evidence as Submitted by BHO**	**Score**
	• The Department of Corrections (DOC) agreed to implement "re-entry pods" within each prison in which the case managers at the prison will contact the BHO care managers to arrange services for the individual upon release. Colorado Access collaborated with the DOC and Colorado Treatment Accountability for Safer Communities (TASC)—a community-based case management program for parolees that serves as a bridge between the criminal justice system and the community. The program was fully designed but never implemented due to contracting barriers (see barriers below). • Colorado Access, MHCD, the Denver County Jail, and DH (including the detoxification unit) worked collaboratively to define a program to notify MHCD when persons were to be released from jail. (Denver County Jail enrolls individuals in the Medicaid program prior to release.) A care manager meets with the individual upon release, accompanies him or her to arranged mental health appointments, arranges for housing if necessary, and assists the member with connections to other services in the community. • Colorado Access conducted outreach to multiple groups associated with county jail systems (e.g., the Sheriff's Association and county commissioners) to develop relationships, introduce objectives, and initiate planning. ABC also identified significant barriers to implementing programs, which include: • HIPAA concerns continue to impede the exchange of data and information regarding members being released from prison. • Lack of pre-existing relationships between the healthcare system and corrections system requires a significant effort by both groups to learn the processes and objectives of the other in order to build trust and enable program development and implementation. • TASC lost its contract with the State, which interrupted plans that had been developed to implement programs developed with the DOC. • Untimely Medicaid enrollment processes and identification of new enrollees to the health plan have been ongoing issues. Colorado Access staff stated that proposed 2016 changes to the State enrollment processes may improve this situation. • County-level participants (e.g., sheriffs, county commissioners) in program planning are vulnerable to turnover (due to elections) and other political or operational priorities. • The ABC-NE region is composed of 12 counties that span an extensive geographic region, making it difficult for ABC-NE staff to develop and maintain county collaborative relationships outside of Weld County. Staff members stated that all planned initiatives and relationship building among the agency and organization participants have been positive developments and provided increased visibility to ABC-D and ABC-NE's objectives to connect persons being released from prison or jails with necessary health and social services. However each program requires significant time and energy to understand the complexity of the system and build sustaining relationships. Despite ongoing efforts and activity, most initiatives remain in the discussion, development, and pre-implementation stages.	

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Requirement	**Evidence as Submitted by BHO**	**Score**
2.G. The Contractor provides outreach, a delivery system, and support to nursing facilities and assisted living residences in its service area, including: ◆ Provision of medically necessary, covered behavioral health services on-site in nursing facilities and assisted living residences for members who cannot reasonably travel to a service delivery site. (Residents able to travel may be required to receive their behavioral health services at a delivery site.) The Contractor will work collaboratively with the facilities to determine which residents are and are not able to travel. ◆ Monthly outreach and coordination for the provision of mental health and substance use disorder services for members in nursing facilities and assisted living residences. ◆ Assigning a primary contact from the BHO to each nursing facility and assisted living residence, who will ensure members are receiving necessary behavioral health services and help problem solve any related member issues. ◆ Establishing an ongoing quarterly meeting with all nursing facilities and assisted living residences to address outstanding issues. ◆ Providing Preadmission Screening and Resident Review (PASRR) Level II requirements and services to members entering nursing facilities, and providing any specialized behavioral health services identified on the assessment. Contract: Exhibit A—2.4.2.4.2.1	Documentation: • CCS413 Access and Availability for Members Residing in Nursing Facilities/Assisted Facilities Description: ABC became proactive with partnering with the director of MHCD nursing homes, to assess nursing homes, to ensure their needs are being met, to problem solve around barriers and challenges: Currently, MHCD provides covered behavioral health services on-site to 16 SNF's in Colorado Access' catchment area with high behavioral health needs currently, including LCSW and psychiatric services. The LCSW's are in each facility a minimum of weekly and in most facilities several times per week and offer individual and group treatment. Two psychiatrists are divided among the facilities per caseload and additionally attend a psych pharm meeting monthly at most of these facilities. These meetings with the SNF's include their Medical Director, Director of Social Services, Administrator, pharmacy consult and often MHCD's LCSW to discuss dosages and interactions of medications. In addition, MHCD's Director of Nursing Homes meets weekly with three facilities, monthly with an additional two facilities and various other facilities as needs arise, but at least quarterly. These meetings have included Colorado Access staff in the past, as well. MHCD reports development of positive working relationship with the facilities and continues, in partnership with Colorado Access staff, to facilitate placements and coordinate treatment of SNF members. Colorado Access's Director of Community Programs is the contact assigned to outreach nursing facilities and to ensure members are receiving needed services and to problem solve barriers. Outreach has been done through email to directors of facilities and in-person visits. This Colorado Access main point of contact is in the process of	Information Only

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Requirement	**Evidence as Submitted by BHO**	**Score**
	collecting and analyzing claims data to ensure that Colorado Access and MHCD is providing support and outreach to the facilities with the most behavioral health needs initially. Colorado Access hosts a Health Neighborhood meeting every other month, inviting contracted providers and protocol partners, including SNF's. Health Neighborhood meeting typically focuses on a training topic. The next meeting is scheduled for November 19, 2015 with care management as the topic. Since July, a nursing home collaborative group has been established within Colorado Access. Initial goals of the group include: • A cross company care management pilot project to outreach SNF's, with the goal of gathering data, educating and assessing greatest needs. • Scheduling of first quarterly meeting with nursing home directors before the end of 2015, once needs have been better determined. • More collaborative cross-company strategy for nursing home and skilled nursing facility engagement. • Addressing gaps. • Need for SNF engagement around transition to LTC (AA). • How best to go out to facilities; how to gather information; how to return with appropriate resources. Finally, Colorado Access, in partnership with BHI has developed a collaborative with the Colorado Choice Transitions team through HCPF and the Continuity of Care with Transition Specialist Program (CCTSP) through Office of Behavioral Health to form a collaborative effort to address issues related to continued institutionalization of individuals with behavioral health disabilities. There will be representation from nursing facilities and assisted living facilities. The goal of this this group	

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Requirement	**Evidence as Submitted by BHO**	**Score**
	is to address outstanding barriers to transitions. This group will work in conjunction with nursing facilities to identify barriers to services and to strengthen the behavioral health services continuum that supports the individual members.	
Findings: ABC had a well-defined process for providing behavioral health services to members residing in long-term care facilities. MHCD, the primary behavioral health provider in ABC-D's service area, provides services to members in 16 long-term care nursing facilities and works with each facility as outlined in the contract requirements. Staff stated that these 16 facilities represent the majority of facilities in the service area that accept Medicaid members. ABC-D providers and care coordinators refer members to the regional SEP to perform Preadmission Screening and Resident Review (PASRR). ABC-D expanded activities in 2015 to evaluate the effectiveness of current services provided to members in long-term care facilities and to identify and address barriers related to transitioning members with significant behavioral health needs into nursing facilities. ABC-D has been working with the Colorado Access RCCOs and a collaboration of skilled nursing facilities (SNFs) to explore the gaps in care and resolve identified issues. ABC described current processes and expanded activities in the "Evidence as Submitted by BHO" section above. ABC-NE is working to organize similar programs in its region.		
2.H. The Contractor works closely and collaboratively with the Regional Care Collaborative Organizations (RCCOs) on care coordination activities. Contract: Exhibit A— 2.4.2.2.3	Documentation: • Examples will be available during the on-site review as requested by HSAG. Description: • Colorado Access maintains its strong commitment to care management as a core competency. Colorado Access is also committed to innovating emerging models and practices that are member-centered and highly coordinated, maximizing efficiency and seamless communications for members and providers. We engaged an external consultant in spring of 2015 to facilitate the transformation of the CM programs across the enterprise. • Staff engaged at all levels; external consultation work with Point B consultants completed 9/25 • We now have a road map laying out clear scope and direction regarding model of care, human capital, tools & technology, and collaboration • This is being translated to a detailed work plan with short-and long-	Information Only

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Requirement	**Evidence as Submitted by BHO**	**Score**
	term transformation activities • The effort is clearly enterprise-wide and will require ongoing, high-level commitment as well as engagement of care management and other staff across the company • Goal is to continue to meet current contractual requirements and also identify areas to reduce duplication and maximize value to the member. • Aim is to make care management more data-driven, both in identifying appropriate populations and members, and also in evaluating impact on outcomes	
Findings: The ABC regions and the Colorado Access RCCO regions significantly overlap, enabling sharing of care coordination information and systems and the development of care coordination teams that cross lines of business. ABC presented several case studies that demonstrated coordination between the BHO and RCCO care coordinators in both ABC regions. In addition, staff stated that ABC care coordinators cross trained with RCCO care coordination staff to enhance joint care coordination for members with complex needs and to prepare for transformation of Colorado Access' enterprise-wide care management program.		
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: Exhibit A— 2.5.1; 2.5.5.3; 2.5.5.4	Documentation: • CCS305- Care Coordination Description: ABC Care Mangers coordinate with multiple providers, and human service agencies on behalf of the member. The activities focus on coordinating provision of services, promoting and assuring service accessibility, with attention to the individual needs, and continuity of care among other activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The Contractor ensures that each member accessing services receives an individual intake and assessment for the level of care needed, performed by a qualified clinician. The intake and assessment process addresses: ◆ Developmental needs. ◆ Cultural and linguistic needs.	Documentation: • This requirement can be found in the Colorado Access provider manual on page 87. Colorado Access audits the provider's compliance through our Medical Record Audits that are completed by the Quality department. • FY15 ABC Medical Record Audit Summary	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Screening for mental illness, substance use, and trauma disorders. *42CFR438.208(c)(2)* Contract: Exhibit A—2.5.10.1		
Findings: The provider manual informed providers of their responsibility to perform an initial and ongoing member assessment and delineated the components of the assessment, including those elements identified in the requirements. However, ABC's monitoring mechanism—medical record audits—is inadequate to ensure that each member accessing services receives an individual assessment with the required components. The audit does not include cultural and linguistic needs and is applied to an inadequate sample of member records—i.e., two records each from five providers annually.		
Required Actions: ABC must enhance the process and scope of monitoring providers to ensure that a representative sample of members accessing services receive an intake assessment with the required components.		
5. The Contractor shares with all health plans, RCCOs, and providers serving each member with special healthcare needs the results of its identification and assessment of the member's needs to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A—2.4.2.4.2.4.1	Documentation: • Examples will be available at the site visit. Description: All care managers, regardless of their program area, are expected to coordinate with each other when the member has more than one program.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor utilizes the information gathered in the member's intake and assessment to build an individualized, culturally sensitive comprehensive service plan that includes: ◆ Measurable goals. ◆ Strategies to achieve the stated goals. ◆ A 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	Documentation: • This can be found in the Colorado Access Provider Manual Page 87 • FY15 ABC Medical Record Audit Summary Description: ABC requires the provider to follow the provider manual. The provider manual on page 87 states these items. Quality completes an annual medical record audit on providers which includes chart standards to ensure provider compliance with this requirement.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
provider/treatment team, and is signed by the member and the reviewing professional. (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.) 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: Exhibit A—2.5.11.1–2.5.11.4		
Findings: The provider manual communicated the provider's responsibility for developing an individualized service plan and specified all elements outlined in the requirement. The medical record audit tool incorporated all required elements of the treatment plan; however, the medical record audit was performed on a number of records (10 total records annually) inadequate to be a valid representation of the overall performance of the health plan. In addition, a medical record audit was performed by ABC-D only.		
Required Actions: ABC must enhance the scope of monitoring providers to ensure that a representative sample of members have a comprehensive service plan that addresses the elements outlined in the requirement.		
7. The Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or approved number of visits) as appropriate for the member's condition. *42CFR438.208(c)(4)*	Documentation • CCS310 Page 5, III Description: COA has an open panel PCP and Specialists – therefore a referral to a specialist is not required.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor shall adequately and timely provide the covered services out of network at no cost to the member. *42CFR206.(b)(4)* Contract: Exhibit A—2.5.9.5	Documentation: • CCS307 (pg 14, II.A.4.) • Network Adequacy Report page 4.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
9. The Contractor must arrange for the provision of all *medically necessary services* * identified under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, 42 CFR Sections 441.50 to 441.62, including: ◆ Referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. (Referral assistance must include giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.) ▪ At a minimum, the Contractor must assure that the medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. ◆ Making appropriate use of State health agencies, State vocational rehabilitation agencies, Title V grantees (Maternal and Child Health/Crippled Children's Services), and other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC). ◆ Offering the family or beneficiary necessary assistance with transportation and necessary assistance with scheduling appointments for EPSDT services. *Medical necessity for EPSDT— Medical Necessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a	Documentation: • CCS 306- Delivering Continuity and transition of Care for Members • This information is found in the ABC member handbook (pg 8-9) • This information can be found in the Colorado Access provider manual (pgs. 92-94)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
manner consistent with accepted standards of medical practice, it: ◆ Is found to be an equally effective treatment among other less conservative or more costly treatment options, and ◆ Meets at least one of the following criteria: ▪ The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability. ▪ The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability. ▪ The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability. ▪ The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living. Medical necessity may also be a course of treatment that includes mere observation or no treatment at all. *42 CFR 441.61 (a) and (b);* *42 CFR 441.62* Contract: Amendment 3— 6.A.2.2.1 10 CCR 2505-10—8.280.8.C and D.5 10 CCR 2505-10—8.280.1		
Findings: The Colorado Access Care Coordination policy (applicable to all Colorado Access lines of business) stated that care coordinators will assist members with access to EPSDT services not covered by the BHO, including collaboration with State and community agencies outlined in the requirement. The ABC provider manual informed providers of their responsibility to contact the (ages 0 through 20) member's primary care provider (PCP) to obtain results of		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
EPSDT screenings and/or to refer the member to the PCP for any screenings needed. The manual informed providers that "any service necessary to treat healthcare needs identified through an EPSDT screening must be provided through the Medicaid program, even if the identified service is not included in the State's Medicaid plan." The assessment standards outlined in the provider manual required that providers document that EPSDT exam results were requested from the PCP and reviewed, if obtained; a referral was made when EPSDT screening had not been done or the child did not have a PCP. However, the provider manual did not inform providers of their responsibility to provide referral assistance for treatment not covered by the BHO but found to be needed as a result of conditions disclosed during EPSDT screening and diagnosis or how to obtain assistance in making referrals, such as referring the member to Colorado Access care management, Healthy Communities, or the Department of Health Care Policy and Financing (the Department) Office of Clinical Services. During on-site interviews, staff members stated there were no additional provider trainings regarding referral for EPSDT services and no mechanisms to monitor ABC providers for compliance with EPSDT referrals. Staff members stated that these requirements were difficult for ABC providers to implement and that staff had been seeking clarification from the Department regarding how to effectively operationalize EPSDT requirements within the BHO.		
Required Actions: ABC must enhance its provider communications and internal procedures to more specifically address the requirement related to referral assistance for treatment not covered by the BHO but found to be needed as a result of conditions disclosed during EPSDT screening and diagnosis. Procedures should address referring members to the Office of Clinical Services/Healthy Communities and assisting members as necessary with scheduling appointments and transportation. HSAG recommends that ABC continue to work with the Department to obtain clarity and guidance regarding EPSDT requirements and consider developing enhanced provider training and/or monitoring related to coordination of EPSDT services.		
10. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (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 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: 10.B; Exhibit A—2.4.2.1.1.6	Documentation: • HIPAA Training Attestation • HIP201 Description: Colorado Access ensures all staff members go through HIPAA training to ensure that in the process of coordinating care, each member's privacy is protected in accordance with 45 CFR.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
11. The Contractor shall form relationships with community partners and government agencies that provide services to members. Agencies include: ◆ Colorado Department of Health Care Policy and Financing, Division of Developmental Disabilities. ◆ Colorado Department of Human Services, Child Welfare. ◆ Colorado Department of Human Services, Office of Behavioral Health. ◆ Colorado Department of Public Health and Environment, STD/HIV Section. ◆ Colorado Department of Public Health and Environment. ◆ Colorado Department of Corrections. ◆ Colorado Prevention Services Division. Contract: Exhibit A—2.4.2.5; 2.4.5.6	Description: Colorado Access is a founding member of the Mile High Health Alliance. The Executive Director of ABC sits on the MHHA board and is a member of the executive committee. MHHA vision is to promote health and assure access to integrated medical and behavioral care, and social services for all. Members include Denver Public Health, Denver Environmental Health, Denver Public Schools, and Denver Human Services. Through MHHA, Colorado Access has formed productive working relationships with key governmental agencies and important safety net providers and stakeholders to address and resolve common issues. Outside of MHHA, Colorado Access works closely with the Denver Department of Human Services to provide services to children in foster care and at risk for out of home placements. Our care coordinators work closely with DDHA case workers. Leadership teams from both agencies are in frequent communication to address complex cases. Colorado Access is working closely with DOC to develop a process to identify members to be released. See 2.F above.	Information Only

Findings:
ABC described its relationships with multiple state and local agencies in elements 2A through 2F above, including DHS and the DOC. ABC initiates or responds to opportunities to work collaboratively with various agencies on developing programs or coordinating care for members as well as participating in interagency work groups and associations. ABC has an ongoing relationship with the Office of Behavioral Health (OBH) through the contracted CMHCs. In addition, Colorado Access developed relationships and programs through other lines of business (i.e., RCCOs) accessible to ABC.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
12. The Contractor shall ensure that behavioral health services are provided to dual or multi- eligible members and assist members in finding qualified Medicare providers who are willing to provide covered services. If qualified Medicare providers cannot be identified or accessed, the Contractor shall provide medically necessary covered behavioral health services. Contract: Exhibit A—2.4.2.4.2.2.1.	Documentation: • ABC307- Access and Availability for Dual Eligible Members	Information Only
Findings: ABC's Access and Availability for Dual Eligible Members policy and procedure stated that ABC will find a Medicare provider for a member or provide services within the Medicaid network. Colorado Access had a Medicare line of business; therefore, ABC has ready access to a list of Medicare providers. Colorado Access can determine member eligibility through its *Access Medical Enrollment Services (AMES)* program, which enrolls members in programs for which they are eligible. Providers and members may request assistance from ABC care managers to find a qualified Medicare provider. Staff members stated that Colorado Access' familiarity with Medicare providers enhances its ability to make referrals and coordinate benefits.		
13. For members with a behavioral health covered diagnosis and a co-occurring noncovered diagnosis, including autism, traumatic brain injury, and developmental disability, the Contractor will assess members using Department-approved criteria and provide medically necessary covered services for the behavioral health diagnosis. ◆ The Contractor has a mechanism for working with developmental disability services, Community Centered Boards (CCBs), Single Entry Point agencies (SEPs), or other appropriate agencies/healthcare providers to secure agreement regarding the medical necessity of behavioral services. ◆ The Contractor provides care coordination to members, including appointment setting, assistance with paperwork, and follow-up to ensure linkage with the appropriate agency. If the Contractor determines that the member does not have a covered behavioral health diagnosis, the	Documentation: • Example available during on site review at HSAG's request • CCS305- Care Coordination • CCS 306- Delivering Continuity and transition of Care for Members	Information Only

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Requirement	**Evidence as Submitted by BHO**	**Score**
Contractor informs the member about how services may be obtained, and refers them to the appropriate providers (e.g., RCCOs, CCBs, and SEPs). Contract: Exhibit A—2.4.2.4.2.3.2–3; 2.5.10.2.2–3		
Findings: Colorado Access' multiple lines of business (BHOs, RCCOs, and SEP) enhanced its ability to coordinate services for members with co-occurring, non-covered diagnoses. Care managers evaluate each case individually and work closely with providers to ensure that all medically necessary needs (behavioral and physical) are addressed by the most appropriate provider. Care managers also ensure that all providers are kept apprised of the member's health status. ABC-NE assigned care coordinators to the CCB in an effort to develop relationships and streamline referrals to needed services. Case study presentations viewed on-site demonstrated ABC's ability and willingness to provide and coordinate services for members with physical and mental health needs.		
14. The Contractor maintains policies, procedures, and strategies for helping to transition members from Mental Health Institutes (Institutes) located at Ft. Logan and Pueblo to safe and alternative environments. The Contractor also: ◆ Care coordinates with the Institutes to have plans in place to provide medically necessary covered services once the member has been discharged from the Institute. ◆ Works with local counties and hospitals in its region in order to transition children from hospitals to safe and alternative step-down environments (e.g., home, residential). ◆ Meets with local counties and hospitals to develop transition protocols and procedures to ensure continuity of care and continuation of services for members. ◆ Works with the Institutes to execute communication and transition plans for members. ◆ Assigns a liaison to serve as a regular point of contact with Institute staff and members who will return to or enter the Contractor's geographic service area.	Documentation: • CCS 306- Delivering Continuity and Transition of Care for Members Description: • Colorado Access collaborated with all of the BHOs in Colorado as well as representatives from both Pueblo State Hospital and Fort Logan State Hospital in an effort to come up with a more effective process to identify the Medicaid members that were transitioning from the state hospitals into the jails to ensure they got the mental health services and supports they need in jail as well as when they transition back into the community. Those meetings were titled the "IMD Transition Meetings". These meetings had a two prong goal – one was to create a list of the point people designated by each BHO that were responsible for coordinating care for this population – the second goal was to create a universal referral process. During those meetings a referral form (Patient Referral for Transitional Services) was created that could be faxed by the state hospital social workers to the designated point person for the correct BHO for that member. • After this process was refined and put into place the next steps	Information Only

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Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Is responsible for ongoing treatment, case management, and other behavioral health services once the member is discharged from an Institute. ◆ Participates on the Institute's Person Centered Planning Board. Contract: Exhibit A—2.4.2.4.2.8	identified were • The need to continue this process with the involvement of the jails and the individual mental health centers to discuss how to access inmates and how to assess needs of members in jail that are not in that county's BHO. • The need to create a list of point people within each jail and within each mental health center that would take on this task of communicating and facilitating the mental health services for this population. • HCPF was asked to facilitate a meeting with our work group and the appropriate point people within DOC. This meeting was put in place and held in June 2015. The contact lists that included the point people for each BHO were shared with the participants at this meeting. During this meeting the "correctional liaisons for the BHOs" were identified and shared with all involved parties (BHOs, HCPF, MHCs, IMDs. A JBBS contact information sheet was also shared with all involved parties.	

Findings:
The Colorado Mental Health Institute is the assigned provider for ABC-NE members in ABC-NE. ABC-NE staff members stated that beds are rarely, if ever, available to its members. For this reason, ABC-NE focused efforts on building relationships with other hospital providers in the region rather than developing procedures for transitioning members out of the institute. ABC-D, in partnership with MHCD—which has allocated beds at Fort Logan—developed a coordinated process for discharge of its members from the Colorado Mental Health Institute at Fort Logan. ABC-D and MHCD care managers meet with Fort Logan staff prior to member discharge to coordinate and schedule follow-up appointments at MHCD. The ABC-D care manager works with providers and community organizations to address any barriers to discharge. Staff stated that Fort Logan provided positive feedback regarding the team transition process. Colorado Access' redesigned care management program includes a care management team dedicated to follow up with adolescents after discharge from a psychiatric hospital.

Results for Standard III—Coordination and Continuity of Care for ABC-D							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	10	**Total Score**		=	7

Total Score ÷ Total Applicable	=	70%

Results for Standard III—Coordination and Continuity of Care for ABC-NE							
Total	Met	=	7	X	1.00	=	7
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	10	**Total Score**		=	7

Total Score ÷ Total Applicable	=	70%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A—2.6.8.1	Documentation: • CS212-Member Rights and Responsibilities, Section I (pg 2) • ABC Member Handbook (pg 20) 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 ☐ N/A
2. The Contractor ensures that its staff and affiliated and network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A—2.6.8.1	Documentation: • CS212 Member Rights and Responsibilities, Sections III-V (pg 2) • Provider Manual, Section IV (pgs 18-19, 55) • Quarterly Grievance and Appeals Reports Q2 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 complaint and appeal procedures, the Notice of Privacy Practices, and Evidence of Coverage documents." (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	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Providers are informed within the Provider Manual that Members have certain rights that they must be aware of (pgs. 18-19, 55). Member Rights and Responsibilities training for staff is contained in the webinar training "Member Rights and Responsibilities" PowerPoint as well as an FAQ sheet that is given to staff. Quarterly grievance and appeals report track concerns related to member rights and are addressed.	
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated and 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 healthcare, 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 healthcare services in accordance with requirements for access and quality of services. *42CFR438.100(b)(2) and (3)* Contract: Exhibit A—2.6.8.1	Documentation: • Member Handbook, Member Rights and Responsibilities (pg 20-25) • 1st Qtr Denver Partnership Newsletter • 1st Qtr Northeast Partnership Newsletter • Provider Manual (pg 6, 85) • Quarterly Grievance and Appeals Reports Q2 Description: Each new Member receives a new member packet mailing, including the ABC Member Handbook. This handbook outlines their rights (pgs. 20-25). On a regular basis, the ABC Partnership Newsletter also reminds our Members that they have rights afforded to them. This can be found in the Partnership Newsletters. We ensure these rights through the monitoring of member grievances related to member rights. See Grievance and Appeals report for Q2.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: Rather than list the specific member rights, Policy CS212—Member Rights and Responsibilities referenced a specific section of the Colorado Code of Regulations (CCR) and the contract between ABC and the Department. While this mechanism of reference is acceptable, the section of CCR referenced in the policy was incorrect and the contract routing number was outdated.		
Required Actions: Colorado Access must revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights.		
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: Exhibit A—2.6.8.1	Documentation: • Member Handbook, Member Rights and Responsibilities (pgs. 20-25). • Provider Manual, (pg 86) 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 (pgs. 20-25), and in the Provider Manual states that this is a Member right (p86). 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 (p23). • Exercise your rights without any change in the way Access Behavioral Care or our providers treat you (p23). 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 Q2.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
5. The 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: Exhibit A—2.6.8.1	Documentation: • ADM205-Nondiscrimnination • ADM229- Member Disability Rights Request and Complaint Resolutions Process Description: Colorado Access policy ADM205 outlines our nondiscrimination policy and adherence to applicable Stated and Federal laws. Colorado Access' policy ADM229 Member Disability Rights Request and Complaint Resolution outlines our policy and adherence to applicable State and Federal laws.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor shall post and distribute member rights to individuals, including: stakeholders, members, providers, member's families, and case workers. Contract: Exhibit A—2.6.8.2	Documentation • Member rights can be found on the Colorado Access website http://www.coaccess.com/your-rights-and-responsibilities Annual Member Mailing Letter • Colorado Access also provides a flier to providers to post in their clinics. • Member Rights are also in the Member Handbook (pgs. 20-25) • Annually Colorado Access sends an "Annual Member Notice"	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard IV—Member Rights and Protections for ABC-D							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	6	**Total Score**		=	5

Total Score ÷ Total Applicable	=	83%

Results for Standard IV—Member Rights and Protections for ABC-NE							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	6	**Total Score**		=	5

Total Score ÷ Total Applicable	=	83%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence 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. ◆ The Contractor shall use National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all contracts. Contract: Exhibit A—2.9.7.2.3.1 NCQA CR1	Documentation • CR301- Provider Credentialing and Recredentialing • CR302- Office Site Visit for Provider CredentialingCR307- Credentialing/Recredentialing Provider Classification and Credentials Committee Determination Process • CR312 – Provider Rights • CR318 – Ongoing Monitoring of Provider Sanctions, Grievances and Occurrences of Adverse Actions • PNS202 – Selection and Retention of ProvidersCMP206- Sanction, Exclusion, Prohibited Affiliations and Opt-Out Screening Page 4, Procedure I. B. 4 • ADM223 – Delegation Page 4, Procedure I. H Page 5, Procedure I. L Page 5, Procedure II. D • ADM301- Adverse Actions Hearing and Appeal Process for Providers Page 10, Procedure II, III • QM201 – Investigation of Potential Clinical Quality of Care Grievances and Referrals	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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: • PNS202 – Selection and Retention of Providers • CR301 – Provider Credentialing and Recredentialing Page 3, Procedure I. (add in criteria from old 301?) • Credentialing Committee minutes available upon request at site visit	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.B. The verification sources used. NCQA CR1—Element A2	Documentation: • CR301 – Provider Credentialing and Recredentialing (pg 12-14, Procedure XV)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	Documentation: • CR301 - Provider Credentialing and Recredentialing (pg 7, Procedure VIII) • CR307 – Credentialing and Recredentialing Provider Review Classification • Provider Credentialing Checklist	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	Documentation: • CR301 - Provider Credentialing and Recredentialing Page 8-10, Procedure IX. Page 17-18, Procedure XVI • CR307 – Credentialing and Recredentialing Provider Review Classification • Credentialing Committee minutes available upon request at site visit	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	Documentation: • CR301 - Provider Credentialing and Recredentialing (pg 6, Procedure VII. File Maintenance and Confidentiality) Description: Credentialing files are maintained using the Apogee Managed Care Credentialing System (Morrisey Associates, Inc.). 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 ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	Documentation: • CR301 - Provider Credentialing and Recredentialing Page 6, Procedure VI. Delegation Page 7-8, Procedure VIII. Credentialing/Recredentialing Criteria and Verification Time Limits • ADM223 – Delegation (pg 4, Procedure I, H) (pg 5, Procedure I, L) (pg 5, Procedure II, D) • See Folder: Delegation Agreements	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.G. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory 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; and that it takes proactive steps to prevent and monitor discriminatory practices). NCQA CR1—Element A7	Documentation: • CR301 - Provider Credentialing and Recredentialing • (pg 4, Procedure III, Non-Discrimination) • Credentials Committee signatures on the Non-Discrimination Acknowledgment can be made available during the site review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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: • CR301 - Provider Credentialing and Recredentialing (pg 6, V. Provider Rights) • CR312 – Provider Rights • Procedure II. Correcting Erroneous Information • CO Health Care Professional Credentials Application (pg 23, 12)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. NCQA CR1—Element A9	Documentation: • CR301 - Provider Credentialing and Recredentialing (pg 18, Procedure XVII. Credentialing Determination Notification)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	Documentation: • CR301 – Provider Credentialing and Recredentialing (pg 5, Procedure IV. Program Resources **(**pg 8-10, Procedure IX. Credentials Committee)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process. NCQA CR1—Element A11	Documentation: • CR301 – Provider Credentialing and Recredentialing (pg 6, Procedure VII. File Maintenance and Confidentiality) • Confidentiality statements signed by the Credentials Committee can be produced upon request during site review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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: • CR301 – Provider Credentialing and Recredentialing (pg 18-19, Procedure XVIII. Provider Listings in the Directories)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.M. The Contractor notifies practitioners about their rights: ◆ The right to review information submitted to support their credentialing or recredentialing application. NCQA CR1—Element B1	Documentation: • CO Health Care Professional Credentials Application **(**pg 23, 12) • CR301 – Provider Credentialing and Recredentialing (pg 6, Procedure V. Provider Rights) • CR312 – Provider Rights	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.N. The right to correct erroneous information. NCQA CR1—Element B2	Documentation: • CO Health Care Professional Credentials Application (pg 23, 12) • CR301 – Provider Credentialing and Recredentialing (pg 6, Procedure V. Provider Rights) • CR312 – Provider Rights (pg 3, Procedure II. Correcting Erroneous Information)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.O. The right to receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	Documentation: • CO Health Care Professional Credentials Application (pg 23, 12) • CR301 – Provider Credentialing and Recredentialing (pg Page 6, Procedure V. Provider Rights) • CR312 – Provider Rights (pg 3, Procedure III. Provider Request for Information on Application Status)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.P. 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 CR6—Element A	Documentation: • CR301 – Provider Credentialing and Recredentialing (pg 10-11, Procedure XI. Ongoing Monitoring of Sanctions) • CR318 – Ongoing Monitoring of Provider Sanctions, Grievances and Occurrences of Adverse Actions • QM201 – Investigation of Potential Clinical Quality of Care Grievances and Referrals (pg 6, M-O)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.Q. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR7—Element A1	Documentation: • ADM301 – Adverse Action Hearing and Appeal Process for Providers • QM201 – Investigation of Potential Clinical Quality of Care Grievances and Referrals (pg 6, M-O)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.R. 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 CR 7—Elements A2 and B	Documentation: • ADM301 – Adverse Action Hearing and Appeal Process for Providers (pg 10-11, Procedure III. A, 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.S. A well-defined appeal process for instances in which the Contractor has taken action against a practitioner for quality reasons, 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 CR7—Elements A3and C	Documentation: • ADM301 – Adverse Action Hearing and Appeal Process for Providers (pg 5, Procedure II. C, pg 17, Attachment B) • QOC Notice Of Action Letter Template	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.T. Making the appeal process known to practitioners. NCQA CR7—Elements A4 and C	Documentation: • QOC Notice Of Action Letter Template	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A1	Documentation: • CR301 – Provider Credentialing and Recredentialing (pg 8, Procedure IX, Credentials Committee)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
4. The credentialing committee: ◆ Reviews credentials for practitioners who do not meet established thresholds. ◆ Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Elements A2 and A3	Documents Submitted • CR301 – Provider Credentialing and Recredentialing (pg 8, Procedure IX, Credentials Committee) • CR307 - Credentialing/Recredentialing Provider Classification and Credentials Committee Determination Process (pg 2, Procedure I. Pre-credentials File Review and Credentials Committee Preparation Process)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 is 180 calendar days). ◆ A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision).	Documentation: • CR301 – Provider Credentialing and Recredentialing (pg 7, Procedure VIII. Credentialing/Recredentialing Criteria and Verification Time Limits, Page 122, Procedure XV. Verification Process)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
◆ 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 is 180 calendar days). ◆ Health professional work history—last five years (verification time limit is 365 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit is 180 calendar days). NCQA CR3—Element A		
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= 1/mil/1 mil). ◆ The correctness and completeness of the application. NCQA CR3—Element C Contract: 13.B.(*v*)	Documentation: • CR301 – Provider Credentialing and Recredentialing (pg10, Procedure X. B) • CO Health Care Professional Credentials Application (pg 20, XII. Attestation Questions, pg 25, Supplemental A, 3-4 pg 26, Supplemental B, 1-2, Page 16, X. Professional Liability Insurance)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence 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 CR3—Element B	Documentation: • CR301-Provider Credentialing and Re-credentialing (pg 10-11, Procedure XI. A, pg 16 Procedure XV.I, 2-3)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
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 CR5—Element A	Documentation: • CR301-Provider Credentialing and Re-credentialing (pg 16, J. 1) • CR302-Office Site Visit for Providers Credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor implements appropriate interventions by: ◆ Continually monitoring member complaints for all practitioner sites. ◆ Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met. ◆ 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. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR5—Element B	Documentation: • CR302-Office Site Visit for Providers Credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
10. The Contractor formally recredentials its practitioners at least every 36 months. NCQA CR4	Documentation: • CR301-Provider Credentialing and Re-credentialing (pg 9, Procedure IX. F)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms—initially and at least every three years— that the provider is in good standing with state and federal regulatory bodies. NCQA CR8—Element A1	Documentation: • CR305 – Organizational Provider Credentialing (pg 4, Procedure IV. Criteria and Verification Requirements) • CMP206 – Sanction, Exclusion, Prohibited Affiliations & Opt-Out Screening (pg3-5, Procedure I., B, 4) • CR318 – Ongoing Monitoring of Provider Sanctions, Grievances and Occurrences of Adverse Actions	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: Colorado Access had written policies and procedures that described the process for credentialing organizational providers. The process included confirming at least every three years that the organization is in good standing with both State and federal regulatory agencies. On-site record review demonstrated that Colorado Access implemented this policy; however, two of the five organizations had not been recredentialed within the three-year time frame.		
Required Actions: Colorado Access must implement a process to ensure that organizations with which it contracts are recredentialed at least every three years.		
11.B. The Contractor confirms—initially and at least every three years—that the provider has been reviewed and approved by an accrediting body. NCQA CR8—Element A2	Documentation: • CR305 – Organizational Provider Credentialing (pg 3-4, Procedure II, C, pg 6, Procedure V. Accreditation or Site Visit by CMS, DMH, OBH or Colorado Access	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
11.C. The Contractor conducts—initially and at least every three years—an on-site quality assessment if there is no accreditation status. NCQA CR8—Element A3	Documentation: • CR305 – Organizational Provider Credentialing (pg 6, Procedure V. Accreditation or Site Visit by CMS, DMH, OBH or Colorado Access, pg 10 Procedure VII.E)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.D. The Contractor's policies specify the sources used to confirm: ◆ That providers are in good standing with state and federal requirements. ◆ The provider's accreditation status. (Includes applicable state or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider.) NCQA CR8—Element A, Factors 1 and 2	Documentation: • CR305 – Organizational Provider Credentialing (pg 6, Procedure V. Accreditation or Site Visit by CMS, DMH, OBH or Colorado Access pg 10, Procedure VII. D-E)or Colorado Access Page 10, Procedure VII. D-E)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that the provider credentials its practitioners. NCQA CR8—Element A, Factor 3	Documentation: • CR305 – Organizational Provider Credentialing (pg 11, Procedure VII. E – Last paragraph)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The Organizational Provider Credentialing policy and procedure included the criteria used to assess unaccredited organizational providers, which included staff hiring and credentialing processes. While on-site record review demonstrated that Colorado Access collected the organization's policies and procedures related to staff hiring and credentialing, some policies collected were not compliant with Colorado Access' credentialing standards.

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
Required Actions: Colorado Access must be sure that unaccredited organizational providers are credentialing practitioners in a manner consistent with Colorado Access policies, procedures, and standards.		
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards. NCQA CR8—Element A, Factor 3	Documentation: • CR305 – Organizational Provider Credentialing (pg 11, Procedure VII. E)	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The Organizational Provider Credentialing policy and procedure described the circumstances under which Colorado Access could substitute a CMS or State quality review in lieu of a site visit; however, the policy did not specify that Colorado Access would confirm that the survey conducted by CMS or the State meets its own quality assessment criteria or standards. HSAG did not find evidence in the records reviewed that Colorado Access confirmed the content of the CMS or State review. Some CMS and State reviews included with the records reviewed indicated the need for corrective action; however, Colorado Access did not document that it confirmed that the corrective actions had been completed. Furthermore, one of the State site reviews documented in the record as being used in lieu of a site visit was more than three years old at the time of the credentialing decision.		
Required Actions: Colorado Access must specify in its policies that it will confirm that CMS and State quality reviews used in lieu of Colorado Access site visits include all criteria and standards identified in Colorado Access' policy. Colorado Access must ensure that CMS and State quality reviews used are no more than three years old at the time of the credentialing decision. Additionally, if the CMS or State quality review required that the organization complete any corrective actions, Colorado Access must document that the organization completed all corrective actions.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
13. The Contractor's organizational provider assessment policies and process include assessment of at least: ◆ Inpatient facilities. ◆ Residential facilities. ◆ Ambulatory facilities. NCQA CR8—Element B	Documentation: • CR305 – Organizational Provider Credentialing (pg 2, Procedure I. Scope of Credentialing Activities)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor has documentation that it has assessed contracted behavioral healthcare (organizational) providers. NCQA CR8—Element C	Documentation: • CR305 – Organizational Provider Credentialing (pg 2, Procedure I. B)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR9	Documentation: • ADM223 - Delegation • See Delegate Audits Folder: o Boulder Valley IPA – BVIPA Credentialing Audit Findings o Denver Health and Hospital Authority- DHHA Credentialing Audit Findings o University Physician Inc – UPI Credentialing Audit Findings o Northern Colorado IPA – NCIPA Credentialing Audit Findings o National Jewish Health – NJH Credentialing Audit Findings	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
16. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the delegated activities and responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor.	Documentation: • See Delegation Agreement Folder: o Credentialing Delegation Agreement_NCIPA - Northern Colorado IPA o Credentialing Delegation Agreement_UPI - University Physician Inc. o Credentialing Delegation Agreement_Boulder Valley IPA o Credentialing Delegation Agreement_National Jewish	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the delegation agreement) if the delegate does not fulfill its obligations. NCQA CR 9—Element A	o Credentialing Delegation Agreement_DHHA- Denver Health	
17. 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 CR9—Element B	Documentation: • HIP203- Business Associate Agreements • ADM223 – Delegation (pg 5, Procedure I.M.) • Template Credentialing Delegation Agreement (pg 5) • See Delegation Agreement Folder: o Credentialing Delegation Agreement_NCIPA - Northern Colorado IPA o Credentialing Delegation Agreement_UPI - University Physician Inc. o Credentialing Delegation Agreement_Boulder Valley IPA o Credentialing Delegation Agreement_National Jewish o Credentialing Delegation Agreement_DHHA- Denver Health • See BAA Agreement Folder: o Boulder Valley IPA o Denver Health and Hospital Authority o University Physician Inc. o Northern Colorado IPA o National Jewish Health o Centura Health	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
18. 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 CR9—Element C	Documentation: • Template Credentialing Delegation Agreement (pg 4, Article Two, B.2, pg 5, Article Three, C.1) • See Delegation Agreement Folder: o Credentialing Delegation Agreement_NCIPA - Northern Colorado IPA o Credentialing Delegation Agreement_UPI - University Physician Inc. o Credentialing Delegation Agreement_Boulder Valley IPA o Credentialing Delegation Agreement_National Jewish o Credentialing Delegation Agreement_DHHA- Denver Health	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR9—Element D	There have been no new delegations in the last 12 months.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
20. 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 CR9—Element E1	Documentation: • See Delegate Audits Folder: o Boulder Valley IPA – BVIPA Credentialing Audit Findings o Denver Health and Hospital Authority- DHHA Credentialing Audit Findings o University Physician Inc. – UPI Credentialing Audit Findings o Northern Colorado IPA – NCIPA Credentialing Audit Findings o National Jewish Health – NJH Credentialing Audit Findings	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. 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 CR9—Element E2	Documentation: • Delegations Audits	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
22. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR9—Element E3	Documentation: • See Delegation Agreements Folder: o Credentialing Delegation Agreement_NCIPA - Northern Colorado IPA o Credentialing Delegation Agreement_UPI - University Physician Inc. o Credentialing Delegation Agreement_Boulder Valley IPA o Credentialing Delegation Agreement_National Jewish o Credentialing Delegation Agreement_DHHA- Denver Health	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
23. The Contractor identified and followed up on opportunities for improvement (at least once in each of the past two years), if applicable. NCQA CR9—Element F	Documentation: • See Delegate Audits Folder: o Boulder Valley IPA – BVIPA Credentialing Audit Findings o Denver Health and Hospital Authority- DHHA Credentialing Audit Findings o University Physician Inc – UPI Credentialing Audit Findings o Northern Colorado IPA – NCIPA Credentialing Audit Findings o National Jewish Health – NJH Credentialing Audit Findings	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard VIII—Credentialing and Recredentialing for ABC-D							
Total	Met	=	42	X	1.00	=	42
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	1	X	NA	=	0
Total Applicable		=	45	**Total Score**		=	42

Total Score ÷ Total Applicable	=	93%

Results for Standard VIII—Credentialing and Recredentialing for ABC-NE							
Total	Met	=	42	X	1.00	=	42
	Partially Met	=	3	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	1	X	NA	=	0
Total Applicable		=	45	**Total Score**		=	42

Total Score ÷ Total Applicable	=	93%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by 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: Exhibit A—2.8.1	Colorado Access maintains a quality improvement program that promotes objective and systematic measurement, monitoring, and evaluation of services and work processes and implements quality improvement activities accordingly. Evidence of compliance: 2015 COA QAPI Program Description	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A—2.8.5.1.1.2	Colorado Access quality measurement and outcome studies are designed to objectively and systematically monitor and evaluate performance of quality and appropriateness of care and service provided to members; to detect potential under- or over-utilization of services, to determine care and services have the desired effect, and to compare results to established goals. Data is collected, reviewed, analyzed, and compared to national benchmarks and established performance goals. Barriers to care and service are identified and opportunities to enhance patient safety, improve care or outcomes, and manage and coordinate care are identified. Evidence of compliance: 2015 COA QAPI Program Description (page 7)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members. *42CFR438.240(b)(4)* Contract: Exhibit A—2.8.5.1.1.3	Colorado Access quality measurement and outcome studies are designed to objectively and systematically monitor and evaluation performance of quality and appropriateness of care and service provided to members; to detect potential under- or over-utilization of services, to determine is care and services have the desired effect, and to compare results to established goals. Colorado Access employs have several mechanisms that allow for the assessment of the quality and appropriateness of care furnished to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	members, including : • Member satisfaction feedback via survey, grievance, and appeal data • Medication utilization monitoring • Medical record reviews Evidence of compliance: 2015 COA QAPI Program Description (page 8)	
4. The Contractor shall monitor its providers' performances on an ongoing basis and hold them accountable to a formal review according to a periodic schedule. Contract: Exhibit A—2.8.2	Whenever possible, Colorado Access evaluates performance not only for the network as a whole or by program or product line, but also by provider. Colorado Access collaborates with network providers both to receive performance data from providers (e.g., Access to Care performance) and to distribute performance data to providers (e.g., performance measures, medical record reviews, encounter data validation, etc.). Examples of provider performance monitoring includes (but is not limited to): • Access to care standards (quarterly) • Encounter Data Validation (annually) • Medical Record reviews (annually) Evidence of compliance: • FY15 Access to Care Tracking • ABC Provider Scorecards CY14 411 audit • ABC-NE Provider Scorecards CY14 411 audit • FY15 ABC Medical Record Audit Summary	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
5. 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 Contractor's detailed findings of program effectiveness. *42CFR438.240(e)(1) and (2)* Contract: Exhibit A—2.8.5.2; 2.8.6.1; 2.8.14	Each year, the Colorado Access Quality department completes an annual evaluation of the effectiveness of the quality activities from the prior fiscal year. This annual report includes ABC's performance for each of the state performance measures, the results and planned interventions for each quality monitoring and/or performance improvement projects, and the effectiveness of implemented interventions. Evidence of compliance: • FY15 ABC-Denver Annual Quality Report • FY15 ABC-NE Annual Quality Report • QPAC Minutes	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare professionals. ◆ Are reviewed and updated periodically as appropriate. *42CFR438.236(b)* Contract: Exhibit A—2.8.4.1	Colorado Access adopts clinical practice guidelines that are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the behavioral healthcare field. These guidelines consider the needs of ABC members, are adopted in consultation with contracted healthcare professionals (via the Colorado Access Quality and Performance Advisory Committee). Each guideline is reviewed annually and updated as necessary. Colorado Access has approved the following behavioral health practice guidelines: Substance Use Disorders, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Metabolic Monitoring of Adults on Antipsychotics, and Bipolar Disorder. Evidence of compliance: • QM311: Clinical Practice Guidelines (page 2) Copies of all guidelines can be found here: http://www.coaccess.com/practice-guidelines	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
7. 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: Exhibit A—2.6.7.9.1; 2.8.4.1	Colorado Access disseminates clinical practice guidelines to all affected providers via the Colorado Access website, as referenced in the Provider Manual. Colorado Access also plans to promote revised guidelines in the Provider Bulletin beginning in 2016. Colorado Access also disseminates clinical practice guidelines to members, potential members, and the public at no cost. Evidence of compliance: • QM311: Clinical Practice Guidelines (page 3) • 2015 Colorado Access Provider Manual (page 73) • Guideline availability on website for providers: http://www.coaccess.com/practice-guidelines • Guideline availability on website for members/public: http://www.coaccess.com/practice-guidelines-members	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. 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: Exhibit A— 2.8.4.1	Colorado Access ensures that decisions regarding utilization management, member education, covered services, and other areas to which the clinical practice guidelines apply are consistent with the guidelines. Evidence of compliance: QM311: Clinical Practice Guidelines (page 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor monitors member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided. Contract: Exhibit A—2.8.9.1	Colorado Access supports and collaborates with the Department of Healthcare Policy and Financing (HCPF) and Health Services Advisory Group (HSAG) in the use of the Experience of Care and Health Outcomes (ECHO) survey. The ECHO results are analyzed in a set of 15 measures (composites marked with an *), including Getting Treatment Quickly*, Office Wait, Amount Treatment has Helped, Perceived Improvement*, Improved Functioning*, and a Global Assessment of Treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Evidence of compliance: • FY15 ABC-Denver Annual Quality Report (page 17-18) • FY15 ABC-NE Annual Quality Report (page 13-14)	
10. 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.) When a quality of care concern is raised, the Contractor: ◆ Investigates the QOC issue(s). ◆ Conducts follow-up with the member to determine if the immediate healthcare needs are being met. ◆ Sends a resolution letter to the originator of the QOC concern. ◆ Refers QOC issues to the Contractor's peer review committee, when appropriate. ◆ Refers the QOC issue to the appropriate regulatory agency, or licensing board or agency, when appropriate. ◆ Documents the incident in a QOC file that includes a description of the QOC concern, steps taken in the QOC investigation, corrective action(s) implemented, and any referrals to peer review or a regulatory agency. Contract: Exhibit A—2.8.10.2	Colorado Access has an established process to investigate concerns directly related to the quality of behavioral healthcare, as identified by network providers, COA employees, or HCPF. As shown in policy QM201, Colorado Access: • Investigates the concern (page 4-5) • Conducts follow up with the members to assure healthcare needs are being met (page 5) • Sends a resolution letter to the originator of the concern (page 7) • Refers QOC to peer review committee, when appropriate (page 5) • Refers QOC to appropriate regulatory agency or licensing board, when appropriate (page 6) • Documents QOC appropriately (page 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: Exhibit A—2.8.12.1	Documentation: • COA Data Flow Description: Colorado Access has multiple systems that collect various types of provider and member data. This data is brought together into our enterprise data base and used for reporting.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
12. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, third party liability, and disenrollments for other than loss of Medicaid eligibility. *42CFR438.242(a)* Contract: Exhibit A—2.8.12.1	Documentation: • COA Data Flow Description: Colorado Access has multiple systems that contain utilization data, grievance and appeal data and TPL. Colorado Access is able to pull the data from these systems and report the information as requested. Colorado Access receives daily and monthly eligibility files from the State that include additions and terminations (disenrollments). These additions and terminations/deletes are loaded into our systems accordingly. Colorado Access does not terminate/disenroll any Medicaid member unless they come across on the eligibility files as a termination.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
13. The Contractor collects data on member and provider characteristics and on services furnished to members (through an encounter data system). *42CFR438.242(b)(1)* Contract: Exhibit A—2.9.4.1	Documentation: • Behavioral Care Encounters Requirements Description: Colorado Access receives monthly encounter files from the capitated mental health centers and claims for covered services from providers. These encounters and claims are processed through our claims payment system and ultimately reported to HCPF through a monthly encounter file.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. 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.	Documentation: • Behavioral Care Encounters Requirements • Configuration and Rule Settings Document Description: Colorado Access' claims payment system has various edits in place that aid in verifying the accuracy and timeliness of the data. The requirements from the HCPF Uniform Services Coding Manual are configured in both the claims payment system and in the COA Encounter Process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
42CFR438.242(b)(2) Contract: Exhibit A—2.9.4.1.2; 2.9.3.7; 2.9.3.8	If claims/encounters are submitted with incomplete data, the claims are sent back to the provider for correction. If claims/encounters are missing a modifier for example, the claim/encounter would be rejected in the COA Encounter Process. All encounter data is submitted to HCPF on a monthly basis in two formats, a proprietary flat-file and an ANSI ASC X12N 837 format.	

Results for Standard X—Quality Assessment and Performance Improvement for ABC-D							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	14

Total Score ÷ Total Applicable	=	100%

Results for Standard X—Quality Assessment and Performance Improvement for ABC-NE							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	14

Total Score ÷ Total Applicable	=	100%

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Access Behavioral Care—Denver

Review Period:	January 1, 2013–November 30, 2015
Date of Review:	December 1, 2015
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Jean Barker and Gary Grindley

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	***09	***77	***00	**36	***64	**12	***00	***38	***60	***81
Provider Type (MD, PhD, NP, PA, MSW)	PsyD	LAC	LCSW		LPC		PhD	LPC	LCSW	LPC
Application/Attestation Date	2/26/14	8/8/14	10/17/14		9/4/12		1/13/15	5/4/14	4/15/14	4/16/14
Credentialing Date (Committee/Medical Director Approval Date)	5/13/14	9/4/14	2/3/15		9/21/12		3/22/15	9/19/14	7/31/14	4/30/14
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	8	8	8		8		8	8	8	8
# Compliant elements	8	8	8		8		8	8	8	8
Percentage compliant	100%	100%	100%		100%		100%	100%	100%	100%

OVERSAMPLE	1	2	3	4	5
Provider ID#	***75	***65	**12	***82	*7
Provider Type (MD, PhD, NP, PA, MSW)	CNM	LPC	Re-cred	Re-cred	LCSW
Application/Attestation Date		6/19/13			5/1/14
Credentialing Date (Committee/Medical Director Approval Date)		11/24/13			6/3/14
The Contractor, using primary sources, verifies that the following are present:					
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☒
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☒ N☐
◆ Work history	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☒ N☐
◆ History of professional liability claims	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☒ N☐
◆ Current malpractice insurance in required amount	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☒ N☐
◆ Signed application and attestation	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☒ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐	Y☒ N☐
# Applicable elements		8			8
# Compliant elements		8			8
Percentage compliant		100%			100%
Total Record Review Score					**Total Applicable: 80**

Total Compliant: 80 | **Total Percentage: 100%**

Comments:
HSAG eliminated Files 4 and 6 because the providers were recredentialed, rather than initially credentialed. HSAG also eliminated Oversamples 3 and 4 for the same reason. Oversample 1 was a certified nurse midwife and not applicable to the behavioral health line of business.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Recredentialing Record Review Tool
for Access Behavioral Care–Denver

Review Period:	January 1, 2013–November 30, 2015
Date of Review:	December 1–3, 2015
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Jean Barker and Gary Grindley

SAMPLE	1	2	3	4	5	6	7	8	9	10
Provider ID#	**57	**63	**59	**50	**29	**85	**60	**08	***37	**09
Provider Type (MD, PhD, NP, PA, MSW)	LCSW	LCSW	PhD	LPC	LMFT	LPC	PhD	LCSW	LPC	LPC
Application/Attestation Date	9/11/13	12/23/13	9/26/13	2/4/14	12/24/13	5/18/14	2/24/14	1/22/14	5/23/14	8/14/14
Last Credentialing/Recredentialing Date	11/14/10	12/16/10	2/18/11	4/14/11	4/21/11	5/12/11	6/23/11	6/9/11	9/1/11	9/22/11
Recredentialing Date (Committee/Medical Director Approval Date)	10/31/13	12/26/13	2/16/14	4/15/14	4/30/14	5/30/14	6/11/14	6/22/14	9/19/14	9/28/14
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	7	7	7	7	7	7	7	7	7	7
# Compliant elements	7	7	7	7	7	7	7	7	7	7
Percentage compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

Comments: None.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Access Behavioral Care—Northeast

Review Period:	January 1, 2013–November 30, 2015
Date of Review:	December 1, 2015
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Jean Barker and Gary Grindley

SAMPLE	1	2	3	4	5	6	7	8	9	10
Provider ID#	***98	***39	***19	**18	***8	***35	***73	***15	***84	**46
Provider Type (MD, PhD, NP, PA, MSW)			PsyD	MD		LPC	SLP	LPC	LCSW	
Application/Attestation Date			8/26/14	1/16/14		7/5/14	2/2/15	9/4/13	10/7/14	
Credentialing Date (Committee/Medical Director Approval Date)			1/19/15	5/6/14		10/19/14	2/8/15	1/12/14	11/23/14	
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☐ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☐ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Work history	Y☐ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ History of professional liability claims	Y☐ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Current malpractice insurance in required amount	Y☐ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☐ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ Signed application and attestation	Y☐ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☐ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐
# Applicable elements			8	9		8	8	8	8	
# Compliant elements			8	9		8	8	8	8	
Percentage compliant			100%	100%		100%	100%	100%	100%	

OVERSAMPLE	1	2	3	4	5										
Provider ID#	***25	***73	***40	**35	***30										
Provider Type (MD, PhD, NP, PA, MSW)	LCSW	LPC	LPC		LPC										
Application/Attestation Date	5/28/14	9/17/14	3/24/14		11/25/14										
Credentialing Date (Committee/Medical Director Approval Date)	9/19/14	11/15/14	4/5/15		12/28/14										
The Contractor, using primary sources, verifies that the following are present:															
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐										
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☒										
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐										
◆ Work history	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐										
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐										
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐										
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐										
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐										
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐										
# Applicable elements	8	8	8		8										
# Compliant elements	8	8	8		8										
Percentage compliant	100%	100%	100%		100%										
Total Record Review Score					**Total Applicable: 81**			**Total Compliant: 81**				**Total Percentage: 100%**			

Comments:
HSAG eliminated Files 1, 2, and 5, and oversample number 4 because the providers were recredentialed, rather than initially credentialed. File 10 was a certified nurse midwife and not applicable to the behavioral health line of business.

Review Period:	January 1, 2013–November 30, 2015
Date of Review:	December 1–3, 2015
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Jean Barker and Gary Grindley

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	**78	**53	**22	***62	***75	**57	***45	**92	**90	**32
Provider Type (MD, PhD, NP, PA, MSW)	LPC	LMFT	LPC	LCSW	LCSW	LMFT	LPC	LCSW	LPC	LPC
Application/Attestation Date	1/13/14	1/13/14	7/15/14	11/28/14	8/6/14	12/2/14	2/10/15	12/10/13	11/19/13	6/29/14
Last Credentialing/Recredentialing Date	4/1/11	5/12/11	10/6/11	1/12/12	12/15/11	5/31/12	6/14/12	3/10/11	2/3/11	9/15/11
Recredentialing Date (Committee/Medical Director Approval Date)	4/30/14	5/30/14	10/10/14	1/31/15	12/12/14	3/28/15	6/28/15	3/24/14	2/16/14	9/19/14
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	7	7	7	7	7	7	7	7	7	7
# Compliant elements	7	7	7	7	7	7	7	7	7	7
Percentage compliant	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

Comments: None.

Appendix C. Site Review Participants for Access Behavioral Care

Table C-1 lists the participants in the FY 2015–2016 site review of **ABC**.

Table C-1—HSAG Reviewers and BHO Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	Compliance Auditor
ABC Participants	**Title**
Alexis A. Giese, MD	Senior Vice President, Behavioral Health
Beth Neuhalfen	Manager, RCCO/CHP; Director, Physical Engagement
Bethany Himes	Executive Director, CHP+ SMCN
Bill Elswick	Credentialing Coordinator
Christine E. Gillespie	Clinical Appeals Manager
Claudine McDonald	Director, Office of Member and Family Affairs
Dave Rastatter	Director, NE Colorado Medicaid
Elizabeth Strammiello	Chief Compliance Officer
Gary Grindley	Credentialing Manager
Janet Milliman	Operations Manager, CHP/SMCN
Jean Barker	Vice President of Commercial Products, Provider Network Services
John Kiekhaefer	Clinical Director, Colorado Access
Kelsey Byars	Credentialing Coordinator
Kristin Brown	Behavioral Health Operations Manager
Landon Palmer	Compliance
Lindsay Cowee	Clinical Quality Manager (Interim Quality Director)
Michelle Tomsche	Behavioral Health Operations Director
Mikhail Babayev	Care Manager
Paula Jung	Manager, ABC Community Based Care Management
Raeanna Wuestner	Care Manager II, ABC
Regina Fetterolf	Manager, BHI and ABC NE Care Management
Reyna Garcia	Senior Director, Customer Service and Claim Appeals
Rob Bremer	Executive Director, Access Behavioral Care
Shelby Kiernan	Director, Integrated Care/Communications
Shawna Marshall	Care Manager
Stephanie Dohrman	Grievance Manager
Renee Fletter	Manager, Provider Relations
Department Observers	**Title**
Melissa Eddleman	Behavioral Health Unit Supervisor
Russ Kennedy	Quality Specialist
Teresa Craig	Program and Contract Manager, CHP+

Appendix D. Corrective Action Plan Template for FY 2015–2016 *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

For this step,	HSAG completed the following activities:
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 compliance site review report via e-mail or through the file transfer protocol (FTP) site (with an e-mail notification to HSAG and the Department). The BHO must submit the CAP using the template provided. For each element receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, persons responsible, 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.

For this step,	HSAG completed the following activities:
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 healthcare regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2015–2016 Corrective Action Plan *for* ABC-D and ABC-NE

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
4. The Contractor ensures that each member accessing services receives an individual intake and assessment for the level of care needed, performed by a qualified clinician. The intake and assessment process addresses: ◆ Developmental needs. ◆ Cultural and linguistic needs. ◆ Screening for mental illness, substance use, and trauma disorders.	ABC's monitoring mechanism—medical record audits—is inadequate to ensure that each member accessing services receives an individual assessment with the required components. The audit does not include cultural and linguistic needs and is applied to an inadequate sample of member records—i.e., two records each from five providers annually.	ABC must enhance the process and scope of monitoring providers to ensure that a representative sample of members accessing services receive an intake assessment with the required components.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
6. The Contractor utilizes the information gathered in the member's intake and assessment to build an individualized, culturally sensitive comprehensive service plan that includes: ◆ Measurable goals. ◆ Strategies to achieve the stated goals. ◆ A 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 and the reviewing professional. (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.) Service planning shall take place annually or if there is a change in the member's level of functioning and care needs.	The medical record audit tool incorporated all required elements of the treatment plan; however, the medical record audit was performed on a number of records (10 total records annually) inadequate to be a valid representation of the overall performance of the health plan. In addition, a medical record audit was performed by ABC-D only.	ABC must enhance the scope of monitoring providers to ensure that a representative sample of members have a comprehensive service plan that addresses the elements outlined in the requirement.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
9. The Contractor must arrange for the provision of all *medically necessary services* * identified under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, 42 CFR Sections 441.50 to 441.62, including: ◆ Referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. (Referral assistance must include giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.) ▪ At a minimum, the Contractor must assure that the medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. ◆ Making appropriate use of State health agencies, State vocational rehabilitation agencies, Title V grantees (Maternal and Child Health/Crippled Children's Services), and other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC). ◆ Offering the family or beneficiary necessary assistance with transportation and necessary assistance with scheduling appointments for EPSDT services.	The assessment standards outlined in the provider manual required that providers document that EPSDT exam results were requested from the PCP and reviewed, if obtained; a referral was made when EPSDT screening had not been done or the child did not have a PCP. However, the provider manual did not inform providers of their responsibility to provide referral assistance for treatment not covered by the BHO but found to be needed as a result of conditions disclosed during EPSDT screening and diagnosis or how to obtain assistance in making referrals, such as referring the member to Colorado Access care management, Healthy Communities, or the Department of Health Care Policy and Financing (the Department) Office of Clinical Services. During on-site interviews, staff members stated there were no additional provider trainings regarding referral for EPSDT services and no mechanisms to monitor ABC providers for compliance with EPSDT referrals. Staff members stated that these requirements were difficult for ABC providers to implement and that staff had been seeking clarification from the Department regarding how to effectively operationalize EPSDT requirements within the BHO.	ABC must enhance its provider communications and internal procedures to more specifically address the requirement related to referral assistance for treatment not covered by the BHO but found to be needed as a result of conditions disclosed during EPSDT screening and diagnosis. Procedures should address referring members to the Office of Clinical Services/Healthy Communities and assisting members as necessary with scheduling appointments and transportation. HSAG recommends that ABC continue to work with the Department to obtain clarity and guidance regarding EPSDT requirements and consider developing enhanced provider training and/or monitoring related to coordination of EPSDT services.

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

Standard IV—Member Rights and Protections		
Requirement	**Findings**	**Required Action**
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated and 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 healthcare, 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 healthcare services in accordance with requirements for access and quality of services.	Rather than list the specific member rights, Policy CS212—Member Rights and Responsibilities referenced a specific section of the Colorado Code of Regulations (CCR) and the contract between ABC and the Department. While this mechanism of reference is acceptable, the section of CCR referenced in the policy was incorrect and the contract routing number was outdated.	Colorado Access must revise its Member Rights and Responsibilities policy to either list the specific member rights or accurately reference a location where staff members can find specific rights.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
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—initially and at least every three years— that the provider is in good standing with state and federal regulatory bodies.	Colorado Access had written policies and procedures that described the process confirming at least every three years that the organization is in good standing with both State and federal regulatory agencies. On-site record review demonstrated that Colorado Access implemented this policy; however, two of the five organizations had not been recredentialed within the three-year time frame.	Colorado Access must implement a process to ensure that organizations with which it contracts are recredentialed at least every three years.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that the provider credentials its practitioners.	The Organizational Provider Credentialing policy and procedure included the criteria used to assess unaccredited organizational providers' credentialing processes. While on-site record review demonstrated that Colorado Access collected the organization's policies and procedures related to staff hiring and credentialing, some policies collected were not compliant with Colorado Access' credentialing standards.	Colorado Access must be sure that unaccredited organizational providers are credentialing practitioners in a manner consistent with Colorado Access policies, procedures, and standards.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards.	The Organizational Provider Credentialing policy and procedure described the circumstances under which Colorado Access could substitute a CMS or State quality review in lieu of a site visit; however, the policy did not specify that Colorado Access would confirm that the survey conducted by CMS or the State meets its own quality assessment criteria or standards. HSAG did not find evidence in the records reviewed that Colorado Access confirmed the content of the CMS or State review. Some CMS and State reviews included with the records reviewed indicated the need for corrective action; however, Colorado Access did not document that it confirmed that the corrective actions had been completed. Furthermore, one of the State site reviews documented in the record as being used in lieu of a site visit was more than three years old at the time of the credentialing decision.	Colorado Access must specify in its policies that it will confirm that CMS and State quality reviews used in lieu of Colorado Access site visits include all criteria and standards identified in Colorado Access' policy. Colorado Access must ensure that CMS and State quality reviews used are no more than three years old at the time of the credentialing decision. Additionally, if the CMS or State quality review required that the organization complete any corrective actions, Colorado Access must document that the organization completed all corrective actions.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review Protocol Activities *for* Access Behavioral Care

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Behavioral Health Quality Improvement Committee (BQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the request for desk review documents via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards and on-site activities. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The BHOs also submitted lists of all Medicaid credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG used a random sampling technique to select records for review during the site visit. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 3:	**Conduct Site Visit**
	◆ 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.

For this step,	HSAG completed the following activities:
	◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO credentialing and recredentialing. ◆ Also while on-site, HSAG collected and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with BHO staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2015–2016 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ HSAG submitted the 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.