Colorado Medicaid
Community Mental Health Services Program

FY 07–08 Site Review Report

for

Colorado Health Partnerships, LLC

June 2008

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

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Overview of FY 07–08 Compliance Monitoring Activities

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

This is the fourth year that HSAG has performed compliance monitoring reviews of the BHOs. For the fiscal year (FY) 07–08 site review process the Department requested a focused review of five areas of performance. HSAG developed a review strategy consisting of five components for review, which corresponded with the five areas identified by the Department. These are: Access to Care (Component 1), Coordination of Care (Component 2), Oversight and Monitoring of Providers (Component 3), Member Information (Component 4), and Review of Corrective Action Plans and Supporting Documentation (Component 5). Compliance with federal regulations and contract requirements was evaluated through review of the five components. This report documents results of the FY 07–08 site review activities. Details of the site review methodology and summaries of the findings, strengths, opportunities for improvement, and required actions for each component are contained within the section of the report that addresses each component. Template data collection tools for Components 1, 3, and 4, as well as completed documents for Components 2 and 5, are found in the appendices.

In developing the data collection tools and in reviewing the five components, HSAG used the BHOs' contract requirements and regulations specified by the BBA with revisions that were issued on June 14, 2002, and effective on August 13, 2002. The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services final protocol *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)* (see Appendix H).

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements in the five areas of review.
- The quality, timeliness, and access to mental health care furnished by the BHO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the area reviewed.
- Activities to sustain and enhance performance processes.

To accomplish these tasks, HSAG:

- Collaborated with the Department to determine the review and scoring methodologies for each component of the review, data collection methods, the schedule, the agenda, and other issues as needed.
- Collected and reviewed documents before and during the on-site portion of the review.
- Analyzed the data and information collected.
- Prepared a report of findings (2007–2008 Site Review Report) for each BHO.

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

Summary of Results

Each component of the review was assigned an overall score of *In Compliance*, *In Partial Compliance*, or *Not In Compliance* based on conclusions drawn from the review activities. Required actions were assigned to any component receiving a score of *In Partial Compliance* or *Not In Compliance.* As appropriate, opportunities for improvement were also identified for some components regardless of the score. While recommendations for enhancement of BHO processes were provided based on these identified opportunities for improvement, these recommendations (as differentiated from required actions) do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **Colorado Health Partnerships, LLC** (**CHP**) for each of the components. Details of the findings for each component follow in subsequent sections of this report.

Table 1-1—Results

Component	Overall Score
Component 1—Access to Care	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 2—Coordination of Care	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 3—Oversight and Monitoring of Providers	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 4—Member Information	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 5—Review of FY 06–07 CAPs	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*

Methodology

HSAG conducted member interviews and telephone assessments of **CHP**'s access processes and compared the results with the BHO's policies and published practices and with information obtained from interviews with key BHO staff members.

HSAG reviewed for compliance with the following contract requirements:

- *Exhibit C.1:* "The Contractor shall assess the need for services."
- *II.F.1.a.5*: "The Contractor shall meet the standards for timeliness of service for routine, urgent, and emergency care."
- *II.F.1.f:* "The Contractor shall allow, to the extent possible and appropriate, each Member to choose his or her health professional."

Member Interviews

The Department provided HSAG with a sample of 10 Medicaid members (with an oversample of 36 Medicaid members) who received or attempted to receive services between the dates of January 1, 2007 and December 31, 2007. The intended sample mix for each BHO was as follows: three Medicaid members who received only an intake visit during the review period, three Medicaid members who received an intake and subsequent services during the review period, and four Medicaid members who were identified by various stakeholder groups.[2-1] HSAG interviewed two adult members, one of whom received services following the intake assessment, and five individuals whose children were Medicaid members who had received an intake assessment, with two receiving subsequent services. There were no Medicaid members identified by the stakeholder groups who met the selection criteria for the sample (members who experienced an issue accessing services between July 1, 2006, and December 31, 2007, and had not had the matter investigated by either the Medicaid ombudsman or the Department). HSAG developed a short questionnaire that was conducted via telephone. Members were asked to describe their experience of obtaining an individual, confidential assessment for entry into services. Interview questions were designed to obtain members' perceptions related to the ease of gaining access to services provided by the BHO and information provided to them during initial and subsequent contact with the BHO.

[2-1] Stakeholder groups are the Mental Health Planning and Advisory Council, the Mental Health Advisory Committee, and the Office of the Ombudsman for Medicaid Managed Care.

Telephone Assessment of BHO Access Processes

HSAG conducted five calls per BHO to assess the processes and practices at each BHO for providing access or intake services to Medicaid members in the BHO's service area. The HSAG caller identified him/herself as an HSAG representative calling on behalf of the Department. The caller then asked a series of situational and standard questions about policies and processes for providing access to services. Answers were recorded by each caller and are summarized in the findings section below. The call worksheets (see Appendix B) included scripts with a set of situations to present to the BHO intake worker. The situations presented to the BHO intake worker were different for each of the four calls. The caller worksheets also included a set of policy or process questions, which were standard questions to be asked during each call. Each scripted call was made to each BHO simultaneously. That is, Call Script 1 was made to each BHO on Tuesday, January 8, 2008, at 2 p.m.; Call Script 2 was made to each BHO on Saturday, January 12, 2008, at 3 p.m. and repeated on Monday, January 28, 2008, at 12:30 p.m.; Call Script 3 was made to each BHO on Wednesday, January 23, 2008, at 9:30 a.m.; and Call Script 4 was made to each BHO on Tuesday, January 29, 2008, at 4 p.m.

Summary of Findings

The Member Request—Routine, Member Request—Urgent, and Member Request—Risk Rating policies described the processes for assessing members based on the level of need. The Psychological Testing policy described how psychological tests were included, as needed, for member assessments. The provider manual included the Initial Assessment Form. The chart audit tool included elements for evaluating the presence and completeness of the assessment, as well as the appropriateness of the treatment plan based on the assessment. **CHP** conducted audits of the community mental health centers (CMHCs) and the external provider network (contracted individual providers) to assess availability of appointments within the required time frames and the availability of 24-hour emergency coverage for the external providers. Review of the quality improvement steering committee (QISC) meeting minutes demonstrated a review and discussion of the quarterly grievance reports and satisfaction survey results regarding access and availability, as well as a review and analysis of the results from **CHP**'s audits to assess access. During HSAG's telephone assessment calls to the **CHP** access line and the contracted CMHCs, each of the staff members indicated that members would be scheduled for an intake assessment to determine the need for services or would be encouraged to go to the nearest emergency room in case of an emergent need.

Members were informed of the standards for timely access to services in the member handbook. Providers were informed of the standards for timely access to services in the provider manual. During the on-site interview, **CHP** management staff reported that providers within the CMHCs as well as individually contracted providers were held to the expectations indicated in the provider manual. The quarterly Access to Care Reports for FY 06–07 indicated that **CHP** was 100 percent compliant with the access standards for emergency and urgent services throughout the fiscal year. The most recent quarterly report available during the site review (October—December 2007) indicated that **CHP** had achieved 99.8 percent compliance with the access standards for routine care. Letters sent to the CMHCs requesting corrective action based on data that fell below the 100

percent requirement for access to routine care within seven days, the CMHCs' responses and associated corrective action plans, and follow-up letters from **CHP** demonstrated that **CHP** required corrective action as needed and monitored progress in completing the corrective action plans.

The Member Request—Routine, Member Request—Urgent, and Member Request—Risk Rating policies described the circumstances under which members could choose providers from outside the **CHP** provider network (i.e., single-case agreements with the chosen provider). The member handbook informed members of the right to choose their provider. The provider manual informed providers of the member's right to choose his or her provider. During each of the telephone assessment calls, the **CHP** and CMHC staff indicated that members were routinely provided a choice between external network providers and the CMHC, and acknowledged that in certain circumstances additional providers could be added to the network or offered single-case agreements. The annual compliance audit of the CMHCs conducted by **CHP** included an element to evaluate whether there was evidence that members were provided a choice of therapists within the CMHC setting.

Summary of Strengths and Opportunities for Improvement

While each staff member spoken to (including the staff member at Colorado West Mental Health Center [CWMHC]) during the telephone assessment calls indicated that members received intake assessments and reiterated the standards for timely access to services, the staff member at CWMHC described a process that could create barriers to accessing timely services. The CWMHC process appeared to apply only to accessing routine services and included the need to obtain either the clinical team's or program director's approval before scheduling the member for an intake appointment. The staff member at CWMHC indicated that if the member called just after the weekly team meeting that is held to discuss and schedule cases, the clinical director would approve the appointment more quickly, and that the process would not interfere with meeting the seven-day requirement for access to care. In two other situations described by the HSAG caller (scheduling an individual with a developmental disability and scheduling an individual enrolled in another BHO service area), the staff member at CWMHC was unsure whether an appointment could be scheduled, but indicated that she would be sure to get the information to the program director for review and potential approval. While the CWMHC staff member did not indicate that intake appointments would be denied, and assured HSAG that appointments would be offered within the required timeframes, she was unsure of the guidelines that applied to certain situations. **CHP** may want to consider evaluating the intake processes and associated training at its more rural centers regarding access-to-care requirements.

Summary of Required Actions

There are no corrective actions required at this time as **CHP** was found to be in compliance with this component.

Methodology

Care coordination (as defined in the FY 07–08 BHO contract) means the process of identifying, screening, and assessing members' needs; identification of and referral to appropriate services; and coordinating and monitoring an individualized treatment plan. This treatment plan should also include a strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment. The focus of the FY 07–08 Coordination of Care record review was to use the clinical record to identify and assess the BHO's and providers' practices related to care coordination with primary care physicians and parents or guardians of children receiving services, specifically with respect to medication management. The Department provided HSAG with a sample of 10 Medicaid members (with an oversample of 5) who were children (0–17 years of age) and who received a medication management visit between January 2007 and September 2007. A reference period of 45 days prior to, and 45 days following, the medication management encounter date was used for review of each record. The purpose of the record review was to identify instances of care coordination between mental health provider(s) and the family (parent or guardian) and between mental health provider(s) and the primary care physician (PCP) related to medication management. Mental health providers may include the prescriber or the therapist.

HSAG reviewed for compliance with the following contract requirements:

- *II.F.1.g.3:* "The Contractor shall coordinate with the Member's medical health providers to facilitate the delivery of health services, as appropriate."
- *II.G.1.c:* "The Member has the right to participate in decisions regarding his or her health care."
- *II.G.5:* "The Contractor shall encourage involvement of the Member, family members, and advocates in service planning."

Summary of Findings

The Coordination of Care policy stated that the primary therapist is responsible for coordinating care with the psychiatrist or other prescribing professional and all other care providers or human services agencies, as appropriate. The Coordination of Care policy also stated that for members with specific diagnoses, the primary therapist would communicate with the PCP within 90 days following the intake assessment, and specified the required content of communication. The policy stated that the frequency of communication with the PCP is determined by the presence or absence of medical conditions and medications prescribed for treating those conditions. During the on-site interview, **CHP** management staff reported that the reviewing clinicians used clinical judgment to determine if communication/coordination with agencies and the PCP was indicated.

The Discharge Planning and the Guardian/Conservatory Input in Discharge Planning policies included the processes for including members, parents, or guardians in treatment and discharge

planning throughout the course of treatment. The clinical chart audit tool included a section for the reviewer to assess the presence of documentation providing evidence of communication and coordination with other care providers, agencies, and PCPs as indicated. The chart audit tool had a section for the reviewer to assess whether the member (or parent/guardian) has been involved in treatment. During the on-site interview, **CHP** management staff stated that the reviewers looked at progress notes and treatment plans to determine if members were involved in goal-setting during treatment sessions and to determine if the goals appeared to be in the member's own words.

The coordination-of-care record review included 10 records of children who had received a medication management visit during the review period. No records from the oversample were reviewed. All 10 records contained evidence that the prescriber or other medical personnel (e.g., a registered nurse) discussed medications with the parent or guardian during the medication management visit or in addition to the medication management session (i.e., via a telephone call). Four records indicated that the cases were medication management-only cases and, therefore, would have had no primary therapist assigned. Five of the remaining six records contained evidence that the primary therapist discussed the child's progress with the family; three of those records included discussion of medications. There were no records that included documentation of communication with the PCP.

Summary of Strengths and Opportunities for Improvement

CHP had a variety of methods to enhance the quality of care coordination. **CHP**'s annual compliance and chart audits not only evaluated for the presence of documentation, but also included evaluation for the content and quality of the documentation reviewed. **CHP**'s Enhanced Clinical Management program used utilization management (UM) and quality data to identify members who should receive intensive case management services. **CHP** had several performance improvement projects designed to improve coordination of care, some of which were in addition to those required by the Medicaid contract or the Medicaid managed care regulations. Additional quality initiatives included studies regarding suicidal thinking and the impact of shared decision making on therapy outcomes. A review of the QISC meeting minutes indicated that future quality projects may include the support of integrated care models in existence and directed by the CMHCs and the development of disease management programs for the top five diagnoses.

CHP's providers documented numerous coordination-of-care activities with family members. In addition, **CHP** had a method to monitor whether medical records contained evidence of communication with the PCP as appropriate; however, **CHP** may want to consider developing criteria or guidelines to ensure that ongoing coordination and communication with PCPs occurs.

Summary of Required Actions

There are no corrective actions required at this time as **CHP** was found to be in compliance with this component.

Methodology

HSAG conducted a desk review of policies and an on-site review of documentation with an interview of key BHO personnel. This component of the compliance monitoring review was designed to examine the BHO's processes for directly monitoring independently contracted providers, and to examine the BHO's processes for monitoring the community mental health centers' (CMHCs) supervision and training of their providers. Specific attention was paid to the BHO's practices related to identifying and responding to issues obtained during its monitoring of the CMHCs. The review period for this component of the review was January 1 through December 31, 2007.

HSAG reviewed for compliance with the following contract requirements:

- *II.F:* "The Contractor shall ensure that required and alternative services are provided through a well-organized service delivery system. The service delivery system shall include mechanisms for ensuring access to quality, specialized care from a comprehensive provider network."
- *II.G.4.h.3:* "Additional Member rights include the right to have an independent advocate, request that a provider be considered for inclusion in the network, and receive culturally appropriate and competent services from participating providers."
- *II.H.10.a.1:* "The Contractor shall be responsible for all work performed under this Contract, but may enter into Provider agreements for the performance of work required under this Contract. No provider agreements, which the Contractor enters into with respect to performance under the Contract, shall in any way relieve the Contractor of any responsibility for the performance of duties required under this Contract."
- *II.H.10.a.3:* "The Contractor shall monitor Covered Services rendered by provider agreements for quality, appropriateness, and patient outcomes. In addition, the Contractor shall monitor for compliance with requirements for Medical Records, data reporting and other applicable provisions of this Contract."

Summary of Findings

The policies, Determining the Status of a Network and Measurement of Access and Availability, described **CHP**'s processes for measuring and determining the sufficiency of the **CHP** network. The Recruitment policy identified the priorities for focusing recruitment efforts. The quarterly Network Adequacy Report demonstrated that **CHP** monitored the service delivery system through monitoring enrollment, penetration rates, and adherence to access standards. The quarterly Single Case Agreement/Out of Network Activity Report demonstrated that one method **CHP** used to respond to the need for network providers was to enter into single-case agreements, and that **CHP** monitored that out-of-network activity. Minutes of the Office of Consumer and Family Affairs (OCFA) and the QISC committee meetings demonstrated that **CHP** monitored and analyzed data from grievances and from the Mental Health Statistical Improvement Project (MHSIP), the Youth Services Survey for Families (YSS-F), and the consumer satisfaction survey completed on behalf of

CHP by Fact Finders, Inc. Minutes of the Quality of Care Committee meetings demonstrated that **CHP** used utilization management data to identify outlier provider practices or specific cases to identify members appropriate for an intensive level of case management services, then followed those cases through record review and a peer-review process.

The new employee checklist included a review of member rights, which included the member's right to have an independent advocate and the right to request that a provider be included in the network. Providers were informed of member rights in the provider manual and members were informed of their rights in the member handbook. During the telephone assessment calls that HSAG conducted, staff at the CMHCs, as well as the **CHP** access line, described the standard procedure as offering members a choice of providers, and stated that, under certain circumstances, providers would be offered participation in the network, or single-case agreements, upon member request.

Screen shots of the **CHP** access system demonstrated that **CHP** intake workers were able to enter member needs and preferences into the database and obtain a selection of independently contracted providers in addition to the nearest CMHC. Search elements included geographic area, language spoken, treatment specialty, and licensure. QISC committee meeting minutes indicated that **CHP** results of the MHSIP reported 92 percent satisfaction with the question regarding culturally appropriate services.

Results of **CHP**'s annual Delegation Oversight audit indicated that **CHP** reviewed CMHC policies and procedures during the audit. In addition, during the audit, **CHP** reviewed the CMHCs' evidence of implementation of procedures related to Medicaid contract compliance, such as requirements related to grievances, appeals, access standards, coordination of care, member rights, distribution of member information, OCFA duties, utilization management, and clinical documentation. Audit reports also demonstrated that **CHP** conducted separate, focused audits to evaluate the CMHCs' practices regarding claims submission and grievance and appeal processing. **CHP** also conducted clinical chart audits for independently contracted providers as well as the CMHCs as evidenced by completed audit forms. The Summary of Corrective Action Plans described each corrective action requested from providers as a result of the FY 07–08 clinical chart audits.

The Quality Management Department Clinical Outcomes Summary Report—2007 provided summary and analysis for Global Assessment Function (GAF) scores (pre- and posttreatment measure comparison), CCAR Item—Level results (pre- and posttreatment measurement), and the CCAR Factor Analysis Results. Other quality initiatives by **CHP** to assess the performance of providers and monitor the quality, appropriateness, and outcomes of services were the following studies: (1) Assessing Impact of a Shared Decision-Making Aid on Reported Mental Health Treatment-Related Outcomes for Adult Medicaid Eligible Mental Health Clients, (2) Understanding Barriers to Accessing Mental Health Treatment During Times of Suicidal Thinking—Consumer Perspectives, (3) Performance Improvement Project—Youth Readmissions, and (4) Performance Improvement Project—Youth Time in Community.

Summary of Strengths and Opportunities for Improvement

CHP had a comprehensive mechanism for monitoring the partner CMHCs and individual providers, which included evaluation of clinical performance as well as performance related to Medicaid contract compliance. **CHP** requested corrective action plans when performance fell below benchmark or required standards. **CHP**'s clinical chart audit processes for CMHCs and independent providers used the same chart audit tool. In addition to the MHSIP and YSS-F administered by the Department of Human Services, Division of Mental Health, **CHP** contracted with Fact Finders, Inc., to administer an additional consumer satisfaction survey, which **CHP** used in trending results and developing quality initiatives. **CHP** also initiated several quality studies in addition to the Department-required performance improvement projects.

Summary of Required Actions

There are no corrective actions required at this time, as **CHP** was found to be in compliance with this component.

Methodology

HSAG compared results of the member interviews and the telephone assessments to BHO policies and to documentation provided to members in writing. This component assessed the accuracy of information provided verbally during the intake process at the BHO and at facilities designated by the BHO to perform the intake function on behalf of the BHO.

HSAG reviewed for compliance with the following contract requirements:

- *II.G.4.b:* "The Contractor shall have in place a mechanism to help Members and potential Members understand the requirements and benefits of the plan."
- *II.G.1.d:* "The Contractor shall establish and maintain written policies and procedures for treating all Members in a manner that is consistent with the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand."

Summary of Findings

The **CHP** member handbook contained a complete description of mandatory and alternative services. **CHP** used a cover letter sent with the member handbook, which described the basic services and referred members to the enclosed handbook for additional information. **CHP** also had an annual member letter reminding members that they could request a member handbook. **CHP** had a consumer Web site (different than the provider-focused **CHP** Web site), which contained the member handbook, information about benefits and services, diagnosis-specific tip sheets, and member-focused articles. During the on-site interview, **CHP** management staff reported that this Web site could be accessed via a link on each of the **CHP** partner CMHCs' Web sites, and that the OCFA directors at each CMHC used this Web site as a resource. **CHP** management staff also reported that OCFA directors were available at each of the CMHCs to answer questions about services and benefits, and that member handbooks were available at **CHP**'s empowerment centers (drop-in center model of service delivery). A review of the OCFA committee meeting minutes indicated that peer specialists were trained and supervised by the OCFA directors to assist members in understanding the Medicaid benefits and services available through **CHP**. **CHP** management staff reported that peer specialists typically assisted members in understanding how to access services such as transportation, wellness education, and support groups, as well as provided services such as peer counseling, role modeling, and classes regarding recovery-focused treatment.

The Member Rights and Responsibilities policy included all member rights. The annual compliance audit form included a section for the reviewer to ask the CMHCs how they inform members of the right to receive information about available treatment options. Providers were notified of member rights through the provider manual. **CHP** management staff reported that the CMHCs as well as

independently contracted providers were required to follow procedures outlined in the provider manual. Members were informed of their rights in the member handbook.

During the member interviews, three members remembered receiving written information from **CHP**, none of whom remembered anything about the content of that information.

Summary of Strengths and Opportunities for Improvement

CHP had a variety of mechanisms designed to help Medicaid members understand the benefits of the State plan and services available from **CHP**. During the HSAG telephone assessment calls, responses (regarding members' choice of providers and accessing services for members eligible within another BHO service area) from each of the CMHCs contacted were consistent with **CHP** access line staff members' responses.

Summary of Required Actions

There are no corrective actions required at this time as **CHP** was found to be in compliance with this component.

6. Component 5—Corrective Action Plan and Document Review

for Colorado Health Partnerships, LLC

Methodology

As a follow-up to the FY 06–07 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all elements for which it received a score of *Partially Met* or *Not Met*. The plan was to include interventions to achieve compliance and the timeline. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with the BHO until HSAG and the Department determined that the BHO completed each of the required actions from the FY 06–07 compliance monitoring site review, or until the time of the on-site portion of the BHO's review.

Summary of Findings

Following the approval of **CHP**'s FY 06–07 corrective action plan, **CHP** submitted documentation, as required. **CHP** completed all required actions for Standard I—Delegation; Standard II—Provider Issues; Standard IV—Member Rights and Responsibilities; Standard IX—Grievances, Appeals, and Fair Hearings; and Standard X—Credentialing.

The CHN Policy 203L—Medical Necessity Determination contained language regarding authorization of emergency services that did not comply with Medicaid managed care regulations. The **CHP** provider manual and the member handbook both included language that indicated that **CHP** did not require authorization of emergency services and that **CHP** had practices that complied with the Medicaid contract and the BBA. During the on-site interview, **CHP** management staff members confirmed that **CHP** did not require authorization of emergency services and that the authorization language in the emergency services section of the policy was in error and occurred inadvertently during the latest revision of the policy.

Summary of Strengths and Opportunities for Improvement

CHP completed all required actions in Standard VI—Utilization Management except for the required action for Element 1B—Written Policies and Procedures.

Summary of Required Actions

CHP must revise its Medical Necessity Determination policy to ensure that the policy is in compliance with all Medicaid managed care regulations and the Colorado BHO Medicaid contract.

Appendix A. Member Interview Worksheet
for Colorado Health Partnerships, LLC

The member interview worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Member Interview Worksheet

Interviewer Name: Barbara McConnell	BHO Name: Colorado Health Partnerships
Member ID: _____ *(not to appear in the report)*	Member Name: _____ *(not to appear in the report)*

Introduce Yourself and Describe (Briefly) HSAG

The State of Colorado has asked us to interview a few Medicaid members to ask about their recent experiences at _____ (name the provider or make a general reference to services if the provider agency is unknown). Do you have a few minutes to talk about your experiences?

Members: (If child, parent was interviewed)

Member 1: Adult (Member was developmentally disabled. HSAG interviewed the mother.)
Member 2: Adult
Member 3: Child
Member 4: Child
Member 5: Child
Member 6: Child
Member 7: Child

Where services were received:

Member 1: Pikes Peak Mental Health Center (PPMHC)
Member 2: Peak Vista Clinic
Member 3: Pikes Peak Mental Health Center
Member 4: Pikes Peak Mental Health Center
Member 5: Pikes Peak Mental Health Center
Member 6: Pikes Peak Mental Health Center
Member 7: Pueblo Mental Health Center

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Member Interview Worksheet

1. *How did you feel about your first appointment at _____? Were you satisfied with your experience during your first appointment at _____?*

How did you feel?

Member 1: "It was OK. My son was comfortable."
Member 2: "It was okay. I was a little uncomfortable in the waiting room."
Member 3: "The kids were in foster care at the time, I went to the family center with them. I thought it was good."
Member 4: "They talked to my son alone. He said he felt comfortable."
Member 5: "It was just an assessment, but it went well. It was nice."
Member 6: "Very good."
Member 7: "It felt good. They did a good job."

Were you satisfied?

Member 1: "Yes."
Member 2: "Yes."
Member 3: "Yes."
Member 4: "I don't know if my son was satisfied. He said he was comfortable. I was satisfied."
Member 5: "Yes."
Member 6: "Absolutely."
Member 7: "Yes."

2. *Can you tell me why you felt that way? Describe why you were/were not satisfied.*

Member 1: "I was optimistic. The person who helped us was very understanding and knowledgeable."
Member 2: "I didn't feel like I belonged there at first, but it turned out OK."
Member 3: "It helped."
Member 4: "They are considering medications. If medication will help, that's OK."
Member 5: "They treated my daughter well. They were courteous and nice."
Member 6: "I had another foster child that had been counseled by the same person, so we requested the same counselor."
Member 7: "I think I was worried, but they reassured us."

3. *Was there anything that bothered you about the appointment or the person you talked to?*

Member 1: "We couldn't go back for a second appointment. I got a call from Medicaid and was told he wasn't eligible. We just didn't get any help after that."
Member 2: "No, just the waiting room."
Member 3: "No, but I thought the kids were tired of talking."
Member 4: "Nothing about Pikes Peak. The system took time. I kept asking and getting ignored (by social services and probation) until it got out of hand."
Member 5: "No."
Member 6: "No."
Member 7: "No."

4. *If so, did you ever talk to anyone about it, or do anything about it?*

Member 1: "No, I didn't know who to complain to."
Member 2: "No, because it wasn't my business. It was just me."
Member 3: NA
Member 4: NA
Member 5: NA
Member 6: NA
Member 7: NA

5. *If yes, did you receive anything in the mail about your complaint?*

Member 1: NA
Member 2: NA
Member 3: NA
Member 4: NA
Member 5: NA
Member 6: NA
Member 7: NA

6. *Were you ever told what you can do if you are unhappy about the help you are getting from your counselor? Did you ever get something about this in the mail?*

Member 1: "No."
Member 2: "I don't remember."
Member 3: "I believe so."
Member 4: "No."
Member 5: "Yes."
Member 6: "Yes."
Member 7: "I'm not sure."

7. *Did you ever get any written information about the BHO (either when you went there or in the mail)?*

Member 1: "No."
Member 2: "I'm not sure."
Member 3: "No."
Member 4: "They gave us some papers."
Member 5: "Yes."
Member 6: "Yes. They gave me a copy of everything."
Member 7: "No. I don't think so."

8. (If yes): What do you remember about the information?

Member 1: NA
Member 2: NA
Member 3: NA
Member 4: "Nothing. They asked if we had any questions at the time."
Member 5: "They were written policies."
Member 6: "Nothing. I never needed it."
Member 7: NA

9. Where were you told you could get counseling? Were you given more than one place to go?

Member 1: "I got referrals to other places that didn't pan out."
Member 2: "No."
Member 3: "Yes, I had a choice."
Member 4: "No."
Member 5: "Yes. We were given several options."
Member 6: "We requested a specific therapist and went there."
Member 7: "I think so."

10. Did you go back for counseling after your first appointment?

Member 1: "No."
Member 2: "Just once."
Member 3: "She had ongoing therapy then she was placed in a permanent home."
Member 4: "Not yet."
Member 5: "No."
Member 6: "Several times."
Member 7: "No."

11. (If no): Do you mind telling me why?

Member 1: "I was told we weren't eligible for Medicaid."
Member 2: "I didn't need to. It was a doctor-ordered assessment only."
Member 3: N/A
Member 4: "We have an appointment scheduled."
Member 5: "It was just an assessment. We didn't need to. I agreed with that."
Member 6: NA
Member 7: "No need to."

If the Member Was Denied Services (or Told He or She Didn't Qualify)

12. Did you get a letter explaining why they couldn't help you?

Member 1: "No letter, just a phone call."
Member 2: NA
Member 3: NA
Member 4: NA
Member 5: NA
Member 6: NA
Member 7: NA

13. (If yes): Did it explain anything else you could do to get help if you didn't agree with the letter?

Member 1: NA
Member 2: NA
Member 3: NA
Member 4: NA
Member 5: NA
Member 6: NA
Member 7: NA

14. Is there anything else you would like to tell me about the Medicaid mental health services you have received?

Member 1: "I'm still hopeful."
Member 2: "Overall it was very helpful. They were concerned."
Member 3: "No."
Member 4: "No."
Member 5: "We went back for paperwork once. They were re-doing the building and it smelled toxic. I was a little worried about the workers."
Member 6: "I was very satisfied."
Member 7: "No."

Appendix B. Telephone Assessment Worksheet for Colorado Health Partnerships, LLC

The telephone assessment worksheet follows this cover page.

Telephone Assessment Worksheet 1

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Colorado Health Partnerships Telephone number called: 1-800-804-5008

Date of call: Tuesday, January 8, 2008 Time of call: 2 p.m.

Caller: Barbara McConnell

Name of person answering the phone: P

Offered name: X Had to ask name: _____

Notes:

The phone was initially answered by an automated system, which gave several choices. One choice directed the caller to press a number if the caller is a Medicaid member and has a mental health emergency. One choice directed the caller to press a number if the caller is a Medicaid member requesting authorization for any level of service. The HSAG representative chose the option to obtain authorization for any level of service. The system transferred the call and the phone was answered after one ring.

P offered his name and stated that he was happy to answer questions. He indicated that the line is answered by someone 24 hours per day, seven days per week.

P stated each caller is routinely offered four telephone numbers (one telephone number for the closest CMHC and three telephone numbers for private therapists). For this call, the HSAG caller continued with P to obtain answers to each of the questions.

Person assigned to help or transferred to: _____

Offered name: _____ Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

P explained that this BHO covers two-thirds of Colorado and includes urban, rural, and frontier areas.

Specific questions for the first call:

1. *How would someone (perhaps a parent) obtain services for a child with Asperger's syndrome who has additional symptoms (i.e., if the parent describes symptoms of psychosis or depression)?*

   P stated that he would provide the caller with the numbers of the nearest CMHC and three private therapists. He stated that the therapist would conduct an assessment to verify the Asperger's diagnosis and to determine the mental health diagnoses. He explained that individuals with developmental disabilities often have other diagnoses.

2. *How would you (the BHO) respond to a nursing home calling to obtain services for a resident (for depression)?*

   (If the BHO indicates that the resident would have to travel to a CMHC or provider office, ask how transportation could be arranged or services could be provided at the nursing home.)

   P stated that he would provide the number of the nearest CMHC and would research on his computer the private therapists who specialize in treating the geriatric population.

   P explained that the majority of services provided to residents of nursing homes occur on-site at the nursing home. He also stated that in the urban areas there are transportation services that he could refer the caller to if transportation was necessary. This may be the case if the member chose a private therapist who does not travel to nursing homes.

General questions asked during each call:

3. *What is your next availability for a routine appointment?*

   Call 1 (call placed at 2 p.m. on Tuesday, January 8, 2008): P stated that he would initially ask if the caller felt that he or she was in any immediate danger. If the member stated that there was no danger, he would offer the providers' phone numbers. He indicated that the BHO access line does not schedule appointments, but requires that the providers (independent as well as CMHCs) be able to offer appointments within seven days. He stated that if a provider is unable to schedule an appointment within seven days the provider is required to call and alert the BHO.

   Call 2 (Saturday—CHP access line): J indicated that the CHP system does not have the capability to search by who accepts Medicare. She stated that she had a separate list of Medicare providers in the urban areas and that in the rural areas, she would refer the caller to the nearest CMHC, where there are typically Medicare-approved providers. She said that she would also offer to get the caller's number if he or she did not wish to be seen by the CMHC. She said she could call the nearest CMHC and see if they had a list of private therapists in that area who accepted Medicare.

   Call 2 (Repeated—call placed at 12:30 p.m. on Monday, January 28) (CWMHC): D indicated that each case would have to be staffed by the clinical team before an intake assessment could take place. She stated that staffings occur each Thursday afternoon. If the matter is urgent, or the call

comes in on Thursday afternoon or Friday, the program director could approve the appointment since appointments must be made within seven days (or sooner if urgent).

Call 3 (Call placed at 9:30 a.m. on Wednesday, January 23) (CHP): We would give numbers of providers who schedule their own appointments. Providers are directed to schedule routine appointments within seven days and urgent appointments within 24 hours. Midwestern Mental Health Center at Telluride: "First available appointment is today at 4:00."

Call 4 (Call placed at 4 p.m. on Tuesday, January 29): D (CHP) explained that the access center does not schedule appointments and he would refer the caller to providers or CMHCs for appointments. A (at PPMHC) said she had an appointment available for an adult on February 1 at 10:15 and an appointment for a child available at 1:30 "tomorrow."

3.a. Are callers always directed to a CMHC for services or are they given the choice between a CMHC or a contractor before the appointment is set?

Call 1 (CHP): P restated that it is standard procedure that callers to the BHO access line be offered the phone number for the closest CMHC and three private therapists. He explained that the only exception would be if a member had moved out of the area (i.e., to another BHO's catchment area), in which case, the member would be instructed to call the nearest CMHC to obtain services, and P would authorize services to be provided by that CMHC. He explained that they do not have contracts with private therapists outside of their catchment area, but do have agreements with CMHCs throughout the State.

Call 2 (Saturday): J stated that she typically gives callers contact information for the nearest CMHC and three private providers. J would ask the caller for his or her preferences and needs (male or female provider, what specialty, etc.), then give the caller several options—maybe as many as seven or eight—and encourage the member to call back if he or she needs more names.

Call 2 (repeated): Both A (CHP) and D (CWMHC) stated that all callers are offered both private practice and CMHC providers.

Call 3: A (CHP) stated that members are routinely offered a choice between private contracted therapists and the CMHC. She said that she would ask about preferences regarding male or female, specialty, etc., and would ask if they had been seen before. She explained that some individuals may have gone to the CMHC and may not want to go back, or they may have a specific therapist at the CMHC who they prefer. B (Telluride) stated that there are few private therapists in the area, but that he would refer the caller to CHP to help find one if that was what the caller wanted.

Call 4: D (CHP) said that callers are always given a choice. A (PPMHC) said "no" and that she would refer the caller back to CHP if needed.

3.b. If a member asks if he or she can see someone other than a CMHC provider, what do you tell the member?

Call 1: P restated that it is standard procedure that callers to the BHO access line be offered the phone number for the closest CMHC and three private therapists. He explained that the only exception would be if a member had moved out of the area (i.e., to another BHO's catchment area), in which case, the member would be instructed to call the nearest CMHC to obtain services, and P would authorize services to be provided by that CMHC. He explained that they do not have contracts with private therapists outside of their catchment area, but do have agreements with CMHCs throughout the State.

Call 2 (Saturday): J repeated that members are routinely offered both private therapists and CMHCs from which to choose.

Call 2 (repeated): D (CWMHC) indicated that there are private therapists who she could refer the caller to who are in the CHP network.

Call 3: A (CHP) stated that members are routinely offered a choice between private contracted therapists and the CMHC. She stated that she would ask about preferences regarding male or female, specialty, etc., and would ask if they had been seen before. She explained that some individuals may have gone to the CMHC and may not want to go back, or they may have a specific therapist at the CMHC who they prefer. B (Telluride) stated that there are few private therapists in the area, but that he would refer the caller to CHP to help find one if that was what the caller wanted.

Call 4: D (CHP) said they offer private names routinely. A (PPMHC) said she would refer the caller back to CHP for a list of names.

3.c. If a member calls with a request to see a specific private therapist who is not in your network, what do you tell the member?

Call 1: P indicated that the member would be asked to see a therapist within the CHN network. He stated that the member could see a therapist outside of the network if the CHN network did not have any therapists with the particular specialty required. (He stated this often occurs with members with eating disorders.) Another reason would be if the member has recently become Medicaid-eligible and has a relationship with a therapist with whom he or she would like to continue treatment. In the second case, P stated that the therapist would probably be offered a single-case agreement.

Call 2 (Saturday): J said she would ask the caller why he or she wants to see a specific therapist. If the caller has an ongoing relationship with a therapist, they could offer the therapist a single-case agreement.

Call 2 (repeated): D (CWMHC) stated that she would refer the caller back to CHP for a list of names.

Call 3: A (CHP) stated that they would ask that the therapist contact CHP so they could offer a single-case agreement. B (Telluride) stated that there are few private therapists in the area, but that he would refer the caller to CHP to help find one if that was what the caller wanted.

Call 4: D (CHP) explained that CHP has criteria to approve a single-case agreement. One criterion is that there is an established relationship with a therapist that is important for continuity of care. The second criterion is that the therapist has a specialty (that the member needs) that is unavailable in the network. The third criterion is that the member lives in a rural area where no network providers are available. A (PPMHC) said she would refer the caller to CHP.

4. *What is your next availability for an urgent appointment?*

Call 1: P stated that if the member indicated that the matter was urgent, then P would conference in the crisis worker at the nearest mental health center. P indicated that private providers are required to offer appointments within seven days, so he typically would not use private providers for urgent issues. It would be possible, however, for the member to be seen at the CMHC for the urgent issue, then be seen later by a private therapist.

Call 2 (Saturday): NA

Call 2 (repeated): D (CWMHC) said she would transfer the call to the on-call therapist or ask the on-call therapist to return the call quickly, making sure that there is an appointment available tomorrow.

Call 3: A (CHP) stated that she would conference in the crisis worker at the nearest CMHC to ensure that the member got connected with the worker. B (Telluride) stated that the emergency team sees both urgent and emergent cases and that the caller could be seen by noon or come to a 4 p.m. appointment (same day) if he or she wanted to.

Call 4: A (PPMHC) said that there are no specific appointments on the books (for urgent appointments), but she could get someone from the pool to schedule an appointment for tomorrow. A added that they have a large pool (of providers).

5. *If I was a Medicaid member calling with an emergency what directions would you give me and how long would it take for me to be seen?*

Call 1: P said emergencies are seen immediately. P explained that if the member indicated that he or she was suicidal or in immediate danger, P would keep the member on the phone and call the police to ensure that the member was safe. If the member indicated that he or she was not suicidal or in danger, but felt that the issue was urgent, he would conference in the crisis worker at the CMHC and the member would be seen within the hour.

Call 2 (Saturday): J stated that she would either instruct the caller to go to the nearest emergency room or would call the crisis worker at the CMHC. J said that access is available within one hour in urban areas and two hours in rural areas.

Call 2 (repeated): D (CWMHC) said she would ask the caller if it was OK to have the on-call therapist return a call in 15 to 30 minutes. If not, D would keep the caller on the line and have someone page the on-call therapist.

Call 3: A (CHP) stated that she would ask if anyone was with the caller, would assess for safety, and would conference in the crisis worker at the nearest CMHC. If the member indicated that he or she was alone and A felt that safety was an issue, she may have someone call the police while she stayed on the phone with the caller. If the member indicated that he or she was with someone, A said that she would determine if the person felt safe to be transported to the CMHC. A said that she would have the caller seen within the hour. B (Telluride) stated that the emergency team sees both urgent and emergent cases. The caller could be seen by noon or could come to the 4 p.m. appointment (same day), or B would suggest that the caller go to the nearest emergency room.

Call 4: D (CHP) said he would ask if the caller could safely get to the nearest hospital or to the nearest CMHC to be evaluated. If not, D would send the crisis team out to the caller or call the police for safe transport. A (PPMHC) said she would ask if the caller felt suicidal or homicidal, get the caller's name and number, and give the direct line for the crisis center (in case the member hangs up during the transfer). Then A would transfer the call to the crisis center.

6. *What is the procedure if a member indicates that he or she has moved from another BHO's catchment area, but the eligibility file does not reflect the change?*

Call 1: P stated that the member would be directed to contact the CMHC in the new area. The member would be asked to change his or her eligibility to that area, but services would be authorized by CHN until eligibility changed. He stated that CHN could pay for services in another area indefinitely, and that there is nothing that requires the member to change their eligibility area.

Call 2 (Saturday): J said she would go ahead and get therapy started and let the BHOs sort it out later.

Call 2 (repeated) (CWMHC): D said she was unsure whether they would be able to schedule the caller until he or she completed the Medicaid change or the program director approved scheduling the case. D added that if it was an emergency, clinicians would see the member under the emergency billing code until Medicaid is straightened out. D stated that if the need was routine, she would check with the coverage specialist (insurance person) or the program director, but she said she probably could not schedule until the Medicaid was straightened out.

Call 3: A (CHP) said that she would assess for safety and see if the matter was urgent or emergent. Otherwise, she would check the State system to determine the member's county of eligibility, and refer the member back to his or her BHO to see where in CHP's area the BHO would authorize the member to be seen. A said that she would encourage the member to call back if he or she had problems, and she could call the BHO for them if necessary. B (Telluride) said that he would schedule the individual and get an authorization from the other BHO.

Call 4: D (CHP) said that referrals would be given for providers in the member's area, and that CHP would authorize four or five sessions initially to give the member time to get the Medicaid changed. A (PPMHC) said she would go ahead and schedule the appointment, then ask the member to contact Medicaid to change the address.

Telephone Assessment Worksheet 2

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Colorado Health Partnerships Telephone number called: 1-800-804-5008 (During the recall HSAG was referred to CWMHC, 970-824-6541, and was given name and number for a private licensed professional counselor [LPC])

Date of call: Saturday, January 12, 2008 (recall); Monday, January 28, 2008
Time of call: 3 p.m. (recall), 12:30 p.m.

Caller: Barbara McConnell

Name of person answering the phone: J, A (repeated call)

Offered name: X Had to ask name: _____

Notes:
Saturday: J was very professional.

Repeated call: A was very professional and helpful each time. (This was the second time the HSAG caller had spoken with A). Since this was the second call that A had answered, the HSAG caller asked for a referral to a provider CMHC (rather than ask A the questions again). A gave the HSAG caller the number for CWMHC.

A reminded the HSAG caller that before referring the caller on to the providers, A would check for safety indicators.

Person assigned to help or transferred to: CWMHC—spoke to D

Offered name: X Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Saturday: All

Repeated call: D indicated that Colorado West is very rural and that they have satellite offices in Steamboat, Hayden, Rifle, Rangely, Meeker, Walden, and Grandby to accommodate.

Specific questions for the second call:

1. *What would you tell an elderly man if he called to request outpatient counseling (for depression) and indicated that he has both Medicare and Medicaid, but cannot find a Medicare provider? (This man is not in a facility. He either lives independently or with family.)*

   Saturday: J explained that she was unable to search the system by therapists who are Medicare providers in outlying areas; however, she did have a list of some Medicare providers in Colorado Springs. J said she would get the member's name and offer to call other areas (CMHCs) and see if they could provide lists.

   Repeated call: D stated that Colorado West has a Medicare-approved provider with whom she could schedule.

2. *Would the answer given above change if this man was in a wheelchair?*

   Saturday: J said she would probably refer the caller to the nearest CMHC as the CMHCs are wheelchair accessible and can bill Medicare.

   Repeated call: D said her answer would not change, that the CMHC is wheelchair accessible. In fact, D added that some remodeling was taking place to increase the number of wheelchair-accessible restrooms.

3. *What would a host home provider need to do to obtain services for an adult with Down's syndrome who is a resident of a host home and who has had behavioral changes recently that staff members of the community-centered board are interpreting as signs of depression?*

   Saturday: J would recommend the CMHC, as few private providers are able to deal with the dual diagnosis.

   Repeated call: D indicated that she would get the information from the caller and would have to call the program director. D indicated that Horizons is a service agency for individuals with developmental disabilities and could refer there, but indicated that Horizons was probably not covered under the BHO payment. (She wasn't sure how Horizons would be paid.) She said she could not schedule an appointment with a developmentally disabled individual until the program director approved it.

Telephone Assessment Worksheet 3

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Colorado Health Partnerships Telephone number called: CHP Access Line (1-800-804-5008), then referred to Midwestern Mental Health Center at Telluride (970-728-6303)

Date of call: Wednesday, January 23, 2008 Time of call: 9:30 a.m.

Caller: Barbara McConnell

Name of person answering the phone: A

Offered name: X Had to ask name: _____

Notes:

Person assigned to help or transferred to: Telluride—B

Offered name: X Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

All

Specific questions for the third call:

1. *What is the procedure for alternative care facilities (ACFs) to obtain services for their residents?*

   B (Telluride) indicated that for Medicaid members it would be like any other intake. He stated that CHP either refers to a private therapist or the CMHC, depending on the needs and preferences of the caller. He said that they could offer a provider who would travel and see the member on-site (at the facility), similar to the procedure for nursing home residents, if transportation is a problem.

2. *How would you (the BHO) respond if a Medicaid member called and said his or her family member (e.g., son, daughter, spouse, etc.) was having the following symptoms:*
   - *Spending more time alone*
   - *Exhibiting agitation and anxiety when he or she is around people*
   - *Crying frequently*
   - *Making statements of feeling worthless*
   - *Making statements that he or she should be punished (either for something specific or nonspecific)*
   - *Not eating or sleeping*
   - *Not doing the things he or she used to do*

   (Note to caller: The above is a list of classic warning signs that a person may be at risk for suicide. The purpose of this question is to determine if the BHO would assess for suicide risk if these symptoms are reported, even if the caller does not specifically mention suicide.)

   B (Telluride) stated that this depends on the age of the person. If it is an adult there may be issues related to the Health Insurance Portability and Accountability Act of 1996, so B stated that he would ask if he could talk to the person. Either way, he would assess the safety level and try to get enough detail to determine if there is a potential for suicide. This would at least be an urgent call. He stated that he would determine if the member could get to the CMHC safely or if the police needed to be called for transport to the emergency room. He stated that he would stay on the line until the police arrived, if they were called.

Telephone Assessment Worksheet 4

At the beginning of the call identify yourself as an HSAG employee calling on behalf of the Colorado Department of Health Care Policy & Financing for the purpose of assessing the BHO's access system and processes. If the staff member asks about HSAG you may briefly explain the EQRO processes, but quickly continue the call.

Make sure that the staff member you speak to understands that you are assessing Medicaid processes, so any of the potential clients you may be discussing would be eligible for Medicaid.

BHO: Colorado Health Partnerships Telephone number called: 1-800-804-5008, then PPMHC (719-572-6100)

Date of call: Tuesday, January 29, 2008 Time of call: 4 p.m.

Caller: Barbara McConnell

Name of person answering the phone: D

Offered name: X Had to ask name: _____

Notes:

The HSAG caller asked questions of D then took referral to PPMHC.

Person assigned to help or transferred to: PPMHC—spoke to A

Offered name: X Had to ask name: _____

Notes:

Does this BHO (or the CMHC) provide services in an urban, rural, or frontier area?

Urban

Specific questions for the fourth call:

1. *What is the procedure if a Medicaid member calls and urgently requests medication? The member may have been on medication from a private provider or might be from another state, but is new to Medicaid eligibility and has not yet received services from the BHO.*

   D (CHP) indicated that if the matter was urgent and medications were needed, the CMHC would be the best option. He stated that if the call had been an after-hours call he would refer the caller to the CMHC crisis line or to the hospital for evaluation.

   A (PPMHC) indicated that she would first ask the caller if he or she was suicidal or homicidal. If not, she would offer an appointment within seven days. She looked at the schedule and indicated that there was an urgent opening with a prescriber for "tomorrow."

2. *How would a member who was recently released from a psychiatric hospital (and who has not previously received psychiatric services from this BHO) obtain outpatient services?*

   The member will need medication within seven days.

   Can outpatient therapy services and provision of the medication/prescription be handled with the same initial appointment?

   D (CHP) stated that for patients recently released from the hospital he would recommend the CMHC first because the CMHCs tend to have more types of services available for folks with chronic or severe diagnoses. He indicated that he would suggest that the member call back if he or she decided that the CMHC was not the right option for the member.

   A (PPMHC) stated that she would make the appointment for the intake and if medications were needed (as assessed by the therapist) an appointment with a prescriber could be made within the first three sessions with the therapist. If the matter was urgent, A stated that the medication appointment could be quicker (based on need).

Appendix C. Record Review Worksheet
for Colorado Health Partnerships, LLC

The completed record review worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

The goal of this record review is to identify and describe specific documentation that provides evidence of ongoing communication between the psychiatrist or nurse prescriber and the parents, therapist/care coordinator/case manager, and/or the primary care physician (PCP) regarding a child who has received services through the BHO.

Documentation to be reviewed: Therapist and physician/prescriber progress notes, specific forms used for documentation of service planning meetings, or other pertinent documentation regularly used by the BHO to document ongoing communication with family members or the PCP.

Member ID: Sample 1	Encounter Reference Date: May 21, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/14/07	Medical Progress Note	DO	Father	Unknown	Telephone Call	Yes

Content of Documentation (Brief Description):

This note documented that the father reported an increase in symptoms and a decrease in sedation. Also discussed was the child's response to medications. The provider changed the medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/21/07	Medical Progress Note	DO	Father	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note indicated that the father reported that the child was too sedated, so he had decreased the medications on his own. The note also indicated a discussion of how the child was doing at home and at school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/31/07	Medical Progress Note	DO	Mother	Unknown	Telephone Call	Yes

Content of Documentation (Brief Description):

This note indicated that the mother reported an increase in disturbing symptoms and behaviors to the doctor. The doctor suggested that the child restart medications. The mother was worried about whether the child had another diagnosis.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/1/07	Progress Note	LPC	Parent	LPC	Letter	No

Content of Documentation (Brief Description):

The progress note stated that the parent was sent a letter requesting that the parent contact the LPC to schedule therapy.

HSAG HEALTH SERVICES ADVISORY GROUP

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Record Review Worksheet

Member ID: Sample 2	Encounter Reference Date: June 27, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/7/07	Clinical Progress Note	MA	Mother	N/A	Therapy	Yes

Content of Documentation (Brief Description):

This note documented a discussion regarding medication changes, symptoms, summer plans, and goals.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/07/07	Medical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

The note documented a discussion about the child's symptoms, response to medications, and the child's decreased sleeping. The note also indicated that they discussed medication options.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/27/07	Clinical Progress Note	MA	Mother	N/A	Therapy	Yes

Content of Documentation (Brief Description):

This note documented that the mother reported decreased symptoms since starting medications. The note also documented a discussion regarding the child's progress in therapy.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/27/07	Medical Progress Note	MD	Adoptive Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note also documented a discussion regarding the child's response to medications, symptoms, increased sleeping, and decreased appetite. They discussed changing the current treatment plan.

Member ID: Sample 3	Encounter Reference Date: March 13, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/13/07	Case Management Note	LPC	Father	LPC	Telephone Call	No

Content of Documentation (Brief Description):

This note documented a discussion about the child's mood instability and behavioral goals.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/13/07	Clinical Progress Note	LPC	Unknown	N/A	Therapy	No

Content of Documentation (Brief Description):

This note contained documentation of the events of the therapy session. The note did not indicate if a parent was present (teenager).

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/13/07	Medical Progress Note	MD	Father	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note indicated that they discussed symptoms, response to medications, behavior, decreased compliance with therapy, difficulty in school, the purpose of the medications, and the potential side effects.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/14/07	Case Management Note	LPC	Therapist	Case Manager	Telephone Call	No

Content of Documentation (Brief Description):

The note documented a discussion between the case manager and the therapist about the child's progress, the appropriateness of the goals, and anger management.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/19/07	Case Management Note	LPC	Father	LPC	Telephone Call	No

Content of Documentation (Brief Description):

The progress note documented a discussion of the child's progress to date, response to therapy, and concerns about behavior at home. The family reported that they are looking into a therapeutic ranch. The note indicated that they reassessed the treatment plan.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/21/07	Clinical Progress Note	LPC	Father	LPC	Therapy	No

Content of Documentation (Brief Description):

The note documented a discussion about the child's progress toward goals, anger management, coping skills, compliance with expectations at home, and behavior at school.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/26/07	Case Management Note	LPC	Father	LPC	Telephone Call	Yes

Content of Documentation (Brief Description):

The note documented a discussion about the child's response to treatment and the adequacy of current treatment goals. The discussion also included the child's response to medications and a decrease in symptoms.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/27/07	Clinical Progress Note	LPC	Father	N/A	Therapy	No

Content of Documentation (Brief Description):

The note documented a discussion of coping skills, self-monitoring, and anger management.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/29/07	Case Management Note	LPC	Father	N/A	Case Management Visit	Yes

Content of Documentation (Brief Description):

The note documented a discussion regarding the child's response to therapy. The note indicated that the child was responding well to medications and reported no side effects. The note also documented plans for the child to attend a therapeutic ranch.

Member ID: Sample 4	Encounter Reference Date: May 30, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/1/07	Progress Note	LPC	Unknown	N/A	Therapy	N/A

Content of Documentation (Brief Description):

This note documented a therapy session, but included no indication of communication with the family. There was no documentation of the primary therapist having discussions with the family during the reference period.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/17/07	Medical Progress Note	RN	Family	N/A	Face-to-face	No

Content of Documentation (Brief Description):

The family reported no side effects of medication.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
5/30/07	Medical Progress Note	PA	Unknown	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note indicated that the client discussed symptoms and response to medication. The physician assistant (PA) recommended that the client see a PCP for back pain. It was unclear if anyone was present with the client (17-year-old).

Member ID: Sample 5	Encounter Reference Date: March 12, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/22/07	Progress Note	Case Manager	Mother	N/A	Case Management	Yes

Content of Documentation (Brief Description):

The note indicated that the case manager met with the mother and child prior to the medication management appointment. The documentation included a discussion of how the child was doing in school. The family was encouraged to restart therapy. The record indicated that this was a medication-only case at the time.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/22/07	Medication Assessment	MD	Adoptive Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented a medication intake/psychiatric assessment. The discussion included history, symptoms, diagnosis, and the need for medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/12/07	Medical Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The documentation indicated that the mother and other family members were present. The discussion included medication and the family dynamics.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/29/07	Case Management	FNP	Mother	N/A	Case Management	Yes

Content of Documentation (Brief Description):

This note documented a discussion of case management goals and how the child was responding to medications.

Member ID: Sample 6	Encounter Reference Date: June 29, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/29/07	Medical Progress Note	DO	Grandmother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note documented a discussion regarding the child's mood and behaviors, that the child was sleeping and eating well, and a discussion about closing the case.

Member ID: Sample 7	Encounter Reference Date: March 22, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/1/07	Clinical Progress Note	MA	Family	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented a discussion about family issues with respect to communication and boundaries.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/15/07	Clinical Progress Note	MA	Family	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented a discussion about communication issues and tension in the family.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/22/07	Clinical Progress Note	MA	Family	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented discussion of communication issues and family abuse issues.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/22/07	Medical Progress Note	DO	Adoptive Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note indicated that the mother reported that the child was doing well at school and had decreased symptoms. The mother reported that the child stopped taking medications related to having low blood pressure.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/29/07	Clinical Progress Note	MA	Family	N/A	Therapy	No

Content of Documentation (Brief Description):

This note documented a discussion about family issues with respect to communication and boundaries.

Member ID: Sample 8	Encounter Reference Date: April 20, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
4/20/07	Progress Note	MD	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note documented a discussion with the biological mother regarding increased symptoms, response to medication, plans for medications, and a discussion of the how the child was doing in school. The note indicated that the child was doing poorly in school and that the child was in group therapy. There was no other communication with the family documented during the reference period.

Member ID: Sample 9	Encounter Reference Date: March 31, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
2/22/07	Progress Note	PA-C	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note indicated that the mother reported no side effects from the medication and that the child was doing well in school. The note also documented discussions regarding decreased behaviors, family relationships, continuing medications, and possible side effects of the medications.

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
3/31/07	Progress Note	PA	Mother	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note also indicated that the child was doing well in school and grades were up. They reported no side effects from the medications and no behavioral symptoms. The PA recommended that the child continue the medications.

Member ID: Sample 10	Encounter Reference Date: June 4, 2007
Reviewer Name: Barbara McConnell	Review Date: March 31, 2008

Date of Documentation	Type of Documentation	Credentials of Provider	Communication With	Who Initiated	Type of Contact	Medications Discussed
6/4/07	Progress Note	MD	Grandfather	N/A	Medication Management	Yes

Content of Documentation (Brief Description):

This note documented the medication management encounter referenced for the sample. The note documented plans for the family moving in with the grandparents and a discussion regarding how the child was doing in school and response to medications. This case was with an independently contracted psychiatrist. The record indicated that medication management was the only service this member received from CHP and that the member was seen only every three months by the psychiatrist.

Appendix D. Oversight and Monitoring of Providers Worksheet

for Colorado Health Partnerships, LLC

The oversight and monitoring of providers worksheet follows this cover page.

Colorado Department of Health Care Policy & Financing
Behavioral Health Organization (BHO)
Oversight and Monitoring of Providers Worksheet

The following questions were used to prompt discussion during the on-site portion of the review:

Does the BHO use member satisfaction data to improve the quality of services provided by community mental health centers (CMHCs) and the independent provider network (IPN)? If so, how?

Is member satisfaction information used by the BHO's CMHCs to identify staff training needs?

How does the BHO know whether mental health center staff receives appropriate: (a) supervision, (b) training, and (c) professional development/continuing education?

How does the BHO know that its CMHC providers have a culturally appropriate work force?

How does the BHO know that its provider network (CMHC and IPN) is adequately prepared (in training, skills, and competence) to work with the BHO's members (in terms of member diagnosis, age, etc.)?

Review of the CMHC's policies/procedures for training content to determine if CMHC policies are compliant with BHO policies (intake, grievance system, provider-member communication, advance directives, second opinion, etc.)?

Review of agendas or orientation curriculum and attendance records of the CMHC for compliance with BHO policies?

Review/audit of credentialing records to determine compliance with BHO policies?

Review of policies/procedures for clinical supervision?

Review of forms/tools used for provider supervision?

Provider profiling (reports or data)?

Review of data provided by the CMHC?

Data kept regarding cultural or linguistic competencies?

Review of percentage of Spanish-speaking members at each CMHC?

Utilization data per individual provider?

Trending grievance data?

Other?

How does the BHO ensure that CMHC providers are aware of, and in compliance with, the BHO's practice guidelines and grievance system and of any relevant policies and contract requirements (training completed, skills/certifications, completion of supervisory practices [performance reviews, etc.])?

How does the BHO ensure that the IPN is aware of, and in compliance with, the BHO's practice guidelines, grievance system, policies, and contract requirements?

How has the BHO evaluated the services provided by the CMHC for quality, appropriateness, and patient outcomes (including member satisfaction)?

Quality initiatives?

Chart reviews?

Other?

How has the BHO evaluated the services provided by independent contractors for quality, appropriateness, and patient outcomes (including member satisfaction)?

Has the BHO used complaint/grievance data in the category of professional conduct and competence to improve services provided? (If yes, how? If no, why?)

Appendix E. FY 06–07 Corrective Action Plan for Colorado Health Partnerships, LLC

The FY 06–07 corrective action plan with FY 07–08 findings and results follows this cover page.

Table E-1—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.	CHP's Management Services Agreement will be revised to specify processing of utilization review denials and member grievance activities performed by ValueOptions (VO) for CHP. **September 2007 HCPF/HSAG comments:** The agreement also must specify that VO processes appeals.	9/1/07	I3A_Management_Services_Agreement.pdf
Standard I: Delegation—FY 07–08 Document Review				
3.A. Content of Agreement specifies the activities Document(s) reviewed: ◆ The Colorado Health Partnerships, LLC, Management Services Agreement template Exhibit A of the Management Services Agreement template specified the activities delegated to VO, including processing member denials, grievances, and appeals. CHP staff reported that as of December 2007, the new agreements had been signed and executed. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	CHP's delegation agreements will be revised to specify the reporting responsibilities of the delegates related to distribution of member materials by VO and grievance and appeal processing by VO and by the partner mental health centers. **September 2007 HCPF/HSAG comments:** The specific required actions identified through the site review were as follows: CHP must revise its delegation agreements to specify the reporting responsibilities of the delegates related to the delegated tasks of: 1) Distribution of required member materials by VO. 2) Grievance and appeal processing by VO. 3) Grievance processing by the partner mental health centers. As indicated in the third item above, at the time of HSAG's review, it appeared that CHP's mental health centers were	9/1/07	I3B_Member_Participation_Agreement.pdf See Also: I3A_Management_Services_Agreement.pdf

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
		processing grievances but not appeals. Unless this practice has changed within CHP, the mental health center delegation agreements should address grievance processing but not appeals processing.		
Standard I: Delegation—FY 07–08 Document Review				
3.B. Content of Agreement specifies the reporting responsibilities Document(s) reviewed: ◆ The Colorado Health Partnerships, LLC, Management Services Agreement template ◆ Member Participation Agreement Exhibit A of the Management Services Agreement specified VO's reporting responsibilities with respect to member denial, grievance, and appeal processing and distribution of member materials. Section 2.10 of the Member Participation Agreement addressed the CMHC's responsibilities related to reporting of grievance processing. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	CHP will develop written procedures related to the delegation of administrative responsibilities under the contract to include CHP's procedures for monitoring the performance of delegates on an ongoing basis. **September 2007 HCPF/HSAG comments:** CHP should provide more details about the revised procedures that will be implemented to monitor subcontracts on an ongoing basis.	9/1/07	I4A_B_CHP_Delegation_Monitoring_Review.pdf I4A_B_Attachment A.pdf

Standard I: Delegation—FY 07–08 Document Review

4.A. Contractor has written policies and procedures for monitoring the performance of subcontractors on an ongoing basis

Document(s) reviewed:

- Policy 105, Colorado Health Partnerships, LLC, Delegation Oversight and Monitoring (including Attachment A to the policy)

The Delegation Oversight and Monitoring Policy included the procedures for monitoring and evaluating the performance of delegates. Attachment A to the policy listed the ongoing reports VO is required to submit to CHP. This required action has been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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 administrative responsibilities under that contract, which must include written procedures for monitoring the performance of delegates through formal review.	CHP will develop written procedures related to the delegation of administrative responsibilities under the contract to include CHP's procedures for monitoring the performance of delegates through a formal review. **September 2007 HCPF/HSAG comments:** CHP should provide more details about the revised procedures that will be implemented to monitor subcontracts through formal review.	9/1/07	I4A_B_CHP_Delegation_Monitoring_Review.pdf I4A_B_Attachment A.pdf

Standard I: Delegation—FY 07–08 Document Review

4.B. Contractor has written policies and procedures for monitoring the performance of subcontractors through formal review

Document(s) reviewed:

- Policy 105, Colorado Health Partnerships, LLC, Delegation Oversight and Monitoring

The Delegation Oversight and Monitoring Policy included procedures for an annual on-site visit to monitor the performance of delegates. CHP staff reported that implementation of this revised policy occurred in December 2007. This required action has been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	CHP will include in the written monitoring procedure a process for monitoring provider network development and management, credentialing and recredentialing, grievances and appeals processing, the processing of utilization review (UR) denials, and distribution of required member materials delegated to VO, as well as grievance processing by the partner CMHCs. **September 2007 HCPF/HSAG comments:** CHP should provide more details about the planned monitoring activities and procedures—in particular, how CHP will monitor each of these delegated services for quality.	9/1/07	I5A_CHP_QM_Delegation_Monitoring.pdf See also: I5A_CHP_OCFA.pdf I5A_CHP_grievances.pdf I5A_CHP_appeals.pdf I5A_CHP_clinical.pdf I5A_CHP_finance_delegation.pdf I5A_CHP_medical_delegation.pdf I5B_CHP_IT_Reporting.pdf X2_CHP_Provider_Network_Development.pdf X8_CHP_Credentialing_pdf X8_Cred Stds Monitoring Attch A.pdf CHP Cred File Aud Tool Attch B.xcl IV1A_CHP_Member_Materials_Distribution.pdf
Standard I: Delegation—FY 07–08 Document Review				
5.A. Contractor monitors services for quality Document(s) reviewed: ◆ Colorado Health Partnerships, LLC, Medical Functions Delegation policy ◆ Colorado Health Partnerships, LLC, Provider/Practitioner Credentialing and Recredentialing Delegation policy with Attachment A—template for monitoring credentialing and recredentialing ◆ Colorado Health Partnerships, LLC, Practitioner/Provider Standards and Network Adequacy Delegation policy ◆ Colorado Health Partnerships, LLC, Member Materials Distribution Delegation policy ◆ Colorado Health Partnerships, LLC, Quality Management Delegation policy				

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
◆ Colorado Health Partnerships, LLC, Grievance Delegation policy ◆ Colorado Health Partnerships, LLC, Office of Consumer and Family Affairs Delegation policy ◆ Colorado Health Partnerships, LLC, Finance Function Delegation policy The policies provided for review included procedures for monitoring all delegated functions, whether delegated to the CMHCs or VO. Delegated functions included provider network management; credentialing and recredentialing; utilization management; processing of member grievances, denials, and appeals; Colorado Client Assessment Record (CCAR) and encounter data submission; distribution of required member materials; and maintenance of the quality assessment and performance improvement (QAPI) program by VO, as well as processing member grievances by partner CMHCs. Each of the policies described the process for monitoring the quality of the administrative services VO provided for CHP. CHP staff reported that these were new policies for CHP and that they have been approved by the Board with an effective date and implementation date of December 2007. CHP also provided completed audit forms. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	CHP will include in the written monitoring procedure the process for monitoring data reporting for each delegated service/function. The process will include monitoring data reporting for provider network development and management, credentialing and recredentialing, the processing of UR denials, and distribution of required materials delegated to VO. **September 2007 HCPF/HSAG comments:** CHP should provide more details about the planned monitoring activities and procedures—in particular, how CHP will monitor each of these delegated services for data reporting.	9/1/07	I4A_B_CHP_Delegation_Monitoring_Review.pdf I4A_B_Attachment A.pdf

Standard I: Delegation—FY 07–08 Document Review

5.B. Contractor monitors services for data reporting

Document(s) reviewed:

- Colorado Health Partnerships, LLC, Medical Functions Delegation policy
- Colorado Health Partnerships, LLC, Provider/Practitioner Credentialing and Recredentialing Delegation policy with Attachment A—template for monitoring credentialing and recredentialing
- Colorado Health Partnerships, LLC, Practitioner/Provider Standards and Network Adequacy Delegation policy
- Colorado Health Partnerships, LLC, Member Materials Distribution Delegation policy
- Colorado Health Partnerships, LLC, Quality Management Delegation policy

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
◆ Colorado Health Partnerships, LLC, Grievance Delegation policy ◆ Colorado Health Partnerships, LLC, Office of Consumer and Family Affairs Delegation policy ◆ Colorado Health Partnerships, LLC, Finance Function Delegation policy Each of the policies described CHP's process for monitoring data reporting by VO either to CHP or to the Department on behalf of CHP. This required action has been completed.				

Table E-1—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.	Listed below are several references on the Information System Capabilities and Assessment Tool (ISCAT) that reflect regular auditing that is completed on the encounter data files and claims processing systems (which include automated edits) and that ensure all required fields are valid, complete, and accurate. CHP completes audits on these data files regularly. In the case of encounter data, a report is also provided to the CMHCs detailing any errors identified through CHP's automated data validation program. An example of this report was provided during the performance measure data validation site visit in January. Please see the following sections of the ISCAT form CHP submitted for details of this audit process: ◆ I.G General description ◆ III.6. Error correction ◆ III.12 and 13, Validation edit process—also, the BHO encounter edit list, which was submitted with the	Due date for the FY07 Encounter/Claims Audit	II_12_Chart_Testing_Template.pdf *Completed audit will be submitted by November's due date.

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
		ISCAT ◆ III.17 Verifying completeness ◆ III.18 Regular audits ◆ III.20 Codes and fields edited using automated system ◆ III.22 & 23 Claims reviews/pend process ◆ III.24 Report card identifying variances ◆ III.25b Data validation prior to submission ◆ III.25h & 25i Validation processing/auditing ◆ III.26 Performance monitoring standards and actual results It is CHP's interpretation that the CAP requires actual documentation showing that an audit meeting the specifications listed above be performed for the 411 records selected for the audit. This documentation will be included along with the audit results verifying the presence of medical record documentation.		

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
		September 2007 HCPF/HSAG comments: This intervention is not responsive to the required action. A description of routine business practices on the ISCAT does not relieve CHP from conducting a review of a statistically valid sample of encounter claims as required by the BHO contract, which states on page 49: **Encounter Claims Data for Medicaid Management Information System Submissions** b) The contractor shall take necessary measures to ensure the: (i) Accuracy of all required fields. (ii) Completeness of encounter claims data submitted. (iii) Presence of medical record documentation and each encounter claim. (iv) Submitted data includes paid and denied claims identified in this section of the contract.		

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
		(v) Submitted data excludes duplicate paid claims. (vi) Submitted data includes the most current version of adjusted claims. c) The contractor shall review compliance with these criteria each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department. Please revise this intervention to reflect these requirements. On an annual basis, a sample of 411 claims/encounters will be audited. The audit will include a review of criteria specified in the BHO contract for compliance. See attached template for required elements.		

Standard II: Provider Issues—FY 07–08 Document Review

12. Statistically Valid Sampling

Documents Reviewed:

- CHP's reports of the statistically valid sample of encounter records

The reports demonstrated that CHP reviewed a statistically valid sample of encounter records for compliance with each of the Medicaid contract requirements. This required action has been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	Revise each CMHC's member rights statements to be consistent with the listing of CHP rights and responsibilities Clarify CHP policy on member materials development and distribution to articulate the provider's role in dissemination of these materials. **September 2007 HCPF/HSAG comments:** Please explain how CHP will ensure that consumers receive information that is consistent with member rights and responsibilities. Also, CHP should indicate the specific roles of CHP, VO, the mental health centers and other providers in ensuring that Medicaid members receive consistent information about their rights and identify the new policies, procedures and practices that will be delineated in the revised policy.	8.31.07 7.31.07	IV1A_CHP_Member_Materials_Distribution.pdf See also: IV3_Member_Rights_Poster_English.pdf I5A_CHP_OCFA.pdf

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard IV: Member Rights and Responsibilities—FY 07–08 Document Review				
1.A. 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 receive information about his/her rights. Document(s) reviewed: ◆ Colorado Health Partnerships, LLC, Member Materials Distribution Delegation policy ◆ Member Rights and Responsibilities poster ◆ Policy 304—Member Rights and Responsibilities ◆ Colorado Health Partnerships, LLC, Office of Consumer and Family Affairs Delegation policy ◆ Member handbook The Office of Consumer and Family Affairs Delegation policy described the role of CHP's delegate, VO, in developing and maintaining member materials. The CHP member handbook and the CHP member rights poster contained all member rights as required by the Medicaid contract. These required actions have been completed.				

Table E-1—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.	Revise member rights materials to ensure that member responsibilities are consistent among all member materials. **September 2007 HCPF/HSAG comments:** Please note that during the site review HSAG discovered that some mental health centers were using old or additional materials. While the required action refers to consistency of materials provided to consumers, staff, and providers, the planned intervention refers only to member materials. Please identify the materials that will be revised, the planned distribution, and the process for ensuring that the revised materials are used by the centers.	7.31.07	IV1A_CHP_Member_Materials_Distribution.pdf IV3_304L.pdf See Documents listed below for revisions: IV3_Member_Handbook.pdf IV3_Member_Rights_Poster_English.pdf

Standard IV: Member Rights and Responsibilities—FY 07–08 Document Review

3. Member Responsibilities

Document(s) reviewed:

- Colorado Health Partnerships, LLC, Member Materials Distribution Delegation policy
- Member Rights and Responsibilities poster
- Policy 304—Member Rights and Responsibilities
- Member handbook

The member handbook, the member rights poster, and the Member Rights and Responsibilities policy each contained the member responsibilities explained in a consumer-friendly manner. This required action has been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	Include a statement about educating staff, providers, and the community on advance directives in the current CHP policy and procedure. **September 2007 HCPF/HSAG comments:** Please also provide details regarding the procedures that CHP will use to educate staff, providers, and the community about advance directives.	6.30.07	IV5A_Advance_Directives_P&P.pdf
Standard IV: Member Rights and Responsibilities—FY 07–08 Document Review				
5.A. The contractor has written policies and procedures for advance directives Document(s) reviewed: ◆ Policy 269L—Advance Directives The Advance Directives policy described the processes for providing education about advance directives to members, providers, and the community. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	Policies and procedures 203L, 303L, and 305L will be updated with the most stringent guidelines between the URAC and Medicaid standards by which CHP must abide. **September 2007 HCPF/HSAG comments:** Plan accepted. However, in addressing requirements of both URAC and Medicaid, CHP's UM program description and policies must comply with Medicaid regulations, which may be more strict than those of URAC. Please submit the revised appeals policy that reflects these changes.	9/1/07	VI1B_203L.pdf VIB_303L.pdf VIB_305L_pdf
Standard VI: Utilization Management—FY 07–08 Document Review				
1.B. The UM program includes written policies and procedures Document(s) reviewed: ◆ Policy 203L—Medical Necessity Determination, Lack of Information, and Notification Timelines ◆ Policy 303L—Peer Advisor Adverse Determinations ◆ Policy 305L—Clinical Appeal Process This required action continues. Policy 203L—Medical Necessity Determination, Lack of Information, and Notification Timelines contained language that was not in compliance with Balanced Budget Act of 1997 (BBA) requirements regarding emergency services and authorization processes. CHP must revise the policy to include language that is consistent with Medicaid managed care (BBA) requirements.				

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	One record was out of compliance due to the URAC/Medicaid standard time frame confusion. The policies and procedures related to UR denial decisions will be updated to be consistent. **September 2007 HCPF/HSAG comments:** Also state how CHP has ensured that the individual(s) responsible for the late notice of action has been made aware of the required timelines and indicate how CHP will monitor adherence to this policy.	9/1/07	VI7_Team_Mtg_Minutes_021507.pdf

Standard VI: Utilization Management—FY 07–08 Document Review

7. Record Review—Denials

Document(s) reviewed:

- UM action/appeal log printout

During the FY 07–08 site review, the UM action/appeal log demonstrated that CHP monitored the timeliness of notices of actions and that the notices were sent within the required time frames. This required action has been completed.

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	Training will be provided to all staff members handling grievances about grievances involving clinical issues and the associated documentation required. Staff will continue to use either grievance resolution letters to document the clinical person's expertise or will send additional documentation (i.e., grievance forms) to show the grievance was reviewed by a person with the qualifications to do so. **September 2007 HCPF/HSAG comments:** It is not necessary to inform the consumer of the credentials of the person making the clinical grievance decision. CHP must describe how it will ensure that the person resolving the grievance is appropriately trained and how this will be tracked. **Colorado Health Network (CHN) Update:** Advocacy staff handling grievances was trained on the	9/1/07	IX7_OCFA_Minutes_0307.pdf IX71_Grievance_exmp1.pdf IX72_Grievance_exmp2.pdf

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
		grievance process. During this training, advocates were informed of the need to involve clinical staff persons, or persons with necessary expertise, in deciding the grievance resolution. Two examples of grievance notes were attached to show the involvement of persons with necessary expertise in resolving grievances. This information will be tracked through the BHO. A database modification is planned for December 2007.		
Standard IX: Grievances, Appeals, and Fair Hearings—FY 07–08 Document Review				
7. Record Review—Grievances Document(s) reviewed: ◆ Minutes—OCFA team meeting ◆ Two examples of grievance documentation ◆ Grievance Process policy The Grievance Process policy had been revised and indicated that the letter sent to members must contain the credentials of the individual who made the decision. Examples reviewed on-site during the FY 07–08 site review indicated that the letters contained the credentials of the individuals who made the decisions. This required action has been completed.				

Table E-1—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.	CHP will develop policies and procedures that specify the criteria and mechanism for credentialing and recredentialing licensed independent practitioners. CHP will include in the policy the requirements for annual review of the delegate's policies and procedures and monitoring of the credentialing and recredentialing process. **September 2007 HCPF/HSAG comments:** Plan **a**ccepted. To clarify, please note that the National Committee for Quality Assurance (NCQA) requires BHOs to have their own credentialing policies separate from the credentialing policies and procedures of delegates such as VO.	9/1/07	X2_CHP_Provider_Network_Development.pdf X8_CHP_Credentialing_pdf X8_Cred Stds Monitoring Attch A.pdf
Standard X: Credentialing—FY 07–08 Document Review				
2. Written policies and procedures Document(s) reviewed: ◆ CHP Credentialing policy The Credentialing policy included CHP's responsibilities and what was required of its delegate, VO. This required action has been completed.				

Table E-1—FY 06–07 Corrective Action Plan *for* CHP				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
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.	CHP will develop written policies and procedures specifying the criteria for the initial and ongoing assessment of organizational providers. CHP will include in the policy the requirements for annual review of the delegate's policies and procedures and monitoring of the credentialing and recredentialing processes. **September 2007 HCPF/HSAG comments:** Plan accepted. To clarify, please note that NCQA requires BHOs to have their own credentialing policies separate from the credentialing policies and procedures of delegates such as VO.	9/1/07	X8_CHP_Credentialing_pdf X8_Cred Stds Monitoring Attch A.pdf CHP Cred File Aud Tool Attch B.xcl

Standard X: Credentialing—FY 07–08 Document Review

8. Requirements for Credentialing Policies for Organizational Providers

Document(s) reviewed:

- CHP Credentialing policy

The Credentialing policy included all requirements for the assessment of organizational providers. This required action has been completed.

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

Table F–1 lists the participants in the FY 07–08 site review of **CHP**.

Table F–1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
CHP Participants	**Title**
Gerald Albrent	Director of Quality Management, Pikes Peak Mental Health Center (PPMHC)
Barb Archuleta	Chief Compliance Officer, Spanish Peaks Mental Health Center (SPMHC)
Erica Arnold-Miller	Director of Quality Management, Colorado Health Network (CHN)
Sheila Bowlin	Administrative Assistant
Michelle Denman	Operations Manager, CHN
Stephen Dixon	Clinical Director, CHN
Haline Grublak	Office of Consumer and Family Affairs, CHN
Alex Hale	Call Center Manager, CHN
Gary Hill	Health Information Manager, PPMHC
Steve Holsenbeck, MD	Medical Director, CHN
Chris Jacobson	Quality Management Specialist, CHN
Tina McCrory	Chief Financial Officer, CHN
Arnold Salazar	Chief Executive Officer, CHN
Maggie Tilley	Compliance, CHN
Cheryl Watson	Utilization Manager, PPMHC
Department Observers	**Title**
Katie Brookler	Quality Improvement Manager
Marceil Case	Contract Manager

Appendix G. Corrective Action Plan Process for FY 07–08 for Colorado Health Partnerships, LLC

CHP is required to submit to the Department a corrective action plan for all components scored as *In Partial Compliance* or *Not In Compliance*. The corrective action plan with supporting documents must be submitted within 30 days of receipt of the final report. For each element that requires correction, the plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion.

Table G-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a corrective action plan to the Department within 30 calendar days of receipt of the final EQR site review report via the file transfer protocol (FTP) site with an accompanying e-mail notification regarding the posting. For each of the components receiving a score of *In Partial Compliance* or *Not In Compliance*, the corrective action plan must address the planned intervention(s) to complete the required actions and the timeline(s) for the intervention(s).
Step 2	**Documents submitted with the corrective action plan**
	The BHOs should complete the required actions and submit documentation substantiating the completion of all required corrective actions.
Step 3	**Prior approval for timelines exceeding 30 days**
	If the BHO plans to complete the required action later than 30 days following the receipt of the final report, it must obtain prior approval from the Department in writing.
Step 4	**Progress reports may be required**
	For any planned interventions receiving an extended due date beyond 30 days following receipt of the final report, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements in the corrective action plan.
Step 5	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the corrective action plan and supporting documentation, the Department will inform the BHO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements, or (2) the BHO must submit additional documentation. The Department 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.

The template for the corrective action plan follows.

Table G-2—FY 07–08 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
1. Access to Care				
2. Coordination of Care				
3. Oversight and Monitoring of Providers				
4. Member Information				
5. Review of Corrective Action Plans and Supporting Documentation				

Appendix H. Compliance Monitoring Review Activities for Colorado Health Partnerships, LLC

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

Table H–1—Compliance Monitoring Review Activities Performed

For this step,	HSAG…
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff provided an orientation at the B-QuIC meeting on November 27, 2007, for the BHO and the Department to preview the FY 07–08 compliance monitoring review process and to allow the BHOs to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives responded to questions from the BHO related to the process and federal managed care regulations to ensure that the BHO was prepared for the compliance monitoring review. HSAG maintained contact with the BHO as needed throughout the process and provided information to key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the BHO's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the FY 07–08 BHO contract to develop HSAG's monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The BHO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the five components. ◆ Documents requested included applicable policies and procedures, minutes of key BHO committee or other group meetings, reports, logs, and other documentation. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

Table H–1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
Activity 4:	**Conducted Interviews**
	Prior to the on-site portion of the review: ◆ HSAG conducted interviews of Medicaid members who had received or requested to receive services from the BHO. ◆ HSAG conducted telephone assessments of the BHO's access processes. During the on-site portion of the review: ◆ HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	During the on-site portion of the review: ◆ HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document, i.e., the original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents that HSAG needed during its desk audit. ◆ HSAG requested and reviewed additional documents that HSAG needed to review during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	Following the on-site portion of the review: ◆ HSAG met with BHO staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 07–08 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions to be required of the BHO to achieve full compliance with managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 07–08 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG coordinated with the Department to incorporate the BHO's comments and finalize the report. ◆ HSAG distributed the final report to the BHO and the Department.