State of Colorado

Department of Health Care Policy and Financing

Colorado Medicaid
Community Mental Health Services Program

FY 06–07 Site Review Report

for

Colorado Health Partnerships, LLC

May 2007

HSAG Health Services Advisory Group

1600 East Northern Avenue, Suite 100 • Phoenix, AZ 85020
Phone 602.264.6382 • Fax 602.241.0757

CONTENTS

This is the third year that Health Services Advisory Group, Inc. (HSAG) has performed site reviews of the Colorado behavioral health organizations (BHOs). Compliance with federal regulations and contract requirements was evaluated in 10 areas (i.e., delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing). Individual records were reviewed in the areas of grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services to evaluate implementation of select requirements related to the standards. Details of the site review methodology are contained in Appendix D of this report.

This report documents results of the fiscal year (FY) 06–07 site review for **Colorado Health Partnerships, LLC** (**CHP**) related to compliance with requirements in the 10 standard areas and the elements of the record reviews evaluated as part of the site review.

2. Summary of Follow-Up on Prior Year Review

for Colorado Health Partnerships, LLC

As a follow-up to the FY 05–06 site review report, **CHP** was required to submit a corrective action plan (CAP) to the Colorado Department of Health Care Policy & Financing (the Department) addressing all elements for which **CHP** received a score of *Partially Met* or *Not Met*. The plan included interventions to achieve compliance and the timeline. The Department reviewed the CAP and associated documentation, requesting revisions where necessary.

The findings for the FY 06–07 site review were determined from a desk review of the documents submitted by **CHP** to HSAG prior to the on-site portion of the review, interviews with key **CHP** staff members, and a review of records conducted during the site review.

For the review of the 10 standards, the individual elements (i.e., contract requirements) reviewed for each standard were assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable (N/A)*. A summary score was then determined by calculating the percentage of applicable elements found compliant (i.e., *Met*).

Table 3–1 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A*), the overall compliance score for each standard, and the overall compliance score for the review of standards. Details of the review of the 10 standards can be found in Appendix A.

Table 3–1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I	Delegation	13	12	6	4	2	1	50%
II	Provider Issues	26	25	24	1	0	1	96%
III	Practice Guidelines	5	2	2	0	0	3	100%
IV	Member Rights and Responsibilities	18	18	15	3	0	0	83%
V	Access and Availability	20	20	20	0	0	0	100%
VI	Utilization Management	8	8	7	1	0	0	88%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%
VIII	Quality Assessment and Performance Improvement Program	12	12	12	0	0	0	100%
IX	Grievances, Appeals, and Fair Hearings	11	11	11	0	0	0	100%
X	Credentialing	32	8	6	0	2	24	75%
	Totals	**160**	**131**	**118**	**9**	**4**	**29**	**90%**

For the review of records for documentation of services, denials, and grievances, elements in each record reviewed were assigned a score of Yes (compliant), No (not compliant), or Not Applicable (N/A). For each of the scored record reviews, a summary score was then determined by calculating the percentage of applicable elements found compliant.

Table 3–2 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each record review as well as a combined record review compliance score. Details of each record review can be found in Appendix B. The coordination-of-care record review was not scored. A narrative summary of each record review can be found in Section 4.

Table 3–2—Summary of Scores for the Review of Records

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
II	Documentation of Services	**10**	**20**	**20**	**100%**
VI	Denials	**10**	**30**	**29**	**97%**
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	**10**	**Not Scored**	**Not Scored**	**Not Scored**
IX	Grievances	**10**	**40**	**39**	**98%**
	Totals	**40**	**90**	**88**	**98%**

Table 3–3 presents the overall scores (percentage of compliance) for the review of the standards, for the review of records, and for the review of the standards and records combined.

Table 3–3—Overall Compliance Scores

Review of the Standards—Percentage Compliant	**90%**
Review of Records—Percentage Compliant	**98%**
Overall Percentage Compliant	**93%**

This section of the report describes **CHP**'s strengths and required actions related to each of the standards and types of records reviewed. Details of the scores related to the review of the standards can be found in Appendix A and details of the scores related to the review of records can be found in Appendix B.

Standard I—Delegation

Strengths

CHP had developed a delegation agreement with ValueOptions (VO) for the delegation of all administrative tasks related to the management of a BHO. **CHP** had also developed agreements with the partner community mental health centers (CMHCs) to more completely describe the activities provided by the CMHCs. The agreement with VO as well as the CMHC agreements were well thought-out and included the general requirements for subcontracts under the Balanced Budget Act of 1997 (BBA).

Required Actions

While the new agreements clearly specified many of the delegated activities, there were a few responsibilities either missing or not well-defined. **CHP** must revise its agreement with VO to clearly specify processing of utilization review (UR) denials and processing of Medicaid member grievances and appeals as activities performed by VO. **CHP** must include in the VO agreement the reporting responsibilities related to the delegated functions of grievance and appeal processing and distribution of member materials by VO. The agreements with the partner CMHCs must also be revised to include the reporting responsibilities of the CMHCs related to the delegated function of grievance processing.

While there was ample evidence that **CHP** and VO had an excellent working relationship, **CHP**'s monitoring of VO was informal regarding some specific delegated functions and must be formalized. **CHP** must develop written policies and procedures that address the monitoring of delegates on an ongoing basis and through formal review, and formalize monitoring of VO regarding the quality of data reporting related to provider network development, credentialing and recredentialing, grievance and appeal processing, UR denials, and distribution of required member materials by VO. **CHP** must also monitor the quality of grievance processing by the partner CMHCs and specifically monitor data reporting regarding grievance processing by the CMHCs.

Standard II—Provider Issues

Strengths

There was evidence that VO, on behalf of **CHP**, had an effective tracking mechanism to ensure that there was an agreement with each provider. The agreements included all of the requirements. **CHP** had a comprehensive corporate compliance program administered by VO, which included all of the requirements, including a variety of monitoring and auditing activities, an active compliance committee, and effective systems to require corrective action when necessary. In addition to compliance monitoring, the scope of monitoring service provision for quality, appropriateness, member outcomes, and requirements for medical records was broad and included a variety of monitoring methods.

Review of Documentation of Services

A sample of 10 consumer service records was reviewed to assess **CHP**'s compliance with contract requirements related to documentation of services for encounters submitted. **CHP** was compliant with 20 of 20 of the total applicable elements reviewed for a record review score of 100 percent. All records contained documentation of the service provided for the day the encounter was submitted. All records contained documentation that described the service for which the encounter was submitted.

Required Actions

While the **CHP** partner CMHCs each reviewed a statistically valid sample of encounter data and submitted the review to VO for oversight and VO reviewed encounters for subcontracted providers, the reviews did not include each of the required criteria. In addition to reviewing for the presence of medical record documentation, **CHP**, or its delegate(s), must review and document compliance with the other contract criteria for submission of encounter claims (the accuracy and completeness of all fields and the presence of both paid and denied claims) as part of the encounter claims audit.

Standard III—Practice Guidelines

Strengths

CHP made a substantial number of evidence-based clinical practice guidelines available to providers, consumers, family members, and other interested parties on the **CHP** Web site. The guidelines were developed following a review of professional literature and in close collaboration with experts in the field. **CHP** actively involved consumers in the development and dissemination of practice guidelines, including working closely with consumers and family members to produce a series of tip sheets. **CHP** actively reviewed and revised existing clinical practice guidelines through its Clinical Advisory/Utilization Management Committee (CAUMC).

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard IV—Member Rights and Responsibilities

Strengths

CHP, through its Management Services Agreement with ValueOptions (VO), had policies, procedures, and practices to ensure that consumer rights information was distributed to new Medicaid enrollees and consumers, as well as to providers and interested community organizations.

Provider site visits and contract compliance audits were performed to ensure that providers took rights into account when providing services to consumers. Monitoring results were reviewed at the Quality Improvement Steering Committee and reported to the Class B Board.

CHP had a very active Office of Consumer and Family Affairs (OCFA), with consumer representatives/advocates employed at each of the partner CMHCs. The OCFA committee had developed an impressive and ambitious list of goals related to advocacy and recovery, and had assigned responsibility and timelines to each.

Required Actions

Provider responsibility for dissemination of consumer rights information was not clearly stated in **CHP**'s policy, and CMHC-developed consumer information (rights and responsibilities listings) differed from information developed by **CHP** through its delegate VO. In addition, the BHO's listing of consumer responsibilities in consumer informational materials was different from the listing in the policy. The BHO must clarify its policies and procedures for consumer rights and responsibilities information content and distribution, and ensure that Medicaid recipients receive information consistent with those policies.

While **CHP** had revised its policy and implemented all of the required practices and procedures related to advance directives, one requirement related to staff, provider, and community education was not documented in the new policy. **CHP** must revise its policy to include a description of the advance directives training or education it requires for staff, providers, and the community.

Standard V—Access and Availability

Strengths

CHP, through its delegation agreement with VO, had policies, procedures, and practices for ensuring timely access to and availability of services in the CMHC and non-CMHC provider network. The BHO also had processes for ensuring the availability of alternative services and services to individuals who were dually eligible or resided in nursing facilities.

CHP had numerous initiatives under way to further the BHO's practice of the recovery model, including hiring advocates and peer specialists in the delivery system; developing a family crisis pilot program; planning and initiating a suicide focus group study; disseminating recovery literature through provider newsletters, trainings, and other forums; and focusing the efforts of its OCFA as primary champions of the recovery model.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard VI—Utilization Management

Strengths

Through its Management Services Agreement with ValueOptions, **CHP** had an active utilization management (UM) program in place to monitor access to and appropriate utilization of covered services. **CHP** used various tools and processes, including staff training, standardized level-of-care (LOC) criteria, interrater reliability studies, and periodic audits to help ensure the consistency of service authorization decisions. **CHP** had extensive UM-related policies and procedures and produced and analyzed reports to help detect both under- and overutilization of services.

Review of Denial Records

A sample of 10 service denial records was reviewed to assess **CHP**'s compliance with contract requirements related to the presence and content of required documentation and the timeliness of resolution. **CHP** was compliant with 29 of the 30 total applicable elements reviewed for an overall score of 97 percent. **CHP** was fully compliant in the following areas: 1) the notice included the reason for denial, and 2) the decision was made by a qualified clinician. A notice of action letter for one case reviewed was not sent in a timely manner to the consumer and provider following a UR denial as required in Exhibit G of the BHO's contract with the Department.

Required Actions

Since several of the BHO's policies and procedures included time frames that were inconsistent with the BBA and with requirements in the BHO's contract with the Department, **CHP** must revise its UM program description and policies and procedures that address the timeliness of medical necessity decisions.

Because not all denial files reviewed met the timeliness standard for issuing a notice of action, **CHP** must ensure that a notice of action is sent in a timely manner to the consumer and provider following a UR denial decision and request extensions when necessary or appropriate to do so.

Standard VII—Continuity-of-Care System

Strengths

CHP had comprehensive policies and procedures that described the BHO's expectations regarding communication and coordination activities and that addressed requirements related to timely coordination of care. BHO staff described various collaborative projects implemented by **CHP** and its partner CMHCs, including the colocation of mental health staff in juvenile detention facilities and the provision of crisis intervention training for local police officers and sheriffs. **CHP** also participated in several integration projects with primary medical care providers, including programs that colocated mental health services at federally qualified health centers, primary medical clinics, and dental clinics.

Review of Coordination of Care—Children Transitioning from Inpatient to Outpatient Services

Ten records were reviewed for evidence of care coordination and outpatient follow-up for children following discharge from an inpatient facility. All 10 records contained evidence of coordination between the hospital and either VO or partner CMHC personnel prior to discharge. One consumer was transferred to a State hospital facility on the day of discharge. One consumer was discharged directly to a corrections facility. Three consumers were discharged to the custody of the Division of Human Services (DHS) with no services provided by **CHP**. Five consumers were given an appointment with either a partner CMHC or a subcontracted independent provider. The BHO records indicated that three consumers were "no show" for the appointments. One of the appointments took place the day following discharge and one was within a week of discharge.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard VIII—Quality Assessment and Performance Improvement Program

Strengths

CHP, through its Management Services Agreement with ValueOptions, had an active quality assessment and performance improvement (QAPI) program in place. The BHO collected, analyzed, and reported information from multiple data sources, including clinical record reviews, performance improvement projects (PIPs), consumer satisfaction surveys, and outcome data to assess the overall quality and effectiveness of its clinical and administrative services. **CHP** also took follow-up action with its contracted providers as appropriate to address any problems related to provider performance in the quality improvement area.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard IX—Grievances, Appeals, and Fair Hearings

Strengths

CHP had delegated the responsibility for grievance processing to the partner CMHCs, and VO was responsible for both grievance and appeal processing. The Colorado Health Networks (CHN) policies and procedures for both grievances and appeals specified all processes, timelines, and record-keeping requirements, and addressed the internal monitoring of the processes that would occur.

Review of Grievance Records

CHP provided 10 grievances (clinical care and access complaints) for review of the timeliness of acknowledgment and resolution letters, whether qualified decision-makers were used, and whether the decision/resolution was responsive to the original grievance issue. Four of the 10 records were grievances processed by **CHP** as delegated to VO; two were processed by Pikes Peak Mental Health Center (MHC); three were processed by Colorado West Regional MHC; and one was processed by West Central MHC. All letters of acknowledgment and resolution were sent in a timely manner, contained standardized language, and were written on the letterhead of the entity responsible for processing the grievance. None of the grievances required an extension of the time frame. One grievance decision written by one of the CMHCs did not contain evidence that a qualified clinician had been involved in the review and decision of the grievance. All 10 records had documentation of a decision or resolution that was responsive to the complaint issue.

Required Actions

CHP must ensure that persons making decisions on clinical grievances have the qualifications to do so and that their credentials are included in the documentation of the grievance decision.

Standard X—Credentialing

Strengths

It was clear that VO, on behalf of **CHP**, had a comprehensive credentialing program and was performing all of the required credentialing and recredentialing activities regarding individual and organizational providers. These activities included the credentialing committee's use of a peer-review process to make credentialing decisions, the use of the Colorado Health Care Professional Credentials Application, management of credentialing files in a nondiscriminatory and confidential manner, conducting site visits for high-volume individual practitioners, and completing assessments of organizational providers in a manner that met all of the requirements.

Required Actions

The National Committee for Quality Assurance (NCQA) requirements do not allow the BHO to rely on the delegate's policies and procedures regarding the credentialing and recredentialing of individual practitioners and assessment of organizational providers. Since **CHP** was relying on VO's policies and procedures, **CHP** must develop its own written policies and procedures. **CHP's** policies and procedures must document the mechanism for credentialing and recredentialing licensed independent practitioners and the assessment of organizational providers, and describe **CHP**'s processes rather than the delegate's processes. Since VO's credentialing and recredentialing policies and procedures cannot be applied to meet **CHP**'s requirements, the content of **CHP**'s credentialing and recredentialing policies and procedures will be evaluated with the corrective actions for Standard X, Evaluation Elements 2 and 8.

CHP is required to submit to the Department a CAP for all elements within the standards scored as *Partially Met* or *Not Met* and for all elements within the record reviews scored as *No*. The CAP must be submitted within 30 days of receipt of the final version of this report. For each element that requires corrective action, the BHO must identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. After the Department has approved the CAP, **CHP** will be required to submit documents identified as evidence of compliance.

Table 5-1 describes activities required for the CAP process.

Table 5-1—Corrective Action Plan Process	
Step 1:	**Corrective action plans are submitted.**
	Each BHO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report. CAPs will be submitted via HSAG's file transfer protocol (FTP) site and the BHO will e-mail notification to the Department and HSAG. For each of the elements within the standards receiving a score of *Partially Met* or *Not Met*, and for each element within the record reviews receiving a *No*, the CAP must address the planned intervention(s) to achieve compliance and the timeline(s) for the intervention(s).
Step 2:	**Plans are reviewed and approved.**
	HSAG and the Department will review the CAPs. The Department will notify each BHO as to the adequacy of its plan. If the Department determines that a CAP is adequate to bring the BHO into full compliance with the applicable contract requirements, the Department will notify the BHO in writing that the plan is approved. If the Department determines that a CAP is not adequate to bring the BHO into full compliance with one or more contract requirements, the Department will require the BHO to submit a revised CAP. Following the review of the revised plan, the Department will notify the BHO in writing of its decision to approve the plan or to require further revisions.
Step 3:	**Progress reports may be required.**
	Based on the nature and seriousness of the noncompliance, the Department may require the BHO to submit regular reports to the Department detailing progress made on one or more elements in the CAP.

Table 5-1—Corrective Action Plan Process	
Step 4:	**Corrective actions are implemented.**
	Each BHO is expected to implement all corrective actions and achieve full compliance with the applicable contract requirements within 60 calendar days of the Department's written notification of having approved the BHO's CAP. The Department may extend the time frame for implementation of one or more of the corrective actions if requested by a BHO in writing and with cause.
Step 5:	**Substantiating documentation is submitted.**
	When all Department-approved corrective actions have been implemented, the BHO will submit documentation to the Department substantiating the completion of all required corrective actions and compliance with the related contract requirements.
Step 6:	**Documentation substantiating implementation of the plans is reviewed and approved.**
	Following a review of the documentation, the Department will inform the BHO as to whether: (1) the documentation is adequate to demonstrate completion of all required actions and compliance with the related contract requirements, or (2) the BHO must take additional actions and/or submit additional documentation. The Department 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 contract requirements.

Table 5-2 can be used by the BHO to document its planned interventions for any required actions that are listed.

Table 5-2—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard I: Delegation				
3. Content of Agreement The written agreement: A. Specifies the activities delegated to the subcontractor.	CHP must revise the Management Services Agreement to clearly specify processing of utilization review denials and processing of Medicaid member grievances and appeals as activities performed by VO for CHP.			
B. Specifies the reporting responsibilities delegated to the subcontractor.	CHP must revise its delegation agreements to specify the reporting responsibilities of the delegates related to the delegated tasks of distribution of required member materials by VO, grievance and appeal processing by VO, and grievance processing by the partner mental health centers.			
4. Policies and Procedures The Contractor has written procedures for monitoring the performance of subcontracts: A. On an ongoing basis	Although CHP delegated administrative responsibilities to VO, including development and maintenance of policies and procedures, because CHP held the contract with the Department, CHP must develop written procedures related to the delegation of administrative responsibilities under that contract, which must include the BHO's procedures for monitoring the performance of delegates on an ongoing basis.			
B. Through formal review.	Although CHP delegated administrative responsibilities to VO, including development and maintenance of policies and procedures, because CHP held the contract with the Department, CHP must develop written procedures related to the delegation of			

Table 5-2—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
	administrative responsibilities under that contract, which must include written procedures for monitoring the performance of delegates through formal review.			
5. Monitoring of Delegates The Contractor monitors services provided through subcontracts for: A. Quality	CHP must monitor each delegated service provided through subcontracts for the quality of the services provided. Monitoring must include provider network development and management, credentialing and recredentialing, grievances and appeals processing, the processing of UR denials, and distribution of required member materials delegated to VO, and grievance processing by the partner CMHCs.			
B. Data reporting	CHP must monitor each delegated service provided through subcontracts for data reporting related to the delegated function. Monitoring must include provider network development and management, credentialing and recredentialing, the processing of UR denials, and distribution of required member materials delegated to VO.			

Table 5-2—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard II: Provider Issues				
12. Statistically Valid Sampling The BHO reviews compliance with criteria for submission of encounter claims data each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department.	While the CHP partner CMHCs each reviewed a statistically valid sample of encounter data and submitted the review to VO for oversight and VO reviewed encounters for subcontracted providers, the reviews did not include each of the required criteria. In addition to reviewing for the presence of medical record documentation CHP, or its delegate(s), must review and document compliance with the other contract criteria for submission of encounter claims (the accuracy and completeness of all fields and the presence of both paid and denied claims) on a statistically valid sample of encounter claims.			
Standard IV: Member Rights and Responsibilities				
1. Written policy on member rights The Contractor has written policies and procedures for treating members in a manner that is consistent with the member's right to: A. Receive information about his/her rights.	CHP must ensure that all consumers receive information that is consistent with the CHP Medicaid rights and responsibilities listing. CHP should also clarify its policies, procedures, and practices regarding the role of the BHO or its delegate, VO, in the development and distribution of consumer informational materials, and the role providers have for developing and distributing consumer materials, if any.			

Table 5-2—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
3. Member Responsibilities The Contractor has written requirements for member participation and responsibilities in receiving covered services.	CHP must ensure that Medicaid consumer responsibilities and expectations for participation are consistently communicated to consumers, staff, and providers.			
5. Advance Directives A. The Contractor has written policies and procedures for Advance Directives.	CHP must include in the advance directives policy its procedures for educating staff, providers, and the community on advance directives.			
Standard VI: Utilization Management				
1. Utilization Management B. The UM program includes written policies and procedures.	To be consistent with the BBA and with contract requirements, CHP must revise its UM program description and policies and procedures that address (1) timeliness of medical necessity decisions and (2) noticing requirements.			
7. Record Review—Denials	CHP must ensure that a notice of action is sent in a timely manner to the consumer and provider following a UR denial decision.			
Standard IX: Grievances, Appeals, and Fair Hearings				
7. Record Review—Grievances	CHP must ensure that persons making decisions on clinical grievances have the qualifications to do so, and that the credentials of those individuals are included in the documentation of the grievance decision.			

Table 5-2—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard X: Credentialing				
2. Written policies and procedures The Contractor documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs, and who render services or authorize services to members, and who fall within the Contractor's scope of authority and action.	Because NCQA requirements do not allow the BHO to rely on the delegate's policies and procedures, CHP must develop policies and procedures that document the mechanism for credentialing and recredentialing licensed independent practitioners and that describe CHP's processes rather than the delegate's processes.			
8. Requirements for Credentialing Policies for Organizational Providers The Contractor has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.	Because NCQA requirements do not allow the BHO to rely on the delegate's policies and procedures, CHP must develop written policies and procedures that address the initial and ongoing assessment of organizational providers and that describe CHP's processes rather than the delegate's processes.			

The review of the standards follows this cover page.

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
1. Pre-delegation Assessment	Prior to entering into subcontracts, the Contractor evaluates the proposed subcontractor's ability to perform the activities to be delegated.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings Colorado Health Partnerships (CHP) entered into new agreements with ValueOptions (VO) and the partner community mental health centers (CMHCs) during the review period. Although the agreements were new, the relationships were not. Therefore, CHP had knowledge of the delegates' ability to perform the delegated functions. CHP and VO staff reported that there were no other delegation agreements entered into during the review period.	
II.C.1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
2. Written Agreements II.C.2	The Contractor has a written agreement with each subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP delegated all BHO administrative functions to VO (provider network development and management, provider credentialing, utilization management including utilization review and service denials, processing of Medicaid member grievances and appeals, CCAR and encounter data submission, distribution of required member materials, and the maintenance of the quality assessment and performance improvement program) . The Management Services Agreement described the relationship between CHP and VO. In addition, CHP delegated the processing of Medicaid member grievances to the partner mental health centers. The Member Participation Agreements described the relationship between CHP and the partner mental health centers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement	The written agreement: A. Specifies the activities delegated to the subcontractor.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Provider network development and management, claims management and data submission, credentialing and recredentialing, administration of the utilization management (UM) program, development and distribution of member materials, and administration of the quality assessment and performance improvement (QAPI) program were specified in the Management Services Agreement. Processing of UR denials and processing of Medicaid member grievances and appeals were not clearly specified in the Management Services Agreement as activities VO performed. The Member Participation Agreement specified that Medicaid member grievances were also processed at the partner mental health centers.	
	Required Actions CHP must revise the Management Services Agreement to clearly specify processing of UR denials and processing of Medicaid member grievances and appeals as activities performed by VO for CHP.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement	B. Specifies the reporting responsibilities delegated to the subcontractor.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Management Services Agreement specified the reporting responsibilities of VO regarding provider network development and management, claims management and data submission, credentialing and recredentialing, administration of utilization management, denials processing, and administration of the QAPI program. It did not specify the reporting responsibilities related to the delegated activities of grievance and appeal processing, or distribution of required member materials. The Member Participation Agreement did not specify the reporting responsibilities related to grievance processing by the partner community mental health centers (CMHCs).	
	Required Actions CHP must revise its delegation agreements to specify the reporting responsibilities of the delegates related to the delegated tasks of distribution of required member materials by VO, grievance and appeal processing by VO, and grievance processing by the partner mental health centers.	
	C. Includes provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Sections 6.2 and 6.3 of the Management Services Agreement and Section 6.2 of the Member Participation Agreement included provisions for revoking delegation or imposing other sanctions if the subcontractor's performance became inadequate.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement II.C.2	D. Specifies that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any responsibilities delegated to the subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Sections 1.1 and 1.2 of the Management Services Agreement and Section 2.5 of the Member Participation Agreement included clauses requiring that services provided under the agreement be provided in accordance with the requirements of the contract between CHP and the Department.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
4. Policies and Procedures	The Contractor has written procedures for monitoring the performance of subcontracts: A. On an ongoing basis	☐ **Met** ☐ **Partially Met** ☑ **Not Met** ☐ **N/A**
	Findings CHP had no policies or written procedures that addressed monitoring the performance of CHP's delegates.	
	Required Actions Although CHP delegated administrative responsibilities to VO, including development and maintenance of policies and procedures, because CHP held the contract with the Department, CHP must develop written procedures related to the delegation of administrative responsibilities under that contract, which must include the BHO's procedures for monitoring the performance of delegates on an ongoing basis.	
	B. Through formal review	☐ **Met** ☐ **Partially Met** ☑ **Not Met** ☐ **N/A**
	Findings CHP had no policies or written procedures that addressed monitoring the performance of CHP's delegates.	
II.C.4	**Required Actions** Although CHP delegated administrative responsibilities to VO, including development and maintenance of policies and procedures, because CHP held the contract with the Department, CHP must develop written procedures related to the delegation of administrative responsibilities under that contract, which must include written procedures for monitoring the performance of delegates through formal review.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
5. Monitoring of Delegates	The Contractor monitors services provided through subcontracts for: A. Quality	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP partnership board meeting minutes indicated that during Class B Board meetings of the partnership, the chief executive officer (CEO) of CHP and the Class B Board reviewed reports provided by ValueOptions regarding claims management and data reporting, utilization management, and the QAPI program. These reports included information regarding the quality of the above services performed by VO. There was no evidence that CHP monitored VO for the quality of VO's performance regarding the delegated activities of provider network development and management, credentialing and recredentialing, grievances and appeals processing, the processing of UR denials, or distribution of required member materials. There was also no evidence of CHP's monitoring of grievance processing by the partner CMHCs.	
	Required Actions CHP must monitor each delegated service provided through subcontracts for the quality of the services provided. Monitoring must include provider network development and management, credentialing and recredentialing, grievances and appeals processing, the processing of UR denials, and distribution of required member materials delegated to VO, and grievance processing by the partner CMHCs.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
5. Monitoring of Delegates II.C.3	B. Data reporting	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP partnership board meeting minutes indicated that during Class B Board meetings of the partnership, the CEO of CHP and the Class B Board reviewed reports provided by ValueOptions regarding claims management and data reporting, utilization management, and the QAPI program. The board discussions included a review of the data reporting performed by VO on behalf of CHP and a review of the data VO was required to provide CHP regarding the above activities. There was no evidence that CHP monitored VO regarding the data VO was required to report to CHP regarding provider network development and management, credentialing and recredentialing, the processing of UR denials, or distribution of required member materials.	
	Required Actions CHP must monitor each delegated service provided through subcontracts for data reporting related to the delegated function. Monitoring must include provider network development and management, credentialing and recredentialing, the processing of UR denials, and distribution of required member materials delegated to VO.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
6. Corrective Action II.C.5	If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor take corrective action.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section 6.2 of the Member Participation Agreement and the Management Services Agreement included provisions for corrective action in the case of inadequate performance. There were no examples of corrective action required by the delegates during the review period.	
	Required Actions None	
7. Termination of Subcontracts II.C.9	The Contractor notifies the Department in writing of its decision to terminate any existing subcontract applicable to the performance of services under the Contract.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Although CHP had no policy that addressed the termination of provider contracts, the CEO of CHP indicated that it was his role to notify the Department if any delegation contracts were terminated. The CHP CEO also indicated that no delegation subcontracts had been terminated during the review period.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
8. Access to Records II.C.8	All subcontracts provide for access to all records by the Secretary of the U.S. Department of Health and Human Services, for 3 years following disposition of property or equipment. **Findings** Section 5 of the Member Participation Agreement and the Management Services Agreement provided for access to records by government personnel and were consistent with 45 Code of Federal Regulations (CFR), Part 74. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard I					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
6	4	2	1	12	50%

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
1. Provider Discrimination	A. The Contractor does not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ValueOptions, as the administrative delegate for Colorado Health Partnerships (CHP), had several policies that had nondiscrimination language. VO Policy N201P, Practitioner Credentialing Process, described the eligibility of providers and the extent to which providers met objective credentialing requirements regarding education, licensure, and professional standing, as well as other stated requirements. VO staff provided the form, Practitioner Credentialing Quality Control Bi-Annual Audit for Potential Discrimination, and described a process whereby this audit would take place in response to provider complaints. VO staff reported that the audit would be performed by ValueOptions corporate personnel. VO staff also reported that corporate VO had not performed any of these audits during the review period.	
	Required Actions None	
	B. If the Contractor declines to include individual or groups of providers in its network, it gives the affected providers written notice of the reason for its decision.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Although there was not a specific policy that indicated providers were notified of the reason for denial of participation in the network, VO provided an example of a letter that had been sent to a provider. The letter contained the reason for denying participation in the network.	
II.H.4.a	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	A. The Contractor has a mandatory compliance plan and administrative and management arrangements or procedures that are designed to guard against fraud and abuse, and that include: 1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state requirements.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP Compliance Program Description included CHP's commitment to comply with all applicable federal and State requirements, CHP's administrative arrangement with ValueOptions regarding the compliance program, and the composition of the CHP Compliance Committee. The CHP Compliance Program Description also referenced ValueOptions' policies and procedures that included processes designed to guard against fraud and abuse.	
	Required Actions None	
	2. Designation of a compliance officer and compliance committee that is accountable to senior management.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The quality director of CHP, a VO employee operating under the delegation agreement for administrative services, was the designated compliance officer and a member of the compliance committee. The CHP CEO and CHP board representatives were members of the compliance committee. A review of the compliance committee meeting minutes demonstrated that the compliance committee was an active committee throughout the review period.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	3. Training and education for the compliance officer and the Contractor's employees.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP Compliance Program Description described training for VO employees (this included the compliance officer). Compliance committee meeting minutes provided evidence of planning for training on compliance for VO and CHP employees.	
	Required Actions None	
	4. Provisions for internal monitoring and auditing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP Compliance Program Description and several VO policies included provisions for internal monitoring and auditing of CHP's partner CMHCs. A review of the compliance committee meeting minutes demonstrated that several types of audits were completed and presented to the committee. The meeting minutes also described follow-up to issues discovered from the audit results.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity II.G.5.c.1-7 II.H.5.d	5. Provisions for prompt response to detected offenses and for development of corrective action initiatives.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP Compliance Program Description and several VO policies included provisions for prompt response to detected offenses. A review of the compliance committee meeting minutes demonstrated response to results of the audits performed and development of corrective action plans, when necessary.	
	Required Actions None	
	B. The Contractor reports possible instances of Medicaid fraud to the Department within ten (10) business days of receipt of information. The Referrals include specific background information, the name of the Provider and a description of how the Contractor became knowledgeable about the occurrence.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There was an instance of possible fraud that was discussed in the January 2006 compliance committee meeting. The quality director provided a copy of the letter that had been sent to the Department December 9, 2005, informing the Department of the possible fraud. The letter contained all of the requirements and was sent to the Department within the 10-day requirement.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
3. Provider Agreements II.H.10.a.2	The Contractor has a written agreement with each provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Member Participation Agreement was the provider agreement between the partner CMHCs and CHP. CHP also provided for review a Facility Agreement template and a Practitioner Agreement template. There was evidence on-site that VO, as the administrative delegate of CHP, had an effective tracking mechanism to ensure that there was a provider agreement with each provider. A sample of credentialing files for individual and organizational providers contained signed agreements.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
4. Content of Agreement	The written agreement: A. Specifies the activities of the provider	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section 2 of the Practitioner Agreement, the Facility Agreement, and the Member Participation Agreement specified the activities assigned to the provider.	
	Required Actions None	
	B. Specifies the reporting responsibilities of the provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each type of agreement required adherence to the provider manual. The provider manual described Colorado Client Assessment Record (CCAR) reporting. Encounter claim reporting was addressed in the Member Participation Agreement (for the partner CMHCs). Billing was addressed in the provider manual (for subcontracted providers).	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
4. Content of Agreement II.H.10.a.2	C. Includes provisions for revoking the agreement or imposing other sanctions if the provider's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section 2 of the Facility and Practitioner Agreements and Section 6 of the Member Participation Agreement included provisions for revoking the agreement or imposing other sanctions if a provider's performance became inadequate.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment	The Contractor provides that its Medicaid members are not held liable for: A. The Contractor's debts in the event of the Contractor's insolvency.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section 3.4 of the Member Participation Agreement provided that consumers could not be held liable in the event of CHP's insolvency. Section 3.3 of the Practitioner Agreement and 3.4 of the Facility Agreement included language parallel to the Member Participation Agreement, and these sections, in conjunction with Section 1 of the Provider Contract Addendum and the Facility Contract Addendum, met the requirement.	
	Required Actions None	
	B. Covered services provided to the member for whom the Department does not pay the Contractor, or the Department or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section 3.4 of the Member Participation Agreement provided that consumers could not be held liable in the event of CHP's nonpayment. Section 3.3 of the Practitioner Agreement and 3.4 of the Facility Agreement included language parallel to the Member Participation Agreement, and these sections, in conjunction with Section 1 of the Provider Contract Addendum and the Facility Contract Addendum, met the requirement.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment II.H.11.a	C. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section 3.3 of the Practitioner Agreement, Section 3.4 of the Facility Agreement, and Section 3.4 of the Member Participation Agreement included the provision that the subcontractor may not bill, charge, collect deposits from, or seek compensation from covered persons.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	The Contractor monitors covered services provided under provider agreements for: A. Quality	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There was evidence of completed chart audits for both partner CMHCs and subcontracted providers. The chart audits included a review for the quality of the services provided.	
	Required Actions None	
	B. Appropriateness	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There was evidence of completed chart audits for both partner CMHCs and subcontracted providers. The chart audits included a review for appropriateness of services provided.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	C. Member outcomes	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP Readmission Report , the CHP summary of results for the Fact Finders Satisfaction Survey, UM Activity summaries, and the Emergency Room Visit Follow-up study were examples of monitoring member outcomes for services provided by partner CMHCs and subcontracted providers.	
	Required Actions None	
	D. Requirements for medical records	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There was evidence of completed chart audits for both partner CMHCs and subcontracted providers. The chart audits included a review for CHP's medical records requirements.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	E. Requirements for data reporting	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP Data Report Card provided an example of monitoring partner CMHCs and subcontracted providers for data reporting requirements.	
II.H.10.a.3	**Required Actions** None	
7. Policies and Procedures	The Contractor has written procedures for monitoring the performance of providers on an ongoing basis.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Colorado Health Network (CHN) Policy 245, Clinical Audits of Provider Medical Records; CHN Policy 259L, Enchanced Clinical Mangament of Outpatient Services; CHN Policy 2.10, Roles and Responsibility of the Quality of Care Committee; and the CHP Quality Improvement Program Description/Plan - 2007 described how subcontracted providers and partner CMHCs were monitored on an ongoing basis.	
II.H.10.a.4	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
8. Termination of Provider Agreements II.H.10.d	The Contractor notifies the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area and provides the notice at least ninety (90) days prior to termination of the services unless the termination is based on quality or performance issues.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 3.06 included the provision to notify the Department of any decision to terminate provider agreements when services would be inadequate as a result of the termination. ValueOptions staff, on behalf of CHP, reported that there were no provider terminations that affected the adequacy of the network during the review period.	
	Required Actions None	
9. Prohibited Affiliations II.H.6.a	The Contractor does not knowingly have a relationship of the type described below with the following: An individual or an affiliate of an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings VO Policy HR116 stated that the U.S. Department of Health & Human Services Office of Inspector General (OIG) database was used to ensure that employees, contractors, volunteers, and others were not ineligible to participate in any federal reimbursement program. During the interview, ValueOptions and CHP staff confirmed the use of the OIG database.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
10. Marketing II.H.8	The Contractor adheres to all contract requirements related to marketing.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings ValueOptions and CHP staff reported that during the review period, CHP did not engage in marketing activities as marketing is defined in the BHO contract with the Department.	
	Required Actions None	
11. Department Approved Member Handbook II.H.8.a	The BHO's Member Handbook was submitted to and approved by the Department prior to distribution.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ValueOptions, on behalf of CHP, provided a letter from the Department dated June 15, 2005, approving the member handbook and reported that the handbook was being distributed at the time of the site review. The member handbook provided for review contained the same content as the member handbook availble on the Department's Web site.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
12. Statistically Valid Sampling II.J.6.c.3.c	The BHO reviews compliance with criteria for submission of encounter claims data each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The reports indicated that the samples included data from each of the network CMHCs, as well as subcontracted providers, and represented the array of services provided by CHP. However, while the CHP partner CMHCs and VO each reviewed a statistically valid sample of encounter records (a total of 411 records) for compliance with contract criteria, the reports submitted by VO indicated that, for this audit of a statistically valid sample of encounter claims, the CMHCs and VO reviewed only for the presence of documentation in the medical record. The reports did not indicate that, as part of the audit, the CMHCs or VO had reviewed for the accuracy and completeness of the data or the inclusion of both paid and denied claims.	
	Required Actions While the CHP partner CMHCs each reviewed a statistically valid sample of encounter data and submitted the review to VO for oversight and VO reviewed encounters for subcontracted providers, the reviews did not include each of the required criteria. In addition to reviewing for the presence of medical record documentation CHP, or its delegate(s), must review and document compliance with the other contract criteria for submission of encounter claims (the accuracy and completeness of all fields and the presence of both paid and denied claims) on a statistically valid sample of encounter claims.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
13. Record Review: Documentation of Services	Presence, timeliness, and accuracy of documentation to support encounter claims.	
	Findings A sample of 10 consumer service records was reviewed to assess CHP's compliance with contract requirements related to documentation of services for encounters submitted. CHP was compliant with 20 of 20 of the total applicable elements reviewed for a record review score of 100 percent. All 10 records contained documentation of the service provided for the day the encounter was submitted. All 10 records contained documentation that described the service for which the encounter was submitted.	
	Required Actions None	

Results for Standard II					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
24	1	0	1	25	96%

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	Any practice guidelines adopted by the Contractor will: A. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the field.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings Minutes from Clinical Advisory/Utilization Management Committee (CAUMC) meetings held May 19, 2006, and November 17, 2006, documented that although several existing clinical practice guidelines were reviewed and revised, CHP did not adopt any new practice guidelines this review period. During the interview, staff confirmed that CHP had not implemented new practice guidelines over the past year.	
	Required Actions None	
	B. Consider the needs of the members.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings Minutes from CAUMC meetings held May 19, 2006, and November 17, 2006, documented that although several existing clinical practice guidelines were reviewed and revised, CHP did not adopt any new practice guidelines this review period. During the interview, staff confirmed that CHP had not implemented new practice guidelines over the past year.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	C. Be adopted in consultation with contracting health care professionals.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings Minutes from CAUMC meetings held May 19, 2006, and November 17, 2006, documented that although several existing clinical practice guidelines were reviewed and revised, CHP did not adopt any new practice guidelines this review period. During the interview, staff confirmed that CHP had not implemented new practice guidelines over the past year.	
	Required Actions None	
	D. Be reviewed and updated periodically as appropriate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 105L, Developing and Updating Treatment Guidelines, required that the CAUMC review and update clinical practice guidelines every two years or more frequently as necessary. The policy also stated that the practice guidelines were referred to the Boards of Managers for final approval. Minutes from a CAUMC meeting held May 19, 2006, documented that clinical practice guidelines for the treatment of bipolar disorders, attention deficit hyperactivity disorder (ADHD), and anxiety disorders of childhood and adolescence were reviewed, revised, and forwarded to the Boards of Managers for final approval.	
II.I.2.a.1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
2. Dissemination II.I.2.a.2	The Contractor disseminates practice guidelines to all affected providers and, upon request, to members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 236L, Distribution of Clinical Level of Care Guidelines and Diagnostic Criteria, included a description of CHP's process for the dissemination of clinical practice guidelines to both internal staff and consumers, family members, and the provider community. The policy stated that clinical care managers were informed of any substantive changes to the guidelines in clinical team meetings and that training regarding the use of practice guidelines was available to provider staff upon request. During the interview, CHP staff reported that approximately five trainings regarding use of clinical practice guidelines had been made available to network providers over the last year. Practice guidelines adopted by CHP were made available to providers, consumers, and family members on the CHP Web site and copies of the documents were included in the BHO's provider manual. During the interview, BHO staff also indicated that the Director of the Office of Consumer and Family Affairs (OCFA) was actively involved in distributing practice guideline tip documents to consumers, family members, and advocates.	
	Required Actions None	

Results for Standard III					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
2	0	0	3	2	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	The Contractor has written policies and procedures for treating members in a manner that is consistent with the member's right to: A. Receive information about his/her rights.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHN policy, Member Handbook Development and Distribution, contained the BHO's standards for consumer information content, format, readability, and distribution methods. CHN Policy 304L, Member Rights and Responsibilities, included the responsibilities of the BHO for distributing consumer informational materials, including rights information to consumers, providers, and community agencies. Examples of consumer rights informational materials that were distributed included the CHN consumer handbook, a Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy letter, and a "Dear Medicaid Recipient" letter. In the interview, staff stated that new Medicaid enrollees in the CHP geographic area were mailed a packet of information by CHP and that a consumer employee managed this process. Staff also stated that when a consumer began receiving services at a CMHC or non-CMHC provider, the provider was responsible for distribution of consumer materials and rights information during the intake appointment. In addition, providers were required to post the ombudsman flyer at their service sites. During the desk review and onsite review, two examples of CMHC rights statements were provided. These statements were different from each other and from the rights and responsibilities listing in the CHP consumer handbook in that three of CHN's rights statements were missing from each, and one listing had 10 consumer responsibilities listed compared with three in the CHP handbook. Staff stated that consumers receive a CMHC-specific packet of information from the CMHCs; however, it was not clear in the policy or interview whether the CMHCs' practice was to provide this CMHC-specific information instead of or in addition to the CHP-developed information. Staff stated that CHP's audits of the CMHCs reviewed their consumer materials to ensure the presence of all required elements on the rights statements. Evidence of monitoring two CMHCs was provided on-site (Spanish Peaks Mental Health Center [MHC] and Southeast Mental Health Services). Both audits appeared to allow the CMHCs to meet the rights listing requirements through other documentation (consent forms, member handbook, posters) besides the consumer rights listing. Review of the CMHCs' consumer responsibilities listing was not on the audit tool.	
	Required Actions CHP must ensure that all consumers receive information that is consistent with the CHP Medicaid rights	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
	and responsibilities listing. CHP should also clarify its policies, procedures, and practices regarding the role of the BHO or its delegate, VO, in the development and distribution of consumer informational materials, and the role providers have for developing and distributing consumer materials, if any.	
	B. Be treated with respect and with due consideration for his/her dignity and privacy.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Member Rights and Responsibilities, and the CHP Member Handbook included the consumer's right to be treated with respect, recognition of their dignity, and need for privacy. The policy was distributed to staff with the requirement to sign an attestation statement about treating consumers in a manner that respected their rights.	
	Required Actions None	
	C. Participate in decisions regarding his/her health care, including the right to refuse treatment except as provided by law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Member Rights and Responsibilities, and the CHP Member Handbook included the consumer's right to participate in decisions about health care, including refusing treatment as allowed by law. The policy was distributed to staff with the requirement to sign an attestation statement about treating consumers in a manner that respected their rights. The BHO's policy on treatment planning included the requirement to involve the consumer and significant others in the treatment planning process. The Wellness Recovery Action Plan (WRAP) model was also provided as an example of consumer participation.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	D. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Member Rights and Responsibilities, and the CHP Member Handbook included the consumer's right to receive information about treatment options in a manner that is understandable. The policy was distributed to staff with the requirement to sign an attestation statement about treating consumers in a manner that respected their rights.	
	Required Actions None	
	E. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Member Rights and Responsibilities, and the CHP Member Handbook included the consumer's right to be free from restraint or seclusion as a means of coercion, discipline, convenience, or retaliation. The policy was distributed to staff with the requirement to sign an attestation statement about treating consumers in a manner that respected their rights.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	F. Request and receive a copy of his/her medical records and to request that they be amended or corrected.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Member Rights and Responsibilities, and the CHP Member Handbook included the consumer's right to ask for, receive, and request the amendment of health information records. The policy was distributed to staff with the requirement to sign an attestation statement about treating consumers in a manner that respected their rights. The BHO also had a Notice of Privacy Practices that was distributed to all new consumers, and the notice contained information about the consumer's rights to see, get a copy of, and ask for changes to the medical record information.	
	Required Actions None	
	G. Be furnished health care services in accordance with 42 C.F.R. Sections 438.206 through 438.210.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Member Rights and Responsibilities, and the CHP Member Handbook included the consumer's right to receive appropriate, culturally competent, and medically necessary services. The policy was distributed to staff with the requirement to sign an attestation statement about treating consumers in a manner that respected their rights. A number of additional BHO policies addressed specific requirements related to service authorization, timely access, and coordination of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights II.G.3	H. Be free to exercise his/her rights without it affecting the way the Contractor and its providers treat the member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Member Rights and Responsibilities, and the CHP Member Handbook included the consumer's right to exercise his or her rights and to express an opinion without any affect on the provision of services. The policy was distributed to staff with the requirement to sign an attestation statement about treating consumers in a manner that respected their rights.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	A. The Contractor ensures that its staff and affiliated providers take these rights into account when furnishing services to members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings In addition to requiring that staff sign the Member Rights and Responsibilities attestation form, the BHO had developed and provided training on "Complaints as Gifts" to ensure that staff and providers regarded information from consumers as improvement opportunities. The practitioner environmental site review (PESR) form, which was used to monitor non-CMHC providers, included review criteria about the confidentiality of member information and the availability of rights information at provider sites, including posting of the ombudsman flyer and an explanation of the grievance process. The CMHC audit tool contained items related to consumer rights information, consumer involvement, cultural competency of staff, and the complaint process. The consumer Mental Health Statistics Improvement Program (MHSIP) data were reviewed by the BHO for responses to items about consumer perception of involvement in care decisions.	
	Required Actions None	
	B. The BHO has a process to ensure the member's right to an independent advocate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The right to an independent advocate was included in the rights listing contained in the consumer handbook. Staff described the referral process to the local National Alliance for the Mentally Ill, the Mental Health Association, and other similar advocacy agencies for consumers requesting or requiring assistance with obtaining an advocate. The OCFA had a listing of additional advocacy groups available.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	C. The BHO has processes to follow-up on all member complaints about a staff person or provider and to ensure that the staff/providers do not retaliate against the member for expressing a concern.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had grievance policies and procedures for following up on consumer complaints and included language in policies and the consumer handbook prohibiting retaliation against consumers who complained. Grievance response letters to consumers contained the information that consumers would not receive unfair treatment from staff for having filed a grievance. A survey to elicit responses from consumers about their experience with the grievance process had been initiated; however, staff stated that there was not a good return rate for the surveys. An element for response on the survey aimed to measure whether the consumer felt that he or she was treated differently after filing a complaint.	
	Required Actions None	
	D. The BHO furnishes to each of its Members information about the assistance available through the Medicaid Managed Care Ombudsman Program and how to access Ombudsman Program Services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Information about the availability of the Medicaid Managed Care Ombudsman Program was contained in the consumer handbook, the provider manual, and a flyer titled How to File a Grievance or Appeal, and the ombudsman flyer was required to be posted at service sites. The BHO monitored this posting through the use of its provider audit tools for both CMHC and non-CMHC providers. Documented evidence of audits was provided. The ombudsman program was highlighted in a provider newsletter article in Spring 2006 and was discussed at a system-wide meeting of advocates during the period under review.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
II.G.3-4		
3. Member Responsibilities	The Contractor has written requirements for member participation and responsibilities in receiving covered services.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings In response to a required action from the previous site review, the BHO revised consumer materials (rights listings, the letter to Medicaid recipients, and the consumer handbook) to contain consistent listings of CHP's consumer responsibility statements. The CHN policy on consumer rights and responsibilities had a different set of consumer responsibilities listed. In addition, examples of CMHC rights and responsibilities that were provided were not consistent with the CHP listing.	
	Required Actions CHP must ensure that Medicaid consumer responsibilities and expectations for participation are consistently communicated to consumers, staff, and providers.	
II.G.2		

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
4. Consumer and Family Affairs II.G.5	The Contractor has an Office of Consumer and Family Affairs to work with members and families.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP Office of Consumer and Family Attairs (OCFA) was depicted on the organizational chart and was described on the CHP Web site, in the consumer handbook, and in the provider manual. A listing of OCFA goals and OCFA meeting minutes were reviewed and showed evidence of a very active and integrated advocacy office. Included in the list of responsibilities were key roles in providing advocacy, assistance with linking consumers with services and supports, providing for processing of grievances, development of consumer information and educational materials, providing education of staff and providers on consumer rights and responsibilities, and promoting the recovery model.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives	A. The Contractor has written policies and procedures for Advance Directives.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings In response to a required action from the previous site review, CHP had amended its policy and procedures regarding advance directives and had communicated and implemented the new procedures. The revised policy contained all elements required to be addressed in policy as listed at 42 Code of Federal Regulations (CFR) 422.128, with the exception of addressing the BHO's procedures for educating staff concerning its policies and procedures on advance directives and for community education regarding advance directives. The BHO provided documented evidence of the staff/provider and community education it had conducted; however, the policy did not reflect the BHO's process.	
	Required Actions CHP must include in the advance directives policy its procedures for educating staff, providers, and the community on advance directives.	
	B. The Contractor provides all adult members with written information on Advance Directives policies, which includes: 1. A description of the applicable state law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP consumer handbook contained information on the advance directives policies of the organization and included a description of the State law. All new Medicaid recipients in the CHP geographic area of responsibility received this information upon enrollment.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives	2. The member's rights under the law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP consumer handbook contained information on the advance directives policies of the organization and included the consumer's rights under the law. All new Medicaid recipients in the CHP geographic area of responsibility received this information upon enrollment.	
	Required Actions None	
	3. The fact that complaints concerning non-compliance with the Advance Directive requirements may be filed with the State Department of Public Health and Environment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP consumer handbook contained information on the advance directives policies of the organization and included information on how to file a complaint about noncompliance with advance directives requirements. All new Medicaid recipients in the CHP geographic area of responsibility received this information upon enrollment.	
II.H.7	**Required Actions** None	

Results for Standard IV					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
15	3	0	0	18	83%

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
1. On-site Nursing Facilities II.F.2-3	The Contractor: - Provides medically necessary mental health services on-site in nursing facilities for members who are residents of nursing facilities and who cannot reasonably travel to a service delivery site for their services. - Considers the ability of the resident to travel when determining the service delivery site (i.e., BHO site or nursing facility).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHN policy, Services for Residents of Nursing Facilities, contained the requirement to provide services in the nursing facility (NF) if the consumer could not travel or assist the consumer to in arranging for transportation to a service site, if appropriate. Both CMHC and non-CMHC provider requirements were addressed in the policy. CHP provided a report of nursing facility visits conducted between January and November 2006, which totalled 2,124. In the interview, staff members stated that their expectation was that any/all providers would be available to provide services in nursing facilities, if the need arose, and that case management teams and crisis teams were available to be deployed to NFs by the CMHCs. An additional specialty geriatric consultant team was available in certain areas to provide NF services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
2. Dual Medicare/Medicaid Eligible	A. The Contractor makes an effort to identify and include providers in the Contractor's network that are capable of billing Medicare for dual Medicare and Medicaid eligible members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP had a policy, Assisting Dual Medicare/Medicaid Eligible Members with Referrals and Access to Services, and a process for including Medicare-eligible providers in the network. All CMHCs under contract with the BHO had the capability to bill Medicare, as did a select set of specialty and independent providers. Data fields in the provider database captured information about providers who could bill Medicare and this information was updated during the recredentialing process.	
	Required Actions None	
	B. If qualified Medicare providers cannot be identified, the Contractor provides the medically necessary mental health services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP's policy, Assisting Dual Medicare/Medicaid Eligible Members with Referrals and Access to Services, described the process by which CHP determined the consumer's need for services and referred the consumer to a Medicare provider, or if one was not available, provided the service through the mental heath center servicing the consumer's geographic region.	
	Required Actions None	
II.F.4		

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	A. The Contractor monitors providers to determine compliance with standards for timely access.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP, through its Management Services Agreement with VO, ensured that providers were monitored on access-to-care standards and requirements for data submission. The non-CMHC providers were surveyed by phone for their next available routine appointment and, if the availability of that appointment was longer than the standard, the providers were sent a letter requiring corrective action. These providers were also remonitored later for improvement. To monitor emergency and urgent appointment standards, the BHO called the non-CMHC providers after hours and timed the call-back responses. Results of these phone surveys were reported to the Quality Improvement Steering Committee. The CMHCs collected and reported their access-to-care data to the BHO, and VO monitored both their data collection policies/procedures and their adherence to the timeliness standards. The BHO provided evidence of monitoring of and communications with providers requiring corrective actions when standards were not met. Committee oversight of the access data and provider monitoring was accomplished through the quality and clinical services committees and the OCFA, and reported to the Class B Board of the BHO.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	B. The Contractor meets standards for timeliness of service including the following: 1. Emergency services are available - By phone within 15 minutes of the initial contact. - In person within one hour of contact in urban and suburban areas. - In person within two hours of contact in rural and frontier areas.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's delegate, VO, demonstrated its processes for the collection of data and oversight of both CMHC and non-CMHC providers for access to emergency services. Staff articulated the expectation for all providers to have mechanisms in place to respond to consumers' emergency service needs.	
	Required Actions None	
	2. Urgent care is available within 24 hours.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's delegate, VO, demonstrated its processes for the collection of data and oversight of both CMHC and non-CMHC providers for access to urgent services. Staff articulated the expectation for all providers to have mechanisms in place to respond to consumers' urgent service needs.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	3. Routine services are available within seven calendar days.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's delegate, VO, demonstrated its processes for the collection of data and oversight of both CMHC and non-CMHC providers for access to routine services. Staff articulated the expectation of all providers to have mechanisms in place to respond to consumers' routine service needs.	
	Required Actions None	
	C. The Contractor takes corrective action if there is a failure to comply with standards for timely access.	
	Findings This element was not reviewed or scored.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services II.F.1.a.7 II.F.1.a.4.a-e II.F.1.a.8 Exhibit C.III.C	D. The authorization process takes into consideration other factors, such as the need for services and supports to assist a Member to gain new skills or regain lost skills that support or maintain functioning and promote recovery.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 202L, Medical Necessity, described the BHO's expectation that services intended to help consumers gain new skills and regain lost skills should be authorized and included in the treatment plans. The outpatient services definitions emphasized a treatment focus on recovery, rehabilitation, and improved functioning. During the interview, staff described and provided evidence of the clinical audit tool that was used to assess the consumer's progress and whether appropriate planning of services had occurred.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	In establishing and maintaining the provider network, the Contractor considers: A. Including both Essential Community Providers and other providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP had a policy, CHN 3.06, Measurement of Access and Availability, that described its standards and methods for assessing and maintaining an adequate network. Examples of quarterly network adequacy reports from the review period provided evidence of 12 contracted CMHCs, one federally qualified health center, and numerous other organizational and individual providers.	
	Required Actions None	
	B. The anticipated Medicaid enrollment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP had a policy, CHN 3.06, Measurement of Access and Availability, that described its standards and methods for assessing and maintaining an adequate network. Included in the policy was a procedure requiring that the evaluation consider the anticipated Medicaid enrollment. The network adequacy reports contained evidence of the Medicaid consumer population by county.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	C. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the enrolled population.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP had a policy, CHN 3.06, Measurement of Access and Availability, that described its standards and methods for assessing and maintaining an adequate network. Included in the policy was a procedure requiring that the evaluation consider the characteristics and health care needs of its population. The network adequacy reports contained evidence of considering the service specialty of the network and listed prescribers, licensed and nonlicensed mental health practitioners by county, and facilities by type.	
	Required Actions None	
	D. The numbers and types (training/experience) of providers required to furnish the contracted Medicaid services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP had a policy, CHN 3.06, Measurement of Access and Availability, that described its standards and methods for assessing and maintaining an adequate network. Included in the policy was a procedure requiring that the evaluation consider the number and type of providers needed to furnish the contracted services. The policy also described procedures used by the quality management and provider relations departments to jointly assess the number and types of providers needed using data available from satisfaction surveys, access-to-care measures, credentialing committee reports, and geographical access reports.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	E. The numbers of network providers who are not accepting new Medicaid patients.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP had a policy, CHN 3.06, Measurement of Access and Availability, that described its standards and methods for assessing and maintaining an adequate network. Included in the policy was a procedure requiring that the evaluation consider the providers who were not accepting new members. The network adequacy reports contained evidence of the number of providers who were not accepting referrals.	
II.F.1.c	**Required Actions** None	
5. Out-of-Network Providers	If the Contractor is unable to provide covered services to a particular member, the Contractor provides the covered services out of network at no cost to the member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 274L, Provision of Services Through an Out of Network Provider, described the procedures that the BHO staff and providers would use to secure out-of-network services at no cost to the consumer. Evidence of the out-of-network provision of services was contained in examples of the quarterly network adequacy reports.	
II.F.1.d	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
6. Geographic Access	A. The Contractor has arrangements to ensure proximity of participating providers to the residences of members so as not to result in unreasonable barriers to access and to promote continuity of care taking into account the usual means of transportation ordinarily used by members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 3.06, Measurement of Access and Availability, described the standards and procedures used to assess the geographic location of providers and eligible members. VO Policy PR302, Network Design and Access Standards, provided criteria that were used to ensure that an adequate number of practitioners (MDs, PhDs, master's degree-level therapists, etc.) were available per 1,000 members. There were also standards in the policy for geographic access based on urban, suburban, and rural locations. During the interview, staff members discussed the unique challenges of having responsibility for largely rural and frontier areas of the State and their use of telemedicine services to accommodate some of the needs.	
	Required Actions None	
	B. The Contractor ensures that providers are located throughout the Contractor's service area, within 30 miles or 30 minutes travel time, to the extent such services are available.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 3.06, Measurement of Access and Availability, described the standards and procedures used to assess the geographic location of providers and eligible members. VO Policy PR302, Network Design and Access Standards, provided criteria that were used to ensure provider proximity to consumers within the standard. The first quarter FY 07 Network Adequacy Report described that 1,215 CHP consumers were located further away from providers than the standard, 30-mile distance, at an average distance of 36.4 miles.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
II.F.1.e II.1.a.5		
7. Selection of Providers	The Contractor allows each member to choose, to the extent possible and appropriate, his or her health professional.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP consumer handbook and CHN Policies 274L, Provision of Services Through an Out of Network Provider, 210 Member Request-Routine, and 211L, Member Request-Urgent, described procedures for allowing consumers to have a choice of providers to the extent possible and appropriate. The quarterly Network Adequacy Reports contained evidence of the BHO's practice to enter into single-case agreements and to contract with out-of-network providers to facilitate consumer choice.	
	Required Actions None	
II.F.1.f		

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
8. Recovery Model Exhibit C.II	The Contractor will demonstrate commitment to the recovery model.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP, through its OCFA staff, described being "pioneers" of the recovery model for more than 10 years. The organization employed 20 paid advocates, and OCFA saw its primary role as championing the recovery model in order to change staff and providers' thinking about recovery. Advocates also routinely met with new employees to discuss the recovery philosophy. The BHO described a comittment to a very local application of the model based on the needed mix of services and other community needs and priorities throughout its large geographic area of responsibility. The BHO was proud of its 40 peer specialists practicing in the network and of the unique family crisis pilot, which was similar to the WRAP model but was for families and youth. Through a subgroup of the Quality Improvement Steering Committee, staff members were developing a study of suicide using focus groups of consumers to understand what prevented them from talking with therapists and others before an attempt. Data from this study were to be used to develop interventions and perhaps conduct a performance improvement project to reduce the number of suicides and attempts and provide consumers with options they would use to seek help when feeling hopeless.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
9. Medication Management Exhibit C.IV.I	The BHO provides or arranges for the monitoring of medications prescribed, and consultation provided to Members by a physician as necessary.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHP Policy, C240P Member Access for Medication Management, addressed the BHO's process for consumer assessment and referral for medication services. There was evidence of the BHO's evaluation of the number and location of prescribers in the network, and documentation of efforts to contract with nonphysician prescribers such as nurse practitioners and physician assistants. A report of medication encounters by provider type for calendar year 2006 (through November 30) was provided for review and documented 26,403 medication management encounters, a total that reflected underreporting due to a claims lag.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
10. Alternative Services Exhibit K.III.A-I	The BHO has sufficient capacity to provide alternative services as described in Exhibit K of the Contract with the Department (effective 3/31/06). These services are available to serve the specified number of Members, and at the specified locations.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP provided a report of FY 05-06 expenditures on alternative services (as reported to the Department) and a separate report that, for the same time period, documented the number of service units that were provided. During the interview, staff described how they used utilization data on a regular basis to assess capacity and use of the services. Based on needs, changes have been made and reported to the Department. For example, a drop-in center at one location was closed due to very low utilization and another one was grant-funded to expand its hours of operation because it had become very well attended. The BHO staff also stated that the majority of alternative services were available through the CMHCs.	
	Required Actions None	

Results for Standard V					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
20	0	0	0	20	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	A. The Contractor has a Utilization Management (UM) Program to monitor the access to and appropriate utilization of covered services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP, through its Management Services Agreement with ValueOptions, demonstrated that it had an active utilization management (UM) program in place to monitor the access to and appropriate utilization of covered services. The CHP 2006 Utilization Management Program Description defined the UM program mission and philosophy, described the UM Committee structure, and provided information regarding the utilization review process, including the process for handling utilization review denials. The BHO also had numerous UM-related policies and procedures, actively monitored the appropriateness and consistency of authorization decisions, and used various UM reports to help detect both under- and overutilization of covered services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	B. The UM program includes written policies and procedures.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO had policies and procedures that provided staff guidance regarding various utilization management activities and processes. ValueOptions (VO) and Colorado Health Network (CHN) policies provided for review included the following: VO Policy C101P, Utilization Management Program Description; VO Policy C102P, Utilization Management Work Plans; VO Policy C110P, Roles and Responsibilities of the Clinical Advisory Committee(s); VO Policy C113P, Utilization Management Program Evaluations; CHN Policy 103L, Revisions to the Utilization Management Description and Work Plan; CHN Policy 202L, Medical Necessity; CHN Policy 203L, Medical Necessity Determination, Lack of Information, and Notification Timelines; CHN Policy 104L, Developing and Updating Clinical Criteria; CHN Policy 303L, Peer Advisor Adverse Determinations; CHN Policy 305L, Clinical Appeal Process; and CHN Policy 404L, Credentialing Licensure and Certification of Clinical Review Staff. Upon review, it was determined that the decision-making timelines included in the CHP 2006 Utilization Management Program Description and CHN Policy 203L, Medical Necessity Determination, Lack of Information, and Notification Timelines, were inconsistent with time frame requirements included in the BBA and the BHO's contract with the Department. For example, Section V.B.1 of the policy incorrectly allowed up to 15 calendar days for standard service authorization decisions that deny or limit services to CHP consumers. In addition, Section V.E.1 of the policy incorrectly allowed 30 calendar days to render medical necessity determinations of retrospective service authorization requests. These time frames were inconsistent with timelines prescribed in Exhibit G of the BHO's contract with the Department.	
	Required Actions CHP must revise its UM program description and policies and procedures that address timeliness of medical necessity decisions and noticing requirements to be consistent with the BBA and with contract requirements.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	C. The Contractor has a mechanism in effect to ensure consistent application of the review criteria for authorization decisions and, as applicable, consultation with the requesting provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 104L, Developing and Updating Clinical Criteria, and CHN Policy 202L, Medical Necessity, described CHP's procedures for determining medical necessity, including the use of standardized clinical level-of-care (LOC) criteria to help ensure the consistency of authorization decisions. Copies of the LOC criteria were posted on the CHP Web site. During the interview, BHO staff reported that all personnel responsible for making authorization decisions received extensive training and were paired for an extended period with senior clinical staff as part of a preceptor program. Staff also indicated that the BHO conducted interrater reliability studies and completed quarterly audits of the timeliness and appropriateness of authorization decisions. The CHN FY 06-07 Combined Quality Management and Care Management Work Plan addressed the planned use of interrater reliability studies to help ensure the consistent application of LOC criteria by care managers. CHN Policy 303L, Peer Advisor Adverse Determinations, stated that the BHO made peer-to-peer consultation available to providers as needed to discuss cases prior to making a UR determination.	
II.J.1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
2. Over-/Under-Utilization II.I.2.e	The Contractor has in effect mechanisms to detect both under-utilization and over-utilization of services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP had policies and processes in place to help detect both under- and overutilization of services. CHN Policy 3.09, Quality of Care Issues and Outlier Practice Patterns, described the BHO's process for identifying, investigating, resolving, and monitoring outlier practice patterns, including suspected under- or overutilization. The Quality Improvement Program Annual Evaluation Fiscal Year 2005-2006 noted that the BHO evaluated possible underutilization of inpatient services for consumers who experienced readmissions following inpatient discharge. Examples of several reports usedby the BHO to monitor under- and overutilization of services were also provided for review. The reports included census data, inpatient admissions/1,000, authorized versus budgeted residential treatment and inpatient days, ADHD consumers with more than 25 treatment sessions per year, and a description of outpatient service data within 7 days and 30 days of an emergency room visit. Information included in the FY 06-07 Site Review Document Request Form stated that utilization data were reviewed by the Class B Board, the CHP Finance and Audit Committee, and the Clinical Advisory/Utilization Management Committee (CAUMC).	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
3. Evaluation of UM Program II.J.I.e	The Contractor has mechanisms to evaluate the effects of the UM program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings During the interview, staff reported that the BHO evaluted the effectiveness of its UM program on an ongoing basis through periodic analysis of utiization management data. Staff stated that a comparative analysis of data across its partner CMHCs was conducted, including a review of average length-of-stay (ALOS) data, inpatient days/1,000, and high-volume providers. VO Policy C113P, Utilization Management Program Evaluations, required that a formal evaluation of the UM program be conducted annually. The policy stated that the evaluation was to include a description of all completed and ongoing utilization management activities, a summary and analysis of UM-related data, and recommended goals for the upcoming year. An annual evaluation of the BHO's UM program was included in the Quality Improvement Program Annual Evaluation Fiscal Year 2005-2006. The report included a discussion of interrater reliability training, summary data related to access-to-care measures, and a discussion regarding the detection of over- and underutilization of services. CHP also provided a copy of its Utilization Management/Care Management Work Plan for 2006.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
4. Clinical Expertise	The Contractor ensures that any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope, that is less than requested, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 303L, Peer Advisor Adverse Determinations, stated that decisions to deny service authorization must be made by BHO staff members who hold a license in the same licensure category as the ordering provider. The policy clarified that psychologists may render UR denials for psychological testing and other outpatient requests made by nonphysician practitioners, but that all UR denials for hospital care must be made by a physician. CHN Policy 404L, Credentialing Licensure and Certification of Clinical Review Staff, stated that the education, training, experience, and professional certification of all staff conducting UR was verified upon hire and at least yearly thereafter. Findings from the denial record review indicated that CHP's practice was consistent with policy and that 100 percent of the UR denials included in the sample had been reviewed by a qualified health care professional with appropriate clinical expertise in treating the member's mental health disorder.	
II.J.1.g	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
5. Co-occurring MI/DD II.E.1	The Contractor has written criteria for determining whether the need for mental health services for a member with co-occurring mental illness and developmental disabilities is a result of the individual's mental illness, or a result of the individual's developmental disability, or developmental delay (if the member is under age 5).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP provided a clinical practice guideline for the treatment of co-occurring disorders for individuals with severe and persistent mental iIllness (SPMI) and a developmental disability (DD). During the interview, CHP staff members stated that they continued to participate with the Department and other BHOs in the refinement of Practice Standards for the Evaluation and Treatment of Covered Mental Illness (MI) in Children, Youth, and Adults with Developmental Disability (DD).	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
6. Compensation for Conducting UM Activities II.F.1.g	The Contractor does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Quality Improvement Program Description/Plan stated that the BHO did not incentivize individuals engaged in utilization review for issuing denials of service or for rendering decisions that result in underutilization. VO Policy C422P, Conflict of Interest for Individuals Performing Clinical Reviews, required that staff making utilization review decisions disclose any potential conflicts of interest and avoid review at health care facilities where they have active privileges and treat patients. VO Policy 421P, Lack of Incentives for Clinical Decision-Making, stated that utilization reviewers were not incentivized in any way to inappropriately restrict care. The policy emphasized that service authorization decisions were to be made solely based on the clinical needs of consumers, benefit availablity, and appropriateness of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
7. Record Review—Denials	Presence and timeliness of required documentation and decisions by qualified clinician.	
	Findings A sample of 10 service denial records was reviewed to assess CHP's compliance with contract requirements related to the presence and content of required documentation and the timeliness of resolution. CHP was compliant with 29 of the 30 total applicable elements reviewed for an overall score of 97 percent. CHP was fully compliant in the following areas: 1) the notice included the reason for denial, and 2) the decision was made by a qualified clinician. A notice of action for one case reviewed was not sent in a timely manner to the consumer and provider following a UR denial as required in Exhibit G of the BHO's contract with the Department.	
	Required Actions CHP must ensure that a notice of action is sent in a timely manner to the consumer and provider following a UR denial decision.	

Results for Standard VI					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
7	1	0	0	8	88%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
1. Written Policies and Procedures II.F.1.h.1	The Contractor has written policies and procedures that ensure coordination of the provision of covered services to its members, and that address expectations for timely coordination of care.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP provided the following coordination-of-care policies for review: CHN Policy 262, Coordination of Care; CHN Policy 254L, Continuity of Care Among Providers and Levels of Care; and VO Policy C210P, Integration of Care with Primary Care Physicians (PCP) and Physical Health Providers (PHP). The policies described the BHO's expectations regarding communication and coordination activities and addressed requirements related to the timely coordination of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	The written policies and procedures address: A. Service accessibility	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 262, Coordination of Care, stated that the primary therapist was responsible for communicating with the consumer's PCP within 90 days of admission and as needed thereafter whenever the consumer had a known medical condition or a diagnosis of panic disorder, anxiety disorder, depression, bipolar disorder, or schizophrenia. The policy also described the role of the primary therapist in assisting the consumer in accessing needed services through other mental health providers and human service agencies.	
	Required Actions None	
	B. Attention to individual needs	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 262, Coordination of Care, stated that the primary therapist was responsible for assessing the individual needs of each consumer and for coordinating the consumer's mental health services, primary medical care, and services provided by other human service agencies as appropriate.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	C. Continuity of care	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 254L, Continuity of Care Among Providers and Levels of Care, described the BHO's requirements regarding the timely exchange of clinical information in cases where the consumer was receiving services from multiple mental health providers. The policy also addressed the importance of sharing pertinent clinical information, with consumer consent, in cases where the individual was transitioning between levels of care.	
	Required Actions None	
	D. Maintenance of health	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 262, Coordination of Care, required that the primary therapist share information regarding the consumer's mental health treatment, including medication information, if any, with the consumer's PCP. The policy also described the key role of the primary therapist in coordinating with other mental health providers, substance abuse providers, and other human service agencies in support of the consumer's mental health.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	E. Independent living	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 262, Coordination of Care, stated that coordination-of-care activities included identifying, providing, arranging for, and/or coordinating services with other agencies to ensure that the consumer received mental health care, primary medical care, and any other supportive services required to allow the consumer to remain in his or her community. CHN Policy 202L, Medical Necessity, included a definition of medically necessary services that addressed the importance of the service in supporting or maintaining the consumer's recovery and promoting independent living. During the interview, staff from the BHO reported that it used standardized level-of-care (LOC) criteria to help assess the most appropriate living situation for consumers and that member choice regarding placement settings was generally respected, unless clinically contraindicated.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	F. Coordination with other medical and behavioral health plans	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 262, Coordination of Care, and VO Policy C210P, Integration of Care with Primary Care Physicians (PCP) and Physical Health Providers (PHP), described the BHO's required process for communicating and coordinating with the consumer's primary medical provider. CHN Policy 254L, Continuity of Care Among Providers and Levels of Care, emphasized the importance of working collaboratively with mental health providers in cases where the consumer was receiving care and treatment from multiple behavioral health practitioners and/or was transitioning between levels of care.	
	Required Actions None	
	G. Confidentiality and privacy consistent with 45 CFR parts 160 and 164 (HIPAA)	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings VO Policy C401P, Confidentiality of Protected Health Information (PHI), addressed the BHO's requirements regarding the safeguarding of protected health information. CHN Policy 304, Member's Rights and Responsibilities, identified that consumers have the right to have information about their diagnosis and treatment kept confidential. CHN Policy 262, Coordination of Care, and CHN Policy 254L, Continuity of Care Among Providers and Levels of Care, included procedures for obtaining a release of information from the consumer or their legal guardian as required by law.	
II.F.1.h.1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination	A. The Contractor provides for care coordination, which addresses the member's need for integration of mental health and other services. This includes identifying, providing, arranging for and/or coordinating with other agencies to ensure that the member receives the health care and supportive services that allow the member to remain in her/his community.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 262, Coordination of Care, described the role of the primary therapist in assessing each consumer's need for services and coordinating with other mental health providers, medical health care providers, and social service agencies in support of the consumer's mental health. CHN Policy 254L, Continuity of Care Among Providers and Levels of Care, stated that after securing consumer or parent/guardian consent, the care manager or primary therapist was responsible for coordinating with other mental health providers serving the consumer to help ensure continuity of care. During the interview, BHO staff stated that it had recently implemented a performance improvement project (PIP) to help ensure that appropriate community-based interventions were in place and that youth were not being unnecessarily readmitted to psychiatric hospitals. Staff also described various collaborative projects that had been implemented by the BHO and its contracted CMHCs, including the colocation of mental health staff in juvenile detention facilities and the provision of crisis intervention training for local police officers and sheriffs.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination II.F.1.h Exhibit C.III.B	B. The BHO, in consultation with the service provider, Member, family, and/or person with legal custody, shall determine the medical and/or clinical necessity of the covered service.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 223L, Treatment Planning, required that consumers and other significant parties involved in their care play an active role in the treatment planning process. CHN Policy 303L, Peer Advisor Adverse Determinations, stated that CHP offered the opportunity for providers to consult telephonically regarding any utilization review request that did not appear to meet medical necessity criteria prior to a utilization management (UM) determination being made. During the interview, BHO staff provided a copy of a clinical chart audit tool used for both CMHC and non-CMHC providers to evaluate consumer and family involvement in the treatment planning process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services	A. The Contractor assists members in obtaining necessary medical treatment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 262, Coordination of Care, described the role of the primary therapist in assisting consumers in securing needed medical care. VO Policy C210P, Integration of Care with Primary Care Physicians (PCP) and Physical Health Providers (PHP), included a list of medical events that may trigger the need to notify the PCP/PHP. The policy identified changes in psychotropic medications, admission to or discharge from an inpatient level of care, and significant lab values or tests as aspects of care that may be reported to the consumer's PCP/PHP with consumer consent.	
	Required Actions None	
	B. If a member is unable to arrange for supportive services to obtain medical care due to his/her mental illness, these supportive services will be arranged for by the Contractor or another person who has an existing relationship with the member whenever possible.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 254L, Continuity of Care Among Providers and Levels of Care, and VO Policy C210P, Integration of Care with Primary Care Physicians (PCP) and Physical Health Providers (PHP), addressed the requirement that supportive services be provided to the consumer on an as-needed basis to assist the member in obtaining medical care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services II.F.1.h	C. The Contractor coordinates with the member's medical health providers to facilitate the delivery of health care services. **Findings** CHP provided a copy of a provider newsletter published in spring 2006 that included information regarding the expectation that providers coordinate with PCPs and that all contacts with medical providers be documented in the clinical record. During the interview, the BHO provided several examples of integration projects that colocated mental health services at primary medical and dental clinics and federally qualified health centers. BHO staff also provided a copy of a clinical chart audit tool used to monitor coordination efforts with primary medical providers by both CMHC and non-CMHC providers. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
5. School-Based Services Exhibit C.IV.I	Mental health services are provided to school-aged children and adolescents on site in their schools, with the cooperation of the schools. **Findings** School-based services were listed as a covered benefit in the CHN Member Handbook. The BHO also provided a copy of an alternative services report that documented the number of school-based encounters for FY 05-06. During the interview, BHO staff reported that services provided in the schools included individual, group, and family counseling, as well as consultation services to teachers and other school personnel. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
6. EPSDT II.E.1	The Contractor provides services identified under the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 248L, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), described the role of the mental health practitioner in the EPSDT process. The policy required that the mental health practitioner: 1) refer consumers younger than 21 years of age to their PCP for periodic screens, as necessary; 2) obtain the results of EPSDT screens that indicate a need for mental health services from the PCP; and 3) consider the results of EPSDT screens in the service planning process. The BHO's provider manual also contained information regarding the EPSDT program, including the expectation that CHP providers communicate and coordinate closely with the PCP for any Medicaid member younger than 21 years of age. During the interview, BHO staff stated that inpatient and outpatient benefit limitations did not apply to Medicaid-eligible consumers younger than 21 years of age. The BHO also provided an example of an Outpatient Benefit Limitation Monitoring Report and Inpatient Benefit Limitation Monitoring Report. These reports were used by the Department and the BHO to track utilization for consumers approaching inpatient and outpatient benefit limitations and to help ensure that covered services continued to be provided, as medically necessary, to youth and young adults under the EPSDT program.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
7. Record Review—Coordination of Care: Inpatient to Outpatient Transition (children). Exhibit C.I	There is evidence of coordination of care provided for children transitioning from an inpatient facility to outpatient services. **Findings** Ten records were reviewed for evidence of care coordination and outpatient follow-up for children following discharge from an inpatient facility. All 10 records contained evidence of coordination between the hospital and either VO or partner CMHC personnel prior to discharge. One consumer was transferred to a State hospital facility on the day of discharge from the hospitalization reviewed. One consumer was discharged directly to a corrections facility. Three consumers were discharged to DHS custody with no services provided by CHP. Five consumers were given an appointment with a provider subcontracted with either CHP CMHC or CHP. The BHO records indicated that three consumers were a "no show" for the appointments. One of these appointments was for the day following discharge and one was within a week of discharge. **Required Actions** None	

Results for Standard VII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
15	0	0	0	15	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
1. Internal Quality Assessment and Performance Improvement Program II.I.1	The Contractor has an internal Quality Assessment and Performance Improvement (QAPI) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP, through its Management Services Agreement with ValueOptions, had several quality management policies and procedures and other documents to demonstrate that the BHO had an active quality assessment and performance improvement (QAPI) program in place. The FY 06-07 Quality Improvement Program Description/Plan described the purpose and scope of the program, provided information regarding the BHO's Quality Improvement Committee structure, and described various quality indicators, studies, and other activities used by CHP to assess the timeliness, appropriateness, and effectiveness of clinical and administrative services. The BHO also conducted an annual evaluation of its QAPI program.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program	The scope of the QAPI program includes, but is not limited to: A. A quality assessment and performance improvement plan that: 1. Delineates current and future quality assessment and performance improvement activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP's FY 06-07 Combined Quality Management and Care Management Work Plan delineated the BHO's current and future quality assessment and performance improvement activities. The work plan addressed conducting activities, including performance improvement projects (PIPs), clinical chart audits, consumer satisfaction surveys, and the collection and analysis of utilization and clinical outcome data. The work plan included a description of each targeted activity, key measures used to assess quality, the name of the staff person or committee responsible for implementation and monitoring, and the due date for completion of each activity.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program	2. Integrates findings and opportunities for improvement identified in studies, performance outcome measurements, member satisfaction surveys, and other monitoring and quality activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Information included in the FY 06-07 Quality Improvement Program Description/Plan and in the Quality Improvement Program Annual Evaluation Fiscal Year 2005-2006 demonstrated that the BHO used data from multiple sources to evaluate the quality of services provided to consumers and families. The reports demonstrated that CHP actively collected, analyzed, trended, and reported quality data from consumer satisfaction surveys, appointment standard indicators, grievance and appeal data, clinical outcome measures, utilization management monitors, and various other quality studies. During the interview, BHO staff reported having two PIPs in place. The first study evaluated ambulatory follow-up after hospital discharge. The second PIP assessed the impact of the availability of community-based services as an alternative to hospitalization for enrolled youth. BHO staff also reported used periodic clinical chart audits to help evaluate the appropriateness of clinical care provided by CMHC and non-CMHC providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program II.I.2	B. Processes for addressing quality of care concerns. **Findings** CHN Policy 3.09, Quality of Care Issues and Outlier Practice Patterns, stated that all quality-of-care issues and trends were investigated and monitored to resolution and that the BHO aggregated quality-of-care (QOC) data each quarter to identify possible service center and/or regional trends. CHN Policy 2.10, Roles and Responsibility of the Quality of Care Committee, indicated that the CHP Quality of Care Committee (QOCC) was responsible for the review and investigation of quality-of-care issues and outlier practice patterns. During the interview, BHO staff confirmed that QOC data were routinely analyzed and trended as part of the quality improvement process. Staff also indicated that information collected through QOC data was considered in the practitioner recredentialing process as appropriate. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	A. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Site Review Document Request Form stated that CHP used grievance and appeal data, anecdotal information, and data from consumer surveys to monitor member perceptions of the accessibility and adequacy of services. CHN Policy 3.06, Measurement of Access and Availability, noted that the BHO used measures of telephonic access to services, including the average speed of answer and abandonment rates, to monitor service accessibility. The policy also indicated that the BHO monitored the timely access to routine, emergent, and urgent appointments with providers each quarter.	
	Required Actions None	
	B. The Contractor's tools to monitor member satisfaction include: 1. Member Surveys	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Quality Improvement Program Description/Plan indicated that CHP used information from both the Mental Health Statistics Improvement Program (MHSIP) survey as well as a telephonic survey conducted by FactFinders, a research firm in Albany, New York. A copy of the FactFinder survey and summary findings for the MHSIP survey were provided for review. During the interview, BHO staff reported having participated in the Youth Services Survey for Families (YSS-F) this review period.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	2. Anecdotal Information	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Site Review Document Request Form stated that CHP received anecdotal information from consumers and family members through various venues. The BHO provided several examples of anecdotal information, including feedback regarding a planned recovery study from a CHP advocacy meeting and meeting minutes from a SyCare recovery forum that documented a discussion regarding the future development of a family-to-family program.	
	Required Actions None	
	3. Grievance and Appeal data	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP demonstrated that it actively used grievance and appeal data to monitor consumer satisfaction. A summary of grievance and appeal data, including the number of grievances and appeals received by the BHO and the average time to resolution, was included in the Quality Improvement Program Annual Evaluation Fiscal Year 2005-2006. CHP also provided a quarterly report of grievance and appeal activity used by the BHO to share information with the Quality Improvement Steering Committee (QISC). The report trended complaints and grievances by type based on state-approved categories and provided comparison data across fiscal years.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	C. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaints is detected, or when a serious complaint is reported.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHN Policy 4.02, Performance Improvement Plans, stated that performance improvement plans are developed when provider performance falls below established performance standards for two consecutive reporting periods. CHN Policy 3.04, Grievance Process, described the BHO's use of corrective action plans in cases where a pattern of grievances is detected or when a serious grievance is reported and substantiated. The policy stated that either the QISC or QOCC monitored corrective action plans. The BHO provided several examples of letters to providers requesting corrective action plans related to performance problems in meeting access-to-care standards.	
II.I.2.d	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
4. Health Information System II.I.h.2	The Contractor has a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to: A. Utilization	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP provided examples of utilization reports produced by the BHO, including admissions/1,000, census data, authorized versus budgeted residential treatment and inpatient days, ambulatory follow-up within seven days of discharge, and ambulatory follow-up after an emergency room visit. The FY 06-07 Site Review Document Request Form indicated that the majority of utilization reports produced by the BHO were queried from CHP's health information system and that utilization data were reported to the Class B Board, the CHP Finance and Audit Committee, and the CAUMC.	
	Required Actions None	
	B. Grievances and Appeals	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Information in the FY 06-07 Site Review Document Request Form stated that CHP maintained an electronic grievance and appeal database to collect and report grievance and appeal information. The database captured information regarding the type of grievance or appeal, documented the outcome following investigation, and allowed the BHO to track the timely resolution of grievances and appeals.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
5. Program Impact Analysis II.I.2.j.1	The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program. **Findings** CHN Policy 2.19, Quality Management Program Evaluations, required that the BHO conduct an annual evaluation of its quality management program to include: 1) an assessment of the overall effectiveness of the program; 2) an assessment of program strengths; 3) any identified barriers to achieving the prior year's program goals and objectives; 4) an analysis of data for quality measures and quality studies conducted by the BHO; 5) actions taken to improve performance, if any; and 6) recommendations for future planning. A review of CHP's Quality Improvement Program Annual Evaluation Fiscal Year 2005-2006 demonstrated that the evaluation was comprehensive and addressed all the elements required in policy. Minutes from a QISC meeting on September 8, 2006, documented that the annual program evaluation was reviewed and approved by the committee. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard VIII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
12	0	0	0	12	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
1. Grievance and Appeal Records Exhibit G: 8.209.3.C	The Contractor maintains a record of grievances and appeals.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP had delegated the processing of grievances to the CMHCs, and VO also processed grievances and appeals for the BHO, although this was not specified in the delegation agreement. Record-keeping, as demonstrated in the review of a sample of grievance correspondence files, was orderly, clear, and complete, with standardized forms in use by all the CMHCs and VO. Appeals were also processed using standardized forms and response letters. Grievances and appeals were entered into an electronic database for tracking, trending, and reporting purposes. The appeals policy explicitly stated the record-keeping requirements of the BHO. During the interview, BHO staff described that all complaints were documented, treated as grievances, and included in the tracking and reporting of data for quality improvement purposes.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
2. Provider Information Exhibit G: 8.209.3.B	The Contractor provides a Department approved description of the grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the Contractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP had provided its description of the grievance, appeal, and fair hearing processes, as contained in the provider manual, to the Department and was awaiting approval. The BHO staff described the process it used for dissemination of new or revised information to providers, including a Web-site posting, individual mailings, and distribution of information on CDs as applicable. In follow-up to a required action from the previous site review, the CHN policy on appeals and the provider manual information had been revised to include the correct time frames for processing of appeals.	
	Required Actions None	
3. Reasonable Assistance Exhibit G: 8.209.4.C	The Contractor provides members with assistance in completing any forms required by the Contractor, putting oral requests for a state fair hearing into writing, and taking other procedural steps including providing interpretive services and toll-free numbers that have adequate TTY/TTD interpreter capability.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHN policies for the processing of grievances and appeals, and the consumer handbook, communicated the requirements for the BHO to provide reasonable assistance to consumers, including assistance with forms and writing oral requests. The requirements also included the availability of interpreter services, including TTY/TTD.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
4. Individuals Who Make Decisions Exhibit G: 8.209.4	The Contractor ensures that the individuals who make decisions on grievances and appeals are: A. Individuals who were not involved with any previous level of review or decision-making.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP's grievances and appeals policies and procedures contained the requirement that individuals making decisions were not involved in a previous level of review or decision-making. The appeals policy defined and described a clinical peer position that was used in the appeals process.	
	Required Actions None	
	B. Individuals who have the appropriate clinical expertise in treating the member's condition or disease if deciding an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance that involves clinical issues, or an appeal that involves clinical issues.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings CHP's grievances and appeals policies and procedures contained the requirement that individuals making decisions on appeals and on clinical grievances must have the qualifications to do so. In the grievance record review, this practice was evident and documented in all records but one.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
5. Accepts Grievances and Appeals Exhibit G: 8.209.4	The Contractor accepts grievances and appeals orally or in writing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHN policies on the processing of grievances and appeals required that grievances and appeals be accepted both orally and in writing. There was evidence of this practice in the review of grievance records.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	A. The Contractor provides the member an opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and informs the member of the limited time available in the case of expedited resolution.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHN Clinical Appeals Process policy and communications to consumers about the appeals process contained the requirement to provide the consumer an opportunity to present evidence for the appeal. In the interview, staff described receiving a very low number of appeals, with very rare requests for expedited appeals, and staff were able to articulate the process for providing the consumer with this assistance during the appeal process.	
	Required Actions None	
	B. The Contractor provides the member and the designated client representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHN Clinical Appeals Process policy and written communications to consumers about the appeals process contained the requirement to provide the consumer and the consumer's representative, if applicable, an opportunity to review the records being considered during the appeal process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	C. The Contractor includes as parties to the appeal, the member and, as applicable, the designated client representative or legal representative.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHN Clinical Appeals Process policy and written communications to consumers about the appeals process contained the requirement to include the consumer and the consumer's representative, as applicable, as parties to the appeal process.	
	Required Actions None	
	D. The Contractor has an expedited review process for appeals when the contractor determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHN Clinical Appeals Process policy and written communications to consumers about the appeals process contained the requirement to provide for an expedited appeals process in situations where taking the time for a standard resolution could jeopardize the health of the consumer.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process Exhibit G: 8.209.4	E. The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The CHN Clinical Appeals Process policy and written communications to consumers about the appeals process contained the statement that no punitive action would be taken against a provider for supporting a consumer's appeal or for requesting that the appeal be expedited.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
7. Record Review—Grievance	Presence and timeliness of required documentation, decisions by qualified clinician, and responsiveness of resolution.	
	Findings CHP provided 10 grievances (clinical care and access complaints) for review of the timeliness of acknowledgment and resolution letters, whether qualified decision-makers were used, and whether the decision/resolution was responsive to the original grievance issue. Four of the 10 records were grievances processed by CHP as delegated to VO, two were processed by Pikes Peak Mental Health Center (MHC), three were processed by Colorado West Regional MHC, and one was processed by West Central MHC. All letters of acknowledgment and resolution were sent in a timely manner, contained standardized language, and were written on the letterhead of the entity responsible for processing the grievance. None of the grievances required an extension of the time frame. One grievance decision written by one of the CMHCs did not contain evidence that a qualified clinician had been involved in the review and decision of the grievance. All records had documentation of a decision or resolution that was responsive to the complaint issue.	
	Required Actions CHP must ensure that persons making decisions on clinical grievances have the qualifications to do so and that the credentials of those individuals are included in the documentation of the grievance decision.	

Results for Standard IX					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
11	0	0	0	11	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
1. Excluded Providers II.H.3.e	The Contractor does not employ or contract with providers excluded from participation in federal health care programs under Title XI of the Social Security Act, Sections 1128 and 1128A. **Findings** VO Policy HR116 stated that the OIG database was used to ensure that employees and contractors were not ineligible to participate in any federal reimbursement program. During the interview, ValueOptions and CHP staff confirmed the use of the OIG database. A sample of credentialing files contained the OIG database printout. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
2. Written Policies and Procedures NCQA CR1	The Contractor documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs, and who render services or authorize services to members, and who fall within the Contractor's scope of authority and action. **Findings** CHP did not have policies that addressed the mechanism for credentialing and recredentialing of licensed independent practitioners. CHP delegated all tasks related to credentialing and recredentialing to ValueOptions. **Required Actions** Because NCQA requirements do not allow the BHO to rely on the delegate's policies and procedures, CHP must develop policies and procedures that document the mechanism for credentialing and recredentialing licensed independent practitioners and that describe CHP's processes rather than the delegate's processes.	☐ **Met** ☐ **Partially Met** ☑ **Not Met** ☐ **N/A**

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	The written policies and procedures specify: A. The types of practitioners to credential and recredential. At a minimum, this includes all physicians and other licensed and/or certified practitioners who have an independent relationship with the BHO and who see enrollees outside the inpatient hospital setting or outside the facility-based settings.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	B. The verification sources used.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	C. The criteria for credentialing and recredentialing.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	D. The process for making credentialing and recredentialing decisions.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	E. The process for managing credentialing files that meet the organization's established criteria.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	F. The process to delegate credentialing or recredentialing.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	G. The process to ensure that credentialing and recredentialing are conducted in a non-discriminatory manner, i.e., the Contractor 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.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	H. The process for notifying a practitioner about any information obtained during the Contractor's credentialing process that varies substantially from the information provided to the organization by the practitioner.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	I. The process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision. Note: The organization (BHO) is not required to notify providers of recredentialing approvals.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	J. The Medical Director or other designated physician's direct responsibility and participation in the credentialing program.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	K. The process to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	L. The process for ensuring that listings in provider directories and other materials for enrollees are consistent with credentialing data, including education, training, certification, and specialty.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	M. The right of practitioners to review information submitted to support their credentialing application.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	N. The right of practitioners to correct erroneous information.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	O. The right of practitioners, upon request, to be informed of the status of their credentialing or recredentialing application.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	P. How the applicant is notified of these rights and of the appeal process.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	Q. The procedure for ongoing monitoring of sanctions, complaints and adverse events (for high-volume providers).	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	S. Procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
	T. An appeal process for instances in which the BHO chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 2.	
CR1-Element A and B NCQA CR9 CR10-Element A and C II.H.3.g		

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
4. Credentialing Committee NCQA CR2	The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing decisions.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Local Credentialing Committee, while described in a ValueOptions policy, was a CHP committee and included CHP and VO personnel. Local Credentialing Committee meeting minutes confirmed the use of the peer-review process.	
	Required Actions None	
5. Provider Application NCQA CR4-Element A	Providers are required to complete an application for inclusion in the Contractor's provider network that addresses: - The provider's health status, and reasons for any inability to perform the essential functions of the position, with or without accommodation - Lack of present illegal drug use - History of loss of license and felony convictions - History of loss or limitation of privileges or disciplinary activity - Current malpractice insurance coverage - The correctness and completeness of the application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each of the credentialing files reviewed contained a signed Colorado Health Care Professional Credentials Application, which included all of the required content.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
6. High Volume Practitioners NCQA CR6-Element B	The Contractor specifies the method to identify high-volume providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings ValueOptions staff, on behalf of CHP, described CHP's method of identifying high-volume providers. High-volume providers were defined as any provider who served 10 or more members in a given month. Staff reported that encounter data were used to identify the providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
7. Evaluation of High Volume Practitioners NCQA CR6-Element B	For high-volume providers, the Contractor conducts: A. An initial site visit	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A sample of credentialing files for high-volume providers contained completed site visits.	
	Required Actions None	
	B. An initial evaluation of treatment record-keeping practices at each site.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The site visit form used for high-volume providers included an evaluation of treatment record-keeping practices.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
8. Requirements for Credentialing Policies for Organizational Providers NCQA CR11	The Contractor has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.	☐ **Met** ☐ **Partially Met** ☑ **Not Met** ☐ **N/A**
	Findings CHP did not have written policies and procedures that addressed the initial and ongoing assessment of organizational providers. CHP delegated all tasks related to the assessment of organizational providers to ValueOptions. Although CHP did not have policies related to organizational providers, a review of organizational provider files demonstrated that VO, on behalf of CHP, completed all requirements related to the assessment of organizational providers, including on-site quality assessments.	
	Required Actions Because NCQA requirements do not allow the BHO to rely on the delegate's policies and procedures, CHP must develop written policies and procedures that address the initial and ongoing assessment of organizational providers and that describe CHP's processes rather than the delegate's processes.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	The Contractor's written policies and procedures include: A. The Contractor confirms that the organization is in good standing with state and federal regulatory bodies.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 8.	
	B. The Contractor determines whether the provider has been reviewed and approved by an accrediting body.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 8.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 8.	
	D. At least every three years, the Contractor confirms that the organizational provider remains in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The policies submitted were ValueOptions policies. There were no CHP policies for content consideration.	
	Required Actions The content of the BHO's policies and procedures will be evaluated with the corrective action for standard X, evaluation element 8.	
NCQA CR11-Element A		

Results for Standard X					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
6	0	2	24	8	75%

The review of the records follows this cover page.

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Colorado Health Partnerships, LLC

Type of Record Reviewed	**Documentation of Services**		
Review Period	**January 1, 2006 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date	**February 1, 2007**	**Participating BHO Staff Member**	**Erica Arnold-Miller and Barb Archuleta**

Table B-1—Documentation of Services

#	Member ID	Provider ID	Date of Encounter	Doc Date Matches Encounter Date	Service Documentation Within 7 Days of Encounter Date	Procedure Code Submitted	Description of Procedure Code	Documentation Describes Procedure Code Submitted
1	*******	232	1/24/2006	Y	NA	90804	PSYCHOTX OV/OP BEHV MOD 20-30 MN;	Y
2	*******	192	4/25/2006	Y	NA	90806	PSYCHOTX OV/OP BEHV MOD 45-50 MN;	Y
3	*******	729	3/29/2006	Y	NA	T1016	CASE MANAGEMENT EACH 15 MINS	Y
4	*******	208	1/31/2006	Y	NA	90801	PSYC DX INTERVIEW EXAMINATION	Y
5	*********	124975	2/2/2006	Y	NA	90847	FAMILY PSYCHOTHERAPY W/PT PRS	Y
6	*******	52	1/25/2006	Y	NA	T1017	TARGETED CASE MANAGEMENT EA 15 MINS	Y
7	*******	210	1/10/2006	Y	NA	90862	PHARM MGMT W/SCRIPT USE & REVIEW	Y
8	*******	171	5/17/2006	Y	NA	90847	FAMILY PSYCHOTHERAPY W/PT PRS	Y
9	*******	00002654	5/18/2006	Y	NA	90772	MEDICATION ADMINISTRATION INJECTION	Y
10	*******	00002690	6/20/2006	Y	NA	T1016	CASE MANAGEMENT EACH 15 MINS	Y
			# Applicable Elements	**10**				**10**
			# Compliant Elements	**10**				**10**
			% Compliant Elements	**100%**				**100%**

TOTALS	
Total # Applicable Elements	**20**
Total # Compliant Elements	**20**
Total % Compliant Elements	**100%**

Table Legend: DOS = Date of Service, Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Colorado Health Partnerships, LLC

Type of Record Reviewed	**Coordination of Care Inpatient to Outpatient Transition (Children)**		
Review Period	**October 1, 2005 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date	**February 1, 2007**	**Participating BHO Staff Member**	**Erica Arnold-Miller and Barb Archuleta**

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)

#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
1	*******	**********	RECUR DEPR PSYCH-SEVERE	6/2/2006	6/8/2006	Y	PARKVIEW MEDICAL CENTER	
The consumer record contained crisis team (CMHC) notes that described the events of the hospitalization. A 6/2/2006, hospital progress note stated that the plan was to discharge to home with follow-up by a mental health clinician at Pueblo Community Health Center on 6/8/2006. There was documentation of an intake assessment at Pueblo Community Health Center that occurred on 6/8/2006.								
2	*******	*********	BIPOLAR I DISORD MOST RECENT EP UNSPEC	3/2/2006		Y	CEDAR SPRINGS BEHAVIORAL HLTH SYSM	
The record contained a case management note from Pikes Peak Mental Health Center. The progress note described consultation with the discharge planner at the hospital. The progess note documented conversations between the hospital and the family therapist and indicated that the child would stay longer. A progress note from the hospital indicated that the child was transferred on 3/2/2006, to the State hospital at Pueblo.								
3	*******	*********	DEPRESSIVE DISORDER NEC	4/6/2006		Y	PARKVIEW MEDICAL CENTER	Spanish Peaks
Spanish Peaks Mental Health Center (SP) case management notes (the hospital liaison) indicated that the child was admitted on 4/2/2006, and that the discharge plan was for home and follow-up at Spanish Peaks with an appointment scheduled for therapy on 4/10/2006. SP case management notes indicated that the consumer was a "no show" for the 4/10/2006 appointment and a physician appointment on 4/19/2006.								
4	*******	*********	BIPOLAR I DISORD MOST RECENT EP UNSPEC	3/15/2006	3/16/2006	Y	CEDAR SPRINGS BEHAVIORAL HLTH SYSM	Independent pro
Spanish Peaks case management (CM) progress notes on 3/10/2006 indicated that the SP case manager was informed by another CMHC in the CHP network that the consumer was admitted to the hospital. CM notes on 3/16/2006 indicated that the case manager called the hospital to request the discharge summary. Notes in the hospital discharge summary stated that the plan was to return to outpatient services in the Colorado Springs area with an independent provider (for CHP). Case management notes (3/16/2006) indcated that follow-up appointments were scheduled with the provider. Outpatient provider progress notes dated 3/16/2006, described a therapy session.								
5	*******	*********	DEPRESS PSYCHOSIS-SEVERE	11/11/2005		Y	COLORADO MENTAL HEALTH INSTITUTE	
The CHP UM care coordinator notes indicated that the consumer was admitted 11/6/2005. Care coordinator notes for 11/9/2005 described communication with the hospital. CHP notes indicated that the child was discharged to DHS custody with no services provided by CHP.								
6	*******	*********	UNSPECIFIED EPISODIC MOOD DISORDER	4/25/2006		Y	COLORADO MENTAL HEALTH INSTITUTE	
The CMHC case management note on 4/25/2006, indicated that the CMHC was aware of the hospitalization and the child's discharge to a corrections facility.								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Colorado Health Partnerships, LLC

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)

#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
7	*******	*********	DEPRESS PSYCHOSIS-UNSPEC	5/31/2006		Y	COLORADO MENTAL HEALTH INSTITUTE	
CMHC case manager notes indicated that the admit date was 5/17/2006. On 5/23/2006, the case management notes indicated that the case manager spoke with the hospital regarding discharge plans. Case management notes indicated that the discharge date was 5/31/2006. CM notes on 7/17/2006, indicated that the consumer was out of the area for the summer and was a "no show" for appointments that had been scheduled.								
8	*******	*********	DEPRESS PSYCHOSIS-UNSPEC	12/12/2005		Y	CEDAR SPRINGS BEHAVIORAL HLTH SYSM	Pikes Peak Ment
On 12/8/2005, a Pikes Peak CMHC crisis team note indicated that the consumer was to be hospitalized with a plan to discharge back to outpatient services provided by Pikes Peak CMHC. A Pikes Peak CMHC note on 12/12/2005, was an intake note that occurred at the hospital prior to discharge. Pikes Peak progress notes indicated that a follow-up was scheduled for 12/14/05, at Pikes Peak. A progress note (Pikes Peak) indicated that the consumer was a "no show" for the 12/14/2005, appointment.								
9	*******	********	POSTTRAUMATIC STRESS DISORDER	1/28/2006		Y	COLORADO MENTAL HEALTH INSTITUTE-	
Spanish Peaks hospital liasion notes on 1/20/2006, indicated that the consumer was admitted to an residential treatment center (RTC) on 1/20/2006, then admitted on 1/23/2006, to Ft. Logan. Liaison notes described discussion between the liaison and both facilities and indicated that the consumer was discharged back to the RTC on 1/28/2006.								
10	*******	********	BIPOLAR AFF, DEPR-UNSPEC	3/1/2006		Y	COLORADO MENTAL HEALTH INSTITUTE	
CMHC progress notes on 2/16/2006 indicated that the consumer was evaluated at the CMHC and admitted on 2/16/2006. A 2/22/2006, case management note from West Central CMHC described discharge planning discussions with the hospital. Case management notes indicated that the consumer was discharged to an RTC in Canon City under DHS custody.								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Colorado Health Partnerships, LLC

Type of Record Reviewed	**Grievances**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Bonnie Marsh**
Review Date	**February 1, 2007**	**Participating BHO Staff Member**	**Chelle Denman**

Table B-3—Grievances Record Review

#	Case ID #	Date Grievance Received	Date of Acknowledgement Letter	Acknowledgement Sent Within 2 Working Days	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved and Notice Sent per Requirement	Appropriate Level of Expertise	Resolution Responsive to Member Grievance?
1	*******	7/30/2006	7/31/2006	Y	8/2/2006	3	NA	Y	Y	Y
Pikes Peak MHC processed this grievance. Consumer complained of pain from injection given by nurse. Issue was referred to the nurse's supervisor to conduct clinical supervision and review of injection technique.										
2	*******	3/17/2006	3/20/2006	Y	3/21/2006	2	NA	Y	Y	Y
Colorado West Regional MHC (CWRMHC) processed this grievance. Consumer complained of not having medication (Coumadin) and oxygen provided while in the crisis stabilization unit. Nursing supervisor was involved in review/decision.										
3	*******	5/17/2006	5/17/2006	Y	5/19/2006	2	NA	Y	N	Y
CWRMHC processed this grievance. Consumer complained that medications and oxygen were not provided and that staff were rude when consumer was admitted to the triage unit. Person consulted for grievance decision/resolution was not identified, so unable to determine whether appropriate level of expertise was used.										
4	*******	9/15/2006	9/18/2006	Y	9/27/2006	8	NA	Y	Y	Y
Pikes Peak MHC processed this grievance. Consumer complained about change of medications. Nurse and medical program manager were consulted.										
5	*******	3/31/2006	3/31/2006	Y	4/21/2006	15	NA	Y	Y	Y
ValueOptions (VO)/CHN processed this grievance. Consumer complained about several issues concerning confidentiality, retaliation, and wanting to change therapist. All issues were addressed in the decision letter, and the letter included the names and credentials of the persons involved in each of the decisions.										
6	*******	4/12/2006	4/12/2006	Y	4/17/2006	3	NA	Y	Y	Y
VO/CHN processed this grievance. Consumer complained about the physician's prescribing practices. Letter documented credentials of reviewer/decision-maker.										
7	*******	1/2/2006	1/3/2006	Y	1/3/2006	1	NA	Y	Y	Y
CWRMHC processed this grievance. Consumer complained about phone use restrictions in the facility and about the psychiatric care received. The decision-maker had a master's degree in social work.										
8	*******	3/15/2006	3/17/2006	Y	4/5/2006	15	NA	Y	Y	Y
VO/CHN processed grievance. Consumer requested a different therapist. The clinical director was consulted, and the consumer was transferred to a new therapist.										
9	*******	4/28/2006	4/21/2006	Y	5/2/2006	7	NA	Y	Y	Y
VO/CHN processed this grievance. Initial phone complaint was on 4/21/2006; however, staff could not understand consumer on the phone. Grievance paperwork and stamped envelope were sent to consumer, and a written complaint was received on 4/28/2006, thus the discrepancy between dates. Appropriate credentials were documented in the letter.										
10	*******	1/25/2006	1/25/2006	Y	1/25/2006	1	NA	Y	Y	Y
West Central MHC processed this grievance. Consumer complained that coordination of appointments with the family did not occur. Clinical staff (licensed clinical social worker) decided the grievance.										

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Colorado Health Partnerships, LLC

Table B-3—Grievances Record Review										
#	Case ID #	Date Grievance Received	Date of Acknowledgement Letter	Acknowledgement Sent Within 2 Working Days	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved and Notice Sent per Requirement	Appropriate Level of Expertise	Resolution Responsive to Member Grievance?
			# Applicable Elements	10				10	10	10
			# Compliant Elements	10				10	9	10
			% Compliant Elements	100%				100%	90%	100%
TOTALS										
			Total # Applicable Elements	40						
			Total # Compliant Elements	39						
			Total % Compliant Elements	98%						

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Colorado Health Partnerships, LLC

Type of Record Reviewed	**Denials**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Tom Cummins**
Review Date	**February 1, 2007**	**Participating BHO Staff Member**	**Alex Hale**

Table B-4—Denials Record Review

#	Member ID	Date of Initial Request	Standard/Expedited Authorization Decision			Termination, Suspension, or Reduction of Previously Authorized Services		Notice Includes Reasons	Decision Made by Qualified Clinician
			Date Notice Sent	# of Days For Decision	Notice Sent per Requirement	Date Notice Sent	Notice Sent per Requirement		
1	*********	3/9/2006	3/9/2006	1	Y			Y	Y
Request was for day treatment services. Request was denied since it was determined that the consumer's needs could be met at a lower level of care. Request denied by a Ph.D. level staff person.									
2	*********	7/12/2006	7/13/2006	1	Y			Y	Y
Request was for continuing authorization for residential treatment for a consumer initially admitted to the residential treatment facility on March 18, 2006. Request was denied since it was determined that the consumer no longer met medical necessity criteria for this level of care. Request was denied by the ValueOptions' Medical Director.									
3	*********	7/17/2006	7/20/2006	3	Y			Y	Y
Request was for retroauthorization for hospital care provided between October 19, 2005, and October 27, 2005. Request was denied for dates of service October 22, 2005, through October 27, 2005. Request was denied since it was determined that the consumer no longer met medical necessity for this level of care. Denial decision was made by the ValueOptions' Medical Director.									
4	*********	4/28/2006	5/3/2006	5	Y			Y	Y
Request was for psychological testing services. Request was denied because the purpose of the testing was educational in nature as opposed to psychiatric. Request was denied by ValueOptions' Ph.D. staff.									
5	*********	1/6/2006	2/1/2006	27	N			Y	Y
Request was for retroauthorization of hospital care. Request was denied since it was determined that requested care was for treatment of a substance abuse disorder. Request was denied by the ValueOptions' Medical Director.									
6	*********	2/24/2006	2/24/2006	1	Y			Y	Y
Request was for continuing authorization for hospital care. Request for service authorization was denied since the consumer did not meet medical necessity criteria. Denial decision was made by the ValueOptions' Medical Director.									
7	*********	7/13/2006	7/14/2006	1	Y			Y	Y
Request was for retroauthorization of inpatient care. Request was denied because the consumer did not have a covered diagnosis. The consumer was reportedly experiencing a reaction to medication and suffered from delerium. The denial was made by the ValueOptions' Medical Director.									
11	*********	2/16/2006	2/17/2006	1	Y			Y	Y
Request was for continuing authorization for hospital care. Utilization review was completed on February 16, 2006, with authorization provided through February 16, 2006. Request for authorization beyond February 16, 2006, was denied since the consumer no longer met medical necessity criteria. The denial was made by the ValueOptions' Medical Director.									
12	*********	1/3/2006	1/6/2006	3	Y			Y	Y
Request was for psychological testing for a young adult with a diagnosis of autism. Request was denied due to a non-covered diagnosis. Request was also for a neuropsychological test which was a non-covered service. Request was denied by a Ph.D. level staff person.									
13	*********	2/1/2006	2/2/2006	1	Y			Y	Y
Request was for continued authorization of inpatient care. Request was denied since consumer did not meet medical necessity criteria for this level of care. Request was denied by the ValueOptions' Medical Director.									

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Colorado Health Partnerships, LLC

Table B-4—Denials Record Review

#	Member ID	Date of Initial Request	Standard/Expedited Authorization Decision			Termination, Suspension, or Reduction of Previously Authorized Services		Notice Includes Reasons	Decision Made by Qualified Clinician
			Date Notice Sent	# of Days For Decision	Notice Sent per Requirement	Date Notice Sent	Notice Sent per Requirement		
				# Applicable Elements	10			10	10
				# Compliant Elements	9			10	10
				% Compliant Elements	90%			100%	100%
TOTALS									
				Total # Applicable Elements	30				
				Total # Compliant Elements	29				
				Total % Compliant Elements	97%				

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix C. Site Review Participants
for Colorado Health Partnerships, LLC

Review Dates

Dates for HSAG's site review for **CHP**, the period under review, and the contract term are shown in Table C–1 below.

Table C–1—Review Dates	
Dates of On-Site Review	February 1–2, 2007
Period Under Review	January 1, 2006–December 31, 2006
Contract Term	FY 06–07

Participants

Participants in the FY 06–07 site review of **CHP** are listed in Table C–2 below.

Table C–2—HSAG Reviewers and BHO Participants		
HSAG Review Team		**Title**
Team Leader	Barbara McConnell, MBA, OTR	Colorado Project Director
Reviewer	Bonnie Marsh, BSN, MA	Executive Director, EQR Services
Reviewer	Tom Cummins, LCSW	Consultant
CHP Participants		**Title**
Gerald Albrent		Director of Quality, Pikes Peak Mental Health Center
Barb Archuleta, MEd LPC		Chief Compliance Officer, Spanish Peaks Mental Health Center
Erica Arnold-Miller, MBA		Director of Quality Management, Colorado Health Partnerships
Kelly Bowen, LCSW		Quality Improvement Manager, Colorado West Regional Mental Health
Michelle Denman		Quality Coordinator, Colorado Health Partnerships
Stephen Dixon, PhD		Director of Clinical Management, Colorado Health Partnerships
Haline Grublak		Director of the Office of Consumer and Family Affairs, Colorado Health Partnerships
Alex Hale, MA, LMFT		Call Center Manager, Colorado Health Partnerships
Steve Holsenbeck, MD		Medical Director, Colorado Health Partnerships
Ruth Icenogle, CPCS		Credentialing Specialist, Colorado Health Partnerships
David Lockert		Consumer/Family Advocate, West Central Mental Health Center
Tina McCrory		Chief Financial Officer, Colorado Health Partnerships
Arnold Salazar		Executive Director, Colorado Health Partnerships
Maggie Tilley, MBA		Human Resources/Compliance, Colorado Health Partnerships

Table C–2—HSAG Reviewers and BHO Participants	
Department Observers	**Title**
Nancy Jacobs	Behavioral Health Benefits Supervisor
Connie Young	Quality Improvement/Behavioral Health Specialist

Overview

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine the MCOs' and PIHPs' compliance with contract requirements and federal regulations. The Department has elected to complete this requirement by contracting with an external quality review organization (EQRO). HSAG is the EQRO for the Department. The U.S. Department of Health and Human Services' (DHHS') Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR.

The site review addressed the BHO's compliance with federal regulations and contract requirements in 10 areas: delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing.

Individual records were reviewed to evaluate implementation of contract requirements for grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services provided.

In developing the monitoring tool, HSAG used the BHO's contract requirements and the regulations specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. The site review adhered to the February 11, 2003, CMS final protocol: *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Regulations.*

Methodology and Process

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements.
- The quality and timeliness of, and access to, mental health care furnished by the BHO.
- Interventions to improve quality.
- Activities to sustain and enhance performance processes.

To accomplish these tasks, HSAG assembled a team to:

- Collaborate with the Department to determine the review and scoring methodology, data collection methods, schedule and agenda, and other issues as requested.
- Collect and review data and documents before and during the on-site portion of the review.
- Analyze the data and information collected.
- Prepare a report of findings and required actions for each BHO.

Site Review Activities

Throughout this process, HSAG worked closely with the Department and the BHO to ensure a coordinated and supportive approach to completing the site review activities.

The following table describes the activities that were performed throughout the site review process.

Table D–1—Site Review Activities Performed

For this step,	HSAG…
Step 1:	**Established the review schedule.**
	Before the site review, HSAG coordinated with the Department and the BHO to set the site review schedule and assign staff to the site review teams.
Step 2:	**Prepared the data collection tools and submitted them to the Department for approval.**
	To ensure that all information was collected, HSAG developed monitoring tools consistent with BBA protocols. To create the monitoring tool standards, HSAG used the requirements as set forth in the contract between the Department and the BHO. HSAG also followed the guidelines specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tools included the NCQA 2006 Standards for the Accreditation of Behavioral Health Organizations and applicable Colorado and federal requirements.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 3:	**Prepared and submitted the Desk Review Form to the Department and the BHO.**
	After review and approval of the monitoring tools by the Department, HSAG forwarded a Desk Review Form to the BHO and requested that the BHO submit specific information and documents to HSAG within 30 days of the request. The Desk Review Form included instructions on how to organize and prepare the documents related to the review of the standards and records.
Step 4:	**Forwarded a BHO Document Request Form to the BHO.**
	HSAG forwarded a BHO Document Request Form to the BHO as an attachment to the Desk Review Form. The BHO Document Request Form contained the same standards and contract requirements as those in the tool used by HSAG to assess the BHO's compliance with contract requirements for each of the 10 standards. The Desk Review Form included instructions for completing the "BHO Information and Associated Documentation" section of this form. This step provided the opportunity for the BHO to identify, for each requirement, the specific BHO documents or other information that provided evidence of compliance, and streamlined the ability of the reviewers to identify all applicable documentation for review.
Step 5:	**Developed a site review agenda and submitted it to the BHO.**
	HSAG developed an agenda to assist BHO staff in planning for participation in the site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective site review, as well as minimizing disruption to the BHO's day-to-day operations. An agenda sets the tone and expectations for the site review so that all participants understand the process and time frames for the review.
Step 6:	**Provided orientation.**
	HSAG staff provided an orientation for the BHO and the Department to preview the site review process and respond to the BHO's and Department's questions. The orientation included identifying the similarities and differences between the FY 05-06 and the FY 06–07 review processes related to the request for information and documentation prior to the on-site portion of the site review, the schedule of review activities, and the process for the review of records.
Step 7:	**Participated in telephone conference calls with the BHO to answer questions and provide any other needed information before the site review.**
	Prior to the site review, HSAG representatives conducted a pre-site review teleconference with the BHO to exchange information, confirm the dates for the site review, and complete other planning activities to ensure that the site review was completed methodically and accurately. HSAG maintained contact with the BHO as needed to answer questions and provide information to key BHO management staff members. This teleconference and subsequent contact gave BHO representatives the opportunity to request clarification and present any questions about the request for documentation for the desk review and the site review processes.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 8:	**Received desk review documents and evaluated information before the on-site review.**
	Reviewers used the documentation received from the BHO to gain insight into the BHO's structure, enrolled population, providers, services, operations, resources, and delegated functions, if applicable, and to begin compiling the information and findings before the on-site portion of the review. During the desk review process, the reviewers: ◆ Documented findings from the review of the materials submitted by the BHO as evidence of compliance with the requirements. ◆ Identified areas and issues requiring further clarification or follow-up during the interviews. ◆ Identified information not found in the desk review documentation to be requested during the on-site portion of the review.
Step 9:	**Received record review listings and posted samples to HSAG's FTP site prepared for each BHO.**
	The Desk Review Form provided the BHO with the purpose, timelines, and instructions for submitting record review lists and for pulling sample records for HSAG's review. HSAG generated four unique record review samples based on data files supplied by the BHO or the Department. These files included the following databases: consumer grievances, consumer denials, consumers who are children and had been discharged from an inpatient facility, and encounters that had been reviewed by the BHO as part of a statically valid sample of encounters. From each of these databases, a random sample of unduplicated records was selected. For each of the record reviews, HSAG selected 10 records for the sample and five additional records for the oversample.
Step 10:	**Conducted the on-site portion of the review.**
	During the site review, BHO staff members were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. Activities completed during the site review included the following: ◆ Conducted interviews with BHO staff. Interviews were used to obtain a complete picture of the BHO's compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the BHO's performance. ◆ Reviewed information and documentation. Throughout the desk review and site review processes, reviewers used a standardized monitoring tool to guide the identification of relevant information sources and to document the findings regarding compliance with the 10 standards. This activity included a review of applicable policies and procedures, meeting minutes, quality studies, reports, records, and other documentation. ◆ Received and reviewed records. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the BHO's policies and procedures. ◆ Summarized findings at the completion of the site review. As a final step, HSAG reviewers met with BHO staff to provide a high-level summary of the preliminary findings from the site review.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 11:	**Calculated the individual scores and determined the overall compliance score for performance.**
	All of the 10 standards in the monitoring tool were reviewed and the information analyzed to determine the BHO's performance on the individual elements within each standard. For the review of records, each element was reviewed and the BHO's documentation analyzed to determine compliance.
Step 12:	**Prepared a report of findings and required actions.**
	After completing the documentation of findings and scoring for each of the 10 standards and for the reviews of records, HSAG prepared a draft report of the site review findings, scores, and required actions for the BHO. The report was forwarded to the Department and the BHO for their review and comment. After the Department's approval of the draft, a final, individual BHO report was issued to the Department and the BHO.

Evaluation and Scoring Methodology

Standards

The BHO's performance in complying with the elements (i.e., contract requirements) related to each of the 10 standards was evaluated against evidence obtained through a review of the BHO's documents and information provided during interviews with BHO staff. A score was assigned and the review findings and related substantiating evidence were documented in the "Findings" sections of the monitoring tool. The score (*Met, Partially Met*, or *Not Met*) indicated the degree to which the BHO's performance was in compliance with the individual elements in each standard. A score of *Not Applicable* (*N/A*) was used if an individual element did not apply to the BHO. Corrective actions required by the BHO to achieve compliance with the requirements were documented in the "Required Actions" section of the monitoring tool.

Scoring Methodology (Definitions)

The BHO received a score of *Met*, *Partially Met*, *Not Met*, or *N/A* for each element of each standard. This methodology follows the CMS final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*: *A protocol for determining compliance with Medicaid Managed Care Regulations*, February 11, 2003, and is defined below.

Met indicates full compliance, defined as either of the following:

- All documentation listed under a regulatory provision, or component thereof, must be present, or
- BHO staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews, or
- Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present and staff have little or no knowledge of processes or issues addressed by the regulatory provisions, or
- For provisions with multiple components, key components of a provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for remaining components.

Not Applicable (***N/A***) signifies that the requirement does not apply, because:

- The standard or element was not applicable to the BHO.

To arrive at an overall percentage of compliance score for each standard, the total number of elements receiving a score of *Met* was divided by the total number of applicable elements.

Record Reviews

The evaluation of records to determine compliance with contract requirements was accomplished through the use of a record review tool developed for each of the applicable reviews (grievances, denials, coordination of care, and documentation of services).

Similar to the methodology followed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for determining the sample size required for confidence when evaluating compliance with elements of performance, a sample of 10 records with an oversample of five records was used for record reviews (unless there were 10 or fewer available records, in which case all available records were reviewed). The samples were selected from all applicable BHO records from January 1, 2006, through September 30, 2006 for the review of grievances and denials. For the review of documentation of services, HSAG used a random sample of 10 records with an oversample of five records selected from the 411 records submitted by each BHO for the validation of the BHO's review of a statistically valid sample of encounter data. For the coordination-of-care record review, HSAG used a sample of 10 records with an oversample of five records selected from the Department's encounter data list of children with inpatient stays and discharge dates between October 1, 2005, and June 30, 2006. Each record was reviewed for evidence of BHO compliance with the applicable elements.

For each type of record review except coordination of care, the BHO received a score of *Yes* (compliant), *No* (not compliant) or *N/A* for each of the elements evaluated. Except for the coordination-of-care record review, the BHO received an overall percentage-of-compliance score for each type of record review and for all the scored record reviews combined. The overall record review score was calculated by dividing the total number of elements scored *Yes* by the total number of applicable elements.

Determination of Overall Compliance Percentage Score

The overall compliance percentage score for each BHO was calculated by dividing the total number of elements that were compliant for the standards and the record reviews by the total number of applicable elements.

References

BBA (Balanced Budget Act). Centers for Medicare & Medicaid Services. CMS and Related Laws and Regulations. Available at: http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr438_04.html.

Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Regulations*, Final Protocol, February 11, 2003.

National Committee for Quality Assurance (NCQA) *2006 Standards for the Accreditation of Behavioral Health Organizations (BHOs)*. Washington, DC.