Colorado Medicaid
Community Mental Health Services Program

FY 2008–2009 Site Review Report

for

Colorado Health Partnerships, LLC

May 2009

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 2008–2009 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 fifth year that HSAG has performed compliance monitoring reviews of the BHOs. For the fiscal year (FY) 2008–2009 site review process, the Department requested a focused review of four areas of performance.[1-1] HSAG developed a review strategy consisting of four components for review, which corresponded with the four performance areas identified by the Department. These were: Member Information (Component 1), Notices of Action (Component 2), Appeals (Component 3), and Underutilization (Component 4). Compliance with federal regulations and contract requirements was evaluated through review of the four components. This report documents results of the FY 2008–2009 site review activities for the review period of July 1, 2007, through June 30 2008. 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. Completed data collection tools for each component are found in the appendices. In addition, HSAG has included an overview of **Colorado Health Partnerships, LLC** (**CHP**) follow-up activities and status regarding the corrective actions that were required as a result of the FY 2007–2008 compliance site review.

In developing the data collection tools and in reviewing the four 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 F).

[1-1] The Department developed these performance areas through surveys of participants from the Medicaid Mental Health Advisory Committee (MHAC) and the Medicaid Mental Health Planning and Advisory Council (MHPAC). The Department developed MHAC to exchange information and identify, evaluate, and communicate issues related to the Colorado Medicaid Community Mental Health Services Program. MHPAC was created as a result of federal laws passed in 1986 and 1992, which require states and territories to perform mental health planning in order to receive federal Mental Health Block Grant funds (Sections 1911–1920 of the Public Health Service [PHS] Act [42 USC 300x-1 through 300x-9] and Sections 1941–1956 of the PHS Act [42 USC 300x-51 through 300x-66]).

Objective of the Site Review

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

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

Summary of Results

HSAG assigned each element within the components in the Compliance Monitoring Tool a score of *Met, Partially Met, Not Met, Not Applicable,* or *Not Scored*. *Not Scored* was used when materials had been previously reviewed and approved by the Department as meeting requirements, but minor revisions would enhance the clarity or compliance of the materials. HSAG assigned each element within the record review tools a score of *Met, Partially Met, Not Met,* or *Not Applicable.* Based on the results from the Compliance Monitoring Tool, the record review scores, and conclusions drawn from the review activities, HSAG assigned each component of the review an overall score of *In Compliance*, *In Partial Compliance,* or *Not In Compliance.* HSAG assigned required actions to any individual element within the Compliance Monitoring Tool or the record reviews receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for enhancement for some components, regardless of the score. While HSAG provided recommendations for enhancement of BHO processes based on these identified opportunities for improvement, they do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **CHP** for each of the components. Details of the findings for each component follow in subsequent sections of this report.

Table 1-1—Summary of Scores for the Components

Component #	Description of Component	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable or Not Scored*	Score (% of *Met* Elements)
1	Member Information	25	23	23	0	0	2	100%
2	Notices of Action	9	8	4	3	1	1	50%
	Notices of Action Record Review	50	40	38	0	2	10	95%
3	Appeals	23	22	16	4	2	1	73%
	Appeals Record Review	21	19	19	0	0	2	100%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**132**	**116**	**104**	**7**	**5**	**16**	**90%**

Table 1-2 presents the overall score for **CHP** for each of the components.

Table 1-2—Results	
Component	**Overall Score**
Component 1—Member Information	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 2—Notices of Action	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*
Component 3—Appeals	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*
Component 4—Underutilization	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and all member informational materials and templates used by the BHO during the review period. While on-site, HSAG reviewed additional documentation and interviewed key BHO personnel. Details of the findings for Component 1 follow in Appendix A—Component 1.

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

CHP had an effective mechanism for ensuring that the BHO mailed the required information within one month of **CHP**'s notification of enrollment. Mailings occurred monthly. **CHP**'s materials were available in Spanish, large print, and audio format. **CHP**'s community mental health centers (CMHCs) had a teletype/telecommunications (TTY/TTD) device for people who are deaf or hard of hearing. For oral interpretation services, **CHP** used contracted interpreters, the language line, or bilingual staff members available at some of the CMHC sites. The member handbook informed members that interpretation services were available free of charge. **CHP** mailed a letter annually, informing members that they may request information about **CHP** and may receive another member handbook. While the member handbook included all of the requirements, there were some areas that represented opportunities for improvement for **CHP**. The member handbook informed members that they may choose their provider; however, **CHP** may also consider specifically informing members of the process for changing providers, upon members' request. The member handbook included the requirements and time frames for filing appeals related to the denial or limited authorization of a requested service; however, the handbook did not contain the requirements and time frames for filing appeals related to the termination, suspension, or reduction of a previously authorized service.

Summary of Strengths

CHP's advance directives materials included all of the required content. **CHP**'s benefits section in the member handbook was easy to understand. In addition, Office of Consumer and Family Affairs (OCFA) representatives from each CMHC had frequent contact with the **CHP** director of consumer and family affairs. **CHP** also informed members of alternative formats for written materials in several ways.

Summary of Required Actions

There were no corrective actions required for this component.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation, interviewed key BHO personnel, and conducted a record review of documentation associated with completed notices of action.

For the record review, a sample of 10 actions with an oversample of 5 actions was selected from all Medicaid member actions sent by **CHP** during the review period. The oversample was used if 1 or more action records was deemed not applicable or was not available during the on-site review. A total of 10 records were reviewed for the timeliness and content of the documentation related to notices of action. (The entire sample was reviewed if the BHO had fewer than 10 notices of action sent during the review period.) Details of the findings for Component 2 follow in Appendix A—Component 2.

Summary of Findings and Opportunities for Improvement

Overall score: In Partial Compliance

CHP had a mechanism for placing appropriate limits on services only for utilization control, and ensuring that medically necessary services were provided in an amount, duration, and scope needed to achieve the purpose for which they were provided. **CHP**'s utilization management (UM) program included a process for sending notices of action when services were denied, terminated, reduced, or authorized in an amount, duration, or scope that was less than requested. The UM policies and procedures included most of the required provisions.

Notice-of-Action Record Review Summary

HSAG reviewed a sample of 10 notice-of-action records. All notices were sent within the required time frame for the type of notice. The number of days to make the decision and send the notice of action ranged from the notice being sent the same day as the request for service (six notices were sent the same day) to nine days to make the decision and send the notice. The average was 1.5 days. A qualified clinician, who had not been involved in a previous level of review, made all the decisions. While notices were sent on the Department-approved template, the template included check boxes for the type of action and only included two types of actions. As a result, members were sent notices containing incorrect information. In addition, members who would not qualify for continuation of benefits (the action was not a termination of previously authorized services) were sent the template containing information about how to request continuation of services. While the BHO was not out of compliance for this, it resulted in a potentially confusing letter.

Summary of Strengths

CHP's documentation system for UM and tracking denials and appeals contained complete descriptions of communication and decision-making processes. There was evidence that authorization decisions were based on medical necessity. The record review also demonstrated that individuals making determinations adverse to members were individuals who had appropriate expertise and were not involved in a previous level of review.

Summary of Required Actions

CHP's definition of action was incomplete and did not include two types of action. **CHP** must revise applicable policies and other documents, such as member materials, to include an accurate and complete definition of action.

Notices of action sent to members were not easy to understand. While the reason for the decision was easy to understand, the manner in which the template letters were used (the same letter was sent regardless of the type of denial or specific circumstance) resulted in notices that included information that did not apply to the member and could result in significant confusion. **CHP** must ensure that each notice of action sent to a member is easy to understand.

In the Clinical Appeal Process policy, time frames for mailing notices of action and language regarding the continuation of benefits was inaccurately placed in the section of the policy that addressed the appeal resolution notice. **CHP** must review and revise all applicable policies to ensure accurate time frames for mailing notices of action and notices of appeal resolution, and include the requirements and time frames for continuation of benefits during the appeal and State fair hearing processes.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation, interviewed key BHO personnel, and conducted a record review of documentation associated with Medicaid member appeals.

For the record review, a sample of 10 appeals with an oversample of 5 appeals was requested. **CHP** submitted 3 records. (The entire sample of 3 appeal records was reviewed since the BHO had fewer than 10 appeals during the review period.) Details of the findings for Component 3 follow in Appendix A—Component 3.

Summary of Findings and Opportunities for Improvement

Overall Score: In Partial Compliance

CHP had an established process that allowed members access to the **CHP** appeal process and the State fair hearing process. **CHP**'s policies, member materials, and provider materials indicated that members and authorized representatives may file orally or in writing. The member handbook, however, did not clarify that oral requests must be followed by a written request. **CHP** should await the Department's clarification regarding this requirement and ensure that materials reflect the appropriate information. **CHP** provided information about the appeal and State fair hearing processes to members in the member handbook, and to providers via the provider manual. **CHP** policies and templates included most of the requirements. While the member handbook included the BBA definition of appeal, **CHP**'s policy and provider manual did not. **CHP** may consider including the definition of appeal in policies and provider materials. **CHP** policies and member materials indicated that members did not need to exhaust the **CHP** appeal process before requesting a State fair hearing; however, the member handbook contained language encouraging members to complete their **CHP** appeal before requesting a State fair hearing. Given the limited time frame for requesting a State fair hearing and the BHO's time frames for resolution and notice, members may miss the deadline for requesting a hearing while waiting to complete the appeal process. **CHP** may consider removing this language from the member handbook.

Appeals Record Review Summary

CHP reported three appeals during the review period. Two appeals were filed using the standard time frame, and acknowledgment letters were sent within two working days. The third request was expedited, so an acknowledgment letter was not required. The member who filed the expedited request also requested an extended time frame. The three appeal files met all time frame

requirements. All three resolution notices included the required content and were written in an easy-to-understand format.

Two appeals were filed orally and one appeal was made via e-mail. Two of the files contained evidence of reasonable assistance. The third request was very articulate, giving the HSAG reviewer reason to believe that assistance from **CHP** was not required, nor requested. Decisions on two appeals were in favor of the member and one appeal decision upheld the original decision to deny services based on lack of medical necessity (the original denial offered therapy options at a different level of service).

For each record reviewed, the original denial decisions were made by Dr. D.; however, Dr. H. signed the notices of action. The letters mailed to the members did not indicate who made the decisions. Furthermore, because the same physician (Dr. H.) signed all three original denials and all three appeal resolution letters, members may conclude that the same physician made all the decisions. Because the BBA requires that the person making the decision on an appeal not be involved in any previous level of review, HSAG suggests that **CHP** consider adding information to the letters or revising practices to avoid the appearance that the same individual decided both the original denial and the appeal. In addition, the new clinical director indicated that during the year she may be consulting the medical director regarding denials (the medical director typically makes appeal decisions). **CHP** may consider tracking cases on which the medical director consulted to ensure that the medical director was not involved (even if the final decision was not his) in the denial decision for appeals.

The resolution letters for appeals that were decided in favor of the member contained State fair hearing rights. **CHP** may consider removing this language from letters that inform members of a decision in their favor since these members are not entitled to a State fair hearing. The BBA specifically requires this language for decisions not wholly in favor of the member.

Summary of Strengths

CHP's appeal records included evidence that **CHP** provided assistance to members in filing appeals and during the appeal process. All required time frames were met as evidenced by the on-site review of appeal records. The record review also demonstrated that **CHP** had an expedited process and used an extension to allow a member to obtain additional information for review.

Summary of Required Actions

CHP's Clinical Appeal Process policy indicated that members did not have access to the State fair hearing process if the provider requested the appeal. **CHP** must clarify its applicable policies to ensure members' access to the State fair hearing process.

CHP's Clinical Appeal Process policy had misplaced language that resulted in incorrect and incomplete information regarding the timing of notices of action (including extension time frames), continuation of benefits during the appeal and State fair hearing processes, and notices of appeal resolution. **CHP** must review and revise all applicable policies (and member materials) to ensure that the BHO provides accurate time frames for sending notices of action and notices of appeal

resolution, and to provide complete information regarding continuation of benefits during the appeal or State fair hearing processes.

While the expedited appeal record that was reviewed clearly contained documentation that oral notice of the resolution was given to the member, **CHP**'s policy did not include reasonable efforts to provide oral notice of resolution for expedited appeals. **CHP** must revise applicable policies to reflect compliance with BBA requirements regarding oral notice for expedited appeals, and to be consistent with **CHP**'s practices.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation and interviewed key BHO personnel. Details of the findings for Component 4 follow in Appendix A—Component 4.

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

CHP used a variety of reports printed from the UM system and quality improvement (QI) projects to identify over- and underutilization. Trends were discussed in the Quality of Care Committee meetings. Trends were evaluated by top diagnosis, treatment type, and provider (organizational providers vs. providers in the external provider network). Trending was performed for both authorized services (outpatient services provided by external providers and intensive levels of care) and nonauthorized services (emergency, case management, medication management, psychotherapy, and vocational services).

Summary of Strengths

CHP had initiated a performance improvement project to evaluate and impact the penetration rate for members 60 years of age and older. Specific studies analyzed emergency services and compared emergency utilization data to utilization data for other treatments and member-specific data to identify trends.

Summary of Required Actions

There were no corrective actions required for this component.

6. Follow-up on FY 2007–2008 Corrective Action Plan

for Colorado Health Partnerships, LLC

Methodology

As a follow-up to the FY 2007–2008 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all components for which it received a score of *In Partial Compliance* or *Not In Compliance*. The plan was to include interventions to achieve compliance and the timeline associated with those activities. 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 2007–2008 compliance monitoring site review, or until the time of the on-site portion of the BHO's FY 2008–2009 site review.

Summary of FY 2007–2008 Required Actions

As a result of the FY 2007–2008 site review, **CHP** was required to revise its Medical Necessity Determination, Lack of Information, and Notification Timelines policy to ensure that the policy is in compliance with all Medicaid managed care regulations and the Colorado BHO Medicaid contract.

CHP submitted a corrective action plan and supporting documentation to HSAG in August 2008.

Summary of Findings

CHP revised its Policy 203L—Medical Necessity Determination, Lack of Information, and Notification Timelines to include time frames for UM determinations and clearly state that urgent and emergent services are provided within the time frames specified in the Colorado Medicaid contract. While the time frames in the policy were either URAC or BBA time frames, the most stringent of the applicable time frames was used. The policy, therefore, was compliant with the BBA (Medicaid managed care regulations).

Summary of Required Actions

CHP successfully completed the FY 2007–2008 required actions. There were no required actions continued from FY 2007–2008.

The completed compliance monitoring tool follows this cover page.

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(3) Contract: II.G.d.g & II.G.d.h	1. The Contractor provides all members the required information (see below) within a reasonable time after the BHO receives notice of enrollment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP's Member Information Requirements policy stated that members would be provided the required information within a reasonable time frame. CHP staff members explained that CHP's policy is to send welcome packets within 30 days of receiving eligibility information from the Department (on the first Monday of each month). The welcome packet included a member handbook, a provider directory, the enrollment letter, and a Health Insurance Portability and Accountability Act (HIPAA) policy letter. Staff members stated that the data file used for the monthly mailing was retained for 18 months in case CHP needed to verify individual mailings or addresses.	
	Required Actions: None	
Contract: II.G.d.b	2. The Contractor has a mechanism to help members and potential members understand the requirements and benefits of the plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP used its enrollment letter, member handbook, and Web site to offer members and potential members help understanding the requirements and benefits of the plan. CHP's enrollment letter briefly described some of the services available to Medicaid members and offered a toll-free telephone number that members could call for more information. The member handbook also offered a toll-free number and informed members that the OCFA is available to help members access and understand the benefits to which they are entitled. Information about OCFA was also on CHP's Web site. CHP staff members described several in-person methods used to distribute the member handbook and discuss the benefits (outreach to board-and-care homes in the service areas, presentations at National Alliance on Mental Illness [NAMI] meetings, and distribution at Department of Social Services offices and public health departments). CHP staff stated that CHP staff members met monthly with OCFA advocates from each of the CMHCs to ensure that they understood roles and processes so that they could help members understand the State plan benefits.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(b)(1)&(3) 42CFR438.10(d) Contract: II.G.d.a; II.G.d.c; & II.G.d.d	3. The Contractor provides all enrollment notices, informational materials (handbooks, newsletters, directories), and instructional materials (health education, grievance system notices) in a manner and format that may be easily understood: ◆ In the prevalent non-English language. ◆ In alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Member Information Requirements policy stated that it is CHP's policy to provide all enrollee materials in a manner and format that is easy to understand. CHP provided several examples of member information written in Spanish and a member handbook in large print.	
	Required Actions: None	
42CFR438.10(c)(4)&(5) Contract: II.G.d.c; II.G.d.e; & II.G.d.f	4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Member Information Requirements policy stated that verbal interpretation into any language is available to members free of charge. Members were informed of the availability of interpreter services free of charge via the member handbook. The member handbook also provided members a toll-free telephone number to request interpretation services. A member's right to interpretation services is repeated on member rights posters, which are printed in English and Spanish and posted at all provider sites (as reported by CHP staff).	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(c)(5) Contract: II.G.d.f	5. The Contractor notifies members that written information is available for prevalent non-English languages and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP members were informed through the enrollment letter and the member handbook that written materials are available in Spanish. Members were reminded of this right in the annual letter.	
	Required Actions: None	
42CFR438.10(d)(2) Contract: II.G.d.f	6. The Contractor notifies members that written information is available in alternative formats and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP's enrollment letter and member handbook informed members that written information is available in large print and audio formats and informed members that they could obtain alternative formats by calling a toll-free number. Members were reminded of the availability of alternative formats via the annual letter.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(2) Contract: II.G.d.k	7. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information (42CFR438.10), upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP members were mailed an annual letter in April 2008. This letter reminded members of the contents of the member handbook and gave members a telephone number they could call to receive a copy of the handbook and provider directory. CHP staff members confirmed that this letter was mailed annually.	
	Required Actions: None	
42CFR438.10(f)(4) Contract: II.G.d.i	8. The Contractor gives written notice of any significant change in information to members at least 30 days before the intended effective date of the change.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP's member handbook informed members that they will be told about any significant changes at least 30 days before the effective date of the change. CHP staff reported that were no examples of significant changes during the review period.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(5) Contract: II.G.d.j	9. The Contractor makes a good-faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who is receiving or has received in the last six months his or her primary mental health care from, or was seen on a regular basis by, the terminated provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP's member handbook informed members that CHP makes an effort to give written notice of terminated contracted providers within 15 days after the receipt of issuance of the notice. CHP's provider manual informed providers that members have the right to be informed if a provider stops seeing clients or changes services. CHP staff members stated that the CMHCs were responsible for notifying members of any change in providers. CHP's contractor audit tool demonstrated that CHP monitors CMHC providers to ensure this was being done. Staff members stated that CHP provides notice if contracted providers terminate or are terminated. Staff provided an example of a notice that had been sent February 17, 1009 (the letter was within the 15-day requirement).	
	Required Actions: None	
42CFR438.10(f) Contract: II.G.d.g.	10. Member information materials include: ◆ Names, locations, and telephone numbers of, and non-English languages spoken by, current contracted providers, including identification of providers who are not accepting new patients. ◆ Any restrictions on freedom of choice among network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The CHP provider directory included the name, location, telephone numbers of, and languages spoken by contracted providers, and identified which providers were not accepting new patients. CHP's member handbook contained names, locations, and addresses of the CMHCs and satellite CMHCs in the CHP's service areas. The member handbook indicated that there were no restrictions on a member's choice of network providers. The directories were mailed to new enrollees and were available on the CHP Web site. While the member handbook addressed how to choose among network providers, CHP may consider describing the procedure for changing providers.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f) Contract: II.G.d.g	11. Member information materials include: ◆ Member rights as specified in 42CFR438.100. ◆ Additional member rights that include the right to: ▪ Have an independent advocate. ▪ Request that a specific provider be considered for inclusion in the network. ▪ Receive a second opinion. ▪ Receive culturally appropriate and competent services from participating providers. ▪ Receive interpreter services for members with communication difficulties or for non-English-speaking members. ▪ Prompt notification of termination or changes in services or providers. ▪ Express an opinion about the Contractor's services to regulatory agencies, legislative bodies, or the media without the Contractor causing any adverse effects upon the provision of covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP employed a variety of methods to inform members of their rights, including the enrollment letter, member handbook, Web site, and posters prominently located at all provider sites. Each of these methods included a complete list of rights. The CHP annual on-site audit of the CMHCs included a section for CHP to ensure that member rights posters are visible at each CMHC.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	12. Member information regarding the grievance, appeal, and fair hearing procedures have been approved by the Department and include: ◆ The right to file grievances. ◆ The right to file appeals. ◆ The right to a State fair hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP provided a letter from the Department dated June 15, 2005, stating that enrollee materials were reviewed for compliance with 42 CFR 438.10 (among other sections) and approved for distribution. Staff reported that the handbook being distributed (revised in 2008) included only minor changes (telephone numbers, corrected typos) from the 2005 handbook. The member handbook included the required information about grievances, appeals, and State fair hearings. CHP had also developed a separate Grievance and Appeal brochure that included information about grievances, appeals, and State fair hearings.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	13. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The requirements and time frames for filing grievances and appeals. ◆ The method for obtaining a State fair hearing. ◆ The rules that govern representation at a State fair hearing.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: CHP used its member handbook and grievance brochures to inform members of their rights regarding grievances, appeals, and State fair hearings. The member handbook included the requirements and time frames for filing grievances and appeals, and for State fair hearings. The grievance brochure did not include the 20-day time frame during which grievances must be filed; however, the timelines were included for filing appeals and for State fair hearings related to the denial or limited authorization of services. Neither document addressed the requirements and time frames for filing an appeal related to the termination, suspension, or reduction of a previously authorized service. Both documents instructed members on how to request a grievance, appeal, and State fair hearing and stated that members could choose someone to file an appeal on his or her behalf. CHP may consider revising member materials to include the requirements and time frames for filing an appeal related to the termination, suspension, or reduction of a previously authorized service and to make all materials related to the grievance system consistent.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	14. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The CHP member handbook explicitly offered members several options for obtaining assistance with filing grievances and appeals. The member handbook included several telephone numbers, including toll-free and TTY/TTD numbers that can be used to ask for help. This information was also included in the denial letters and in the grievance and appeal brochures, which CHP staff members stated are available in provider waiting rooms and drop-in centers.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	15. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The member handbook, the grievance brochure, and the denial letter template all described the circumstances under which members could request that benefits continue during the appeal process, and the circumstances under which the member may be required to pay for those services. However, the time frame for filing a request for continued benefits was incorrect, and the requirements associated with the request for continued benefits was incomplete. CHP may consider revising member materials to reflect accurate and complete information related to continuation of benefits (42 CFR 438.420).	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	16. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook informed members that a provider can file an appeal on behalf of a member (including an appeal to the office of administrative courts) if the member gives written consent.	
	Required Actions: None	
42CFR438.10(f)(6) Contract: II.G.d.g	17. Information provided to members includes: ◆ The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. ◆ Procedures for obtaining benefits, including authorization requirements. ◆ The extent to which and how members may obtain benefits from out-of-network providers. ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract, including any cost-sharing and how transportation is provided.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The CHP member handbook included a list of covered benefits and gave examples of optional services offered at the CMHCs. The member handbook also encouraged members to call Medicaid Customer Service with questions about benefits. The member handbook offered several options for obtaining benefits and explained the extent to which members may obtain benefits from out-of-network providers. CHP's member handbook provided members information regarding how to obtain benefits available under the State plan but not covered by CHP, including how to obtain transportation services.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(6) Contract: II.G.d.g	18. Information provided to members includes: ◆ The extent to which and how after-hours and emergency coverage are provided, including: ▪ What constitutes an emergency medical condition, emergency services, and poststabilization services with reference to the definitions in 42 CFR 438.114(a). ▪ The fact that prior authorization is not required for emergency services. ▪ The process and procedures for obtaining emergency and poststabilization services, including the use of the 911 telephone system or its local equivalent. ▪ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services. ▪ The fact that the member has the right to use any hospital or other setting for emergency care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: CHP informed its members that emergency care is available 24 hours a day, 7 days a week, in the enrollment letter and the member handbook. Members were given five options to receive emergency care, including calling 911. The member handbook's definition of an emergency medical condition and poststabilization services was consistent with BBA language. The member handbook clearly stated that these services do not require preauthorization. Although the member handbook included a list of emergency settings, it also informed members that emergency services could be obtained at any hospital.	
	Required Actions: None	
42CFR438.10 Contract: II.G.d.g	19. Information provided to members includes policies on referral for specialty care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Choice of Providers section of the member handbook explained that CHP would arrange a referral for specialty care if the care was determined to be necessary.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 42CFR438.6(I)(2) 42CFR422.128 Contract: II.G.d.g	20. Member information regarding advance directives for adult members includes: ◆ The member's right to formulate advance directives. ◆ The member's rights under the State law to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State agency. ◆ The Contractor's policies regarding implementation of advance directives, which must include: ▪ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. ▪ The difference between institution-wide conscientious objections and those raised by individual physicians. ▪ Identification of the State legal authority permitting such objection. ▪ Description of the range of medical conditions or procedures affected by the conscientious objection. ▪ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. ▪ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. ▪ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ▪ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. ▪ Provisions for ensuring compliance with State laws regarding advance directives. ▪ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ▪ Provisions for the education of staff concerning its policies and procedures on advance directives. ▪ Provisions for community education regarding advance directives that includes:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	• What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. • A description of applicable state law concerning advance directives.	
	Findings: The member handbook informed members of their right to formulate advance directives and their right to make decisions regarding medical care. The member handbook also informed members that if the State law changed regarding advance directives, CHP would notify members of that change. CHP's member handbook included an address and telephone number where members could file a complaint if they felt a provider was not following his or her advance directive. CHP's advance directive policy included the provision to indicate whether the member had an advance directive in the member's record. The CHP on-site audit tool for evaluating CMHC compliance included a section to evaluate the CMHCs' adherence to advance directive policies. Additional information regarding advance directives was available to members in a brochure available at the CMHCs and to members and other community members on CHP's Web site.	
	Required Actions: None	
Contract: II.G.d.h	21. Information provided to members includes: ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members. ◆ Notice that the member has been enrolled in the Community Mental Health Services Program operated by the Contractor, and that enrollment is mandatory. ◆ The Contractor's hours of operation. ◆ That assistance is available through the Medicaid Managed Care Ombudsman Program and how to access ombudsman services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The CHP member handbook clearly presented the fact that no fees may be assessed for covered mental health services. The member handbook also included the CHP's and the CMHCs' hours of operation. The enrollment letter included information regarding mandatory enrollment and the Medicaid Ombudsman Program.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
Contract: II.G.d.h	22. Information provided to members includes: ◆ Appointment standards for routine, urgent, and emergency situations. ◆ Procedures for requesting a second opinion. ◆ Procedures for requesting accommodations for special needs, including written materials in alternative formats. ◆ Procedures for arranging transportation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook included appointment standards, procedures for requesting second opinions, accommodations for special needs, and arranging transportation.	
	Required Actions:	
42CFR438.10 Contract: II.G.d.h	23. Information provided to members includes: ◆ Information on how members will be notified of any changes in services or service delivery sites. ◆ Procedures for requesting information about the Contractor's Quality Improvement Program. ◆ Information on any member and/or family advisory boards the Contractor may have in place.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook stated that CHP would mail a letter to members to inform them of any changes in services or service delivery sites. The member handbook provided telephone numbers members could call to request information regarding CHP's quality program and about consumer advisory boards.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 Contract: II.G.d.g	24. Additional information that is available upon request: ◆ Physician incentive plans	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook stated that CHP providers do not have incentive plans.	
	Required Actions: None	
42CFR438.10 Contract: II.G.d.g	25. Information that must be made available annually and upon request: ◆ Information on the structure and operation of the Contractor ◆ The Contractor's service area ◆ The benefits covered under the contract ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members ◆ To the extent available, quality and performance indicators, including enrollee satisfaction	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook informed members that they could request information on the structure and operations of CHP. The member handbook also included a list of counties served by CHP and a list of benefits covered under the plan and stated that there is no co-pay for any services provided under the plan. Members were given a telephone number to call for more information about the quality program. The member handbook stated that members would be mailed a letter at least annually notifying them of their right to request the information provided in the handbook. CHP provided a copy of the annual letter, dated April 2008, which instructed members on how to obtain a copy of the member handbook.	
	Required Actions: None	

Results for Member Information							
Total	Met	=	23	X	1.00	=	23
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	2	X	N/A	=	N/A
Total Applicable		=	23	**Total Score**		=	23

Total Score ÷ Total Applicable	=	100%

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.400(b) Contract: Exhibit G—8.209.2	1. The Contractor defines action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: CHP's definition was incomplete. "The denial, in whole or in part, of payment for a requested service" was missing from CHP's definition in policies and in the member handbook. In addition, CHP's definition in the Grievance Process policy included "the failure to act within the timeframes provided below" (with no time frames listed in the same or next section of the policy), instead of "the failure to provide services in a timely manner" and "the failure to act within the time frames for resolution of grievances and appeals." The member handbook included "failure of provider to act within approved timeframes" instead of "the failure to provide services in a timely manner" and "the failure to act within the time frames for resolution of grievances and appeals." Neither the Appeals Process policy nor the Clinical Appeals policy included a definition of "action."	
	Required Actions: CHP must revise applicable policies and other documents to include an accurate and complete definition of action.	
42CFR438.404(a) Contract: Exhibit G—8.209.4.A.1	2. Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The notice-of-action template was written in language that was easy to understand; however, as the templates were applied and used for specific member situations, the notices of action actually sent were confusing. Notices of action were sent to members that included information about continuing benefits (services) when the requirements were not met and the member would not be eligible to request continued services.	
	Required Actions: CHP must ensure that each notice of action sent to members is easy to understand. CHP may consider developing additional templates that apply to other notice situations.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.404(b) Contract: Exhibit G—8.209.4.A.2	3. Notices of action must contain: ◆ The action the Contractor has taken or intends to take. ◆ The reasons for the action. ◆ The member's (and provider's on behalf of the member) right to file an appeal and how to do so. ◆ The member's right to request a State fair hearing and how to do so. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that. ◆ The circumstances under which the member may have to pay for the costs of services if continued benefits are requested.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The notice-of-action template letters addressed all of the required information: however, some of the information was incorrectly addressed. In practice, CHP's notice-of-action template letter included only two choices for checking the action taken. As a result, notice-of-action letters sent to members contained incorrect information. Two actions reviewed during the on-site record review (that were retroactive reviews and denials of payment for services that had been received by the member) stated that the action taken was a denial of treatment. This was inaccurate and potentially confusing to members. The letter also contained an incorrect time frame for filing an appeal and requesting continued benefits. In addition, the notice of action indicated that members may only request expedited appeals if the appeal is related to services already being received. While CHP's letters had addressed each of the requirements in some way, CHP may want to develop a mechanism to ensure that notices of action contain complete and accurate information.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.3	4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within 10 calendar days, on the date the time frames expire ◆ For expedited service authorization decisions, within three days	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: Neither the Medical Necessity Determination, Lack of Information, and Notification Timelines policy nor the Clinical Appeal Process policy included the time frame for mailing notices of action related to standard and expedited service authorization decisions for the denial or limited authorization of a requested service. The on-site record review contained no notices of action related to the termination, suspension, or reduction of previously authorized services. The time frames required for notices of action regarding termination, suspension, or reduction of a previously authorized service were found in the Clinical Appeal Process policy as the time frames required for mailing the appeal resolution notice.	
	Required Actions: CHP must revise its applicable policies and processes to ensure that notices of action related to the termination, suspension, or reduction of previously authorized services are sent within the required time frames.	
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.4	5. If the Contractor extends the time frame for authorization decisions (see Standard I) it provides the member: ◆ Written notice of the reason for the decision to extend the time frame. ◆ The right to file a grievance if the member disagrees with the decision. ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy included language about notification to members if CHP extended the time frame for making authorization decisions; however, the language was inappropriately placed within a section that addressed the mailing of the resolution notice. This language also indicated that the member had appeal rights (rather than the right to file a grievance) if the member disagreed with the decision to extend the time frame. There were no examples in the on-site record review of CHP extending the time frame for authorization decisions. The Medical Necessity Determination, Lack of Information, and Notification Timelines policy did not address extension of time frames for making authorization decisions.	
	Required Actions: CHP must revise its applicable policies to accurately address the time frames for extension of authorization decisions.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(a)(3)(ii) Contract: II.J.a..d.2	6. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medical Necessity Determination, Lack of Information, and Notification Timelines policy stated that all determinations are based on medical necessity and if a service is determined to be medically necessary, it is authorized. In addition, CHP used a specific set of level-of-care guidelines. On-site review of denial and appeal records demonstrated that denial decisions were not arbitrary. The on-site review of notice-of-action records included no actions for denials of service based only on diagnosis or condition (i.e., a developmental disability). Instead, most of the actions were based on lack of medical necessity. CHP staff reported that the executive director had received no direct calls related to denials of service to developmentally disabled individuals and that any complaints regarding that issue would be processed using the grievance system.	
	Required Actions: None	
42CFR438.210(a)(3)(iii) Contract: II.J.a.d.3	7. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medical Necessity Determination, Lack of Information, and Notification Timelines policy indicated that the only review criterion is medical necessity. The policy defined medically necessary services as those services intended to prevent, diagnose, care for, alleviate, or preclude deterioration of a diagnosable condition, and that are expected to improve a condition. On-site review of denial and appeal records demonstrated that decisions were made using the clinical information provided. Review of UM reports demonstrated that CHP reviewed data to ensure that the amount and duration of services indicated appropriate utilization control and appropriate outcomes.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(b)(3) Contract: II.J.a.f	8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Peer Advisor Adverse Determinations policy stated that if the clinical care manager has concerns about medical necessity, the case is referred to a peer advisor, defined as a professional with qualifications that are equal to the requesting provider or an MD/DO. The peer advisor makes the final determination if the case is not initially approved by the care/case manager.	
	Required Actions: The on-site review of denial records indicated that denial and limited authorization decisions were made by a clinical psychologist or a medical director who had not been involved in the team treating and making service plan decisions for the member.	
42CFR438.210(c) Contract: II.J.a.h	9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. (Notice to the provider does not need to be in writing.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Medical Necessity Determination, Lack of Information, and Notification Timelines policy addressed telephone notification to providers and written notification to members. CHP staff members described the processes for member and provider notification of authorization decisions. Staff indicated that the outpatient authorization system was automated. Providers received initial authorization immediately when calling to request outpatient services, and they received immediate authorization from a call center staff member when requesting inpatient services. On-site review of denial records demonstrated that the provider and the member were notified in writing when services were denied or authorized in a limited scope, duration, or type.	
	Required Actions: None	

Results for Notices of Action							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	3	X	.00	=	0
	Not Met	=	1	X	.00	=	0
	Not Applicable or Not Scored	=	1	X	N/A	=	N/A
Total Applicable		=	8	**Total Score**		=	4

Total Score ÷ Total Applicable	=	50%

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(a) Contract: Exhibit G—8.209.1	1. The Contractor has a system in place that includes an appeal process and access to the State fair hearing process.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: Information regarding the appeal process and the State fair hearing process was in the provider manual and the member handbook. The Clinical Appeal Process policy included a description of the appeal process and the State fair hearing process. On-site reviews of denial and appeal records demonstrated that CHP had a process in place. However, page 6 of the Clinical Appeal Process policy indicated that members are not provided access to the State fair hearing process if the provider requested the appeal.	
	Required Actions: CHP must clarify its applicable policies to ensure members' access to the State fair hearing process.	
42CFR438.400(b) Contract: Exhibit G—8.209.2	2. The Contractor defines an appeal as a request for review of an action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The definition of appeal in the member handbook was consistent with the BBA definition. The Clinical Appeal Process policy and the provider manual did not contain a specific definition of appeal. CHP may consider including a definition of appeal in applicable policies and provider materials.	
	Required Actions: None	
42CFR438.402(b)(1) Contract: Exhibit G—8.209.1	3. The Contractor has provisions for who may file: ◆ A member may file a PIHP-level appeal and may request a State fair hearing. ◆ A provider, acting on behalf of a member and with the member's written consent, may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member. (The State permits the provider to act as the member's authorized representative.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy stated who may request an appeal. The provider manual and the member handbook included who may request an appeal and who may request a State fair hearing.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.F	4. The member may file an appeal either orally or in writing and must follow an oral request with a written request (unless the request is for expedited resolution).	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The Clinical Appeal Process policy stated that members may file appeals orally or in writing. The member handbook also provided members a choice of how they may file an appeal; however, the handbook did not inform members that they must follow an oral request for an appeal with a written request. The denial template letter, however, informed members that all oral requests must be confirmed in writing. The on-site review of appeal records demonstrated that members filed appeals orally. The three appeal records reviewed did not contain evidence of following oral appeals with written requests. The BBA requires that an oral request for an appeal be followed by a written request. The Department will send clarification to the BHOs regarding this requirement.	
	Required Actions: None	
42CFR438.402(b)(2) Contract: Exhibit G—8.209.4.B	5. An appeal may be filed 20 calendar days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy included the time frame for filing appeals (this time frame was related to the denial or limited authorization of a requested service). Members were informed via the member handbook and the denial (notice of action) letter. Providers were informed via the provider manual.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.N	6. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing 20 days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The denial template letter informed members of the right to ask for a State fair hearing without first asking CHP for an appeal. The Clinical Appeal Process policy indicated that the State fair hearing process may occur simultaneously with the appeal. The provider manual included the timeline for requesting a State fair hearing, but did not specifically state that members do not need to exhaust the internal appeal process before requesting a State fair hearing. While the member handbook informed members that they may request a State fair hearing anytime during the appeals process, it encouraged members to go through the CHP process first. While this language was not out of compliance, it may result in members missing the deadline for filing a request for a State fair hearing while they are waiting to complete the appeal process. CHP may consider removing this language from the member handbook.	
	Required Actions: None	
42CFR438.406(a) Contract: Exhibit G—8.209.4.C	7. In handling appeals, the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The denial letter offered "help with the appeal process," and provided the TTY/TTD number. The member handbook also offered assistance filing grievances or appeals.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.406(a) Contract: Exhibit G—8.209.4.D	8. The Contractor acknowledges each appeal in writing within two working days of receipt, unless expedited resolution is requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Members were informed of the time frame for acknowledgment of the appeal in the member handbook. The Clinical Appeal Process policy included the provision for acknowledging appeals within two working days. The on-site review of appeal files demonstrated that each of the standard appeals was acknowledged within two working days of the initial request for the appeal.	
	Required Actions: None	
42CFR438.406(a) Contract: Exhibit G—8.209.4.E	9. The Contractor ensures that the individuals who make decisions on appeals are individuals who: ◆ Were not involved in any previous level of review or decision making. ◆ Have the appropriate clinical expertise in treating the member's condition or disease if they are deciding an appeal of a denial based on lack of medical necessity or an appeal of a denial that involves any clinical issues.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy stated that appeals are reviewed by individuals who neither made the original decision nor are a subordinate of the person who made the original decision. The policy also stated that appeal decisions are made by peer advisors (defined as health professionals with an unrestricted license in the profession that is the same or similar to the original decision maker). While the on-site review of appeal records indicated that the clinical director made the denial decisions and the medical director generally made the appeal decisions (one appeal record was sent to ValueOptions corporate offices for decision), during the on-site interview, the new clinical director (new since these denial decisions were made) indicated that the medical director was available for consultation during decision making for denials. CHP may consider documenting consultations and any other involvement in decision making rather than just documenting who the final decision maker was to ensure that individuals making decisions on appeals were not involved in any previous level of review. Since the same physician signed both the denial and appeal resolution letters, CHP may consider naming the individuals involved in decision making in the letters. .	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.406(b) Contract: Exhibit G—8.209.4.G—I	10. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution. ◆ The member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents considered during the appeals process. ◆ That either of the following individuals are included as parties to the appeal: ▪ The member and his or her representative ▪ The legal representative of a deceased member's estate	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy and the member handbook indicated that appeals are accepted in person, in writing, or by telephone. Since the policy did not include that oral appeals must be followed by written requests, the policy did not delineate the difference between filing dates if there were both oral and written requests. The on-site record review indicated that oral requests are processed per the requirements. The Clinical Appeal Process policy, the provider manual, and the member handbook included information about processing appeals and informed members and providers of their right to present evidence and review medical records, and described who may be parties to the appeal.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(b)&(d) Contract: Exhibit G—8.209.4.J	11. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, 10 working days from the day the Contractor receives the appeal ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook informed members of the required time frames for resolution of appeals and for providing notice. The Clinical Appeal Process policy did not include the time frames for notifying members of the disposition of the appeal. The resolution notice section of the policy included the time frames for making authorization decisions (which were misplaced in the policy). Each of the three appeal records reviewed on-site included evidence of written notification to the member within the required time frame.	
	Required Actions: CHP must revise its applicable policies to reflect accurate time frames for resolving appeals and providing notice to the member.	
42CFR438.408(c) Contract: Exhibit G—8.209.4.K & 8.209.5.E	12. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if either: ◆ The member requests the extension. ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy included time frames for the extension of appeal decisions; however, one section of the policy indicated that the extension was related only to standard appeals and not to expedited appeals. In addition, this section contradicted an earlier section in the policy that did not indicate the option for an extension: "should the requested information not be received within the decision time frame, the appeal is conducted based on whatever information is available and a decision is rendered within appropriate timeframes." The Grievance Process policy addressed the extension of grievance resolution time frames. The member handbook informed members that CHP will send a letter if CHP needs more time; however, the handbook did not inform members that they may ask for more time. The on-site review of an expedited appeal demonstrated that the member (after asking for the expedited appeal) asked for additional time to provide clinical information, and was provided additional time.	
	Required Actions: CHP must revise applicable policies and member materials to include complete and accurate information regarding the extension of appeal resolution time frames.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(b)(3) Contract: Exhibit G—8.209.4.K & 8.209.5.E	13. If the Contractor extends the time frames, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the Clinical Appeal Process policy, the Grievance Process policy, and in the member handbook.	
	Required Actions: None	
42CFR438.408(d) Contract: Exhibit G—8.209.4.L	14. For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook stated that CHP would make reasonable efforts to provide oral notice of an expedited resolution. The on-site review of one expedited appeal included documentation of proving oral notice (a telephone call) to the member regarding the appeal decision. The Clinical Appeal Process policy did not address oral notice of resolution for expedited appeals.	
	Required Actions: CHP must revise applicable policies to reflect compliance with BBA requirements regarding oral notice for expedited appeals, and to be consistent with CHP practice.	
42CFR438.408(e) Contract: Exhibit G—8.209.4.M	15. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: ▪ The right to request a State fair hearing and how to do so. ▪ The right to request that benefits continue while the hearing is pending and how to make the request. ▪ That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy and the appeal resolution template letters (for decisions in favor and not in favor of the member)	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
	included the required language. CHP may consider removing the language regarding the State fair hearing and the right to request that benefits continue from the resolution letter in favor of the member.	
	Required Actions: None	
42CFR438.410 Contract: Exhibit G—8.209.4.P—R	16. The Contractor has an expedited review process for appeals when the Contractor determines or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes the following: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: ▪ Transfer the appeal to the time frame for standard resolution. ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two calendar days.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy stated that punitive action is not taken against a provider who requests an expedited resolution. The policy did not include provisions for the denial of a request for expedited resolution. During the on-site interview, CHP staff reported that CHP does not deny requests for expedited resolution. If members request an expedited resolution, CHP grants one. CHP may consider developing a process to deny an expedited resolution if a member's clinical situation does not qualify for expedited resolution.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.414 Contract: Exhibit G—8.209.3.B	17. The Contractor must provide the information about the grievance system specified in 42CFR438.10 to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The right to file grievances. ◆ The right to file appeals. ◆ The right to a State fair hearing. ◆ The requirements and time frames for filing grievances and appeals. ◆ The method for obtaining a State fair hearing. ◆ The rules that govern representation at the State fair hearing. ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone. ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for a State fair hearing is filed within the time frames specified for filing. ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending if the final decision is adverse to the member. ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provider, facility, and partnership agreements with the CMHCs incorporated the provider manual into the agreements. The provider manual included the required information regarding grievances and appeals.	
	Required Actions: None	
42CFR438.416 Contract: Exhibit G—8.209.3.C	18. The Contractor maintains records of all appeals and submits quarterly reports to the Department.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The on-site review of grievance, denial and appeal logs, quarterly reports, and individual case records of denial and appeal records demonstrated record-keeping that met requirements.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.420(b) Contract: Exhibit G—8.209.2 & 8.209.4.S	19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action ▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy did not accurately address continuation of benefits. This requirement language was inaccurately placed under the resolution letter time frames. The appeal record review contained no cases that involved the termination or suspension of services.	
	Required Actions: CHP must revise applicable policies and other applicable materials to describe the requirements for continuation of benefits during the appeal or State fair hearing processes.	
42CFR438.420(c) Contract: Exhibit G—8.209.4.T	20. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal ◆ Ten days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached ◆ A State fair hearing officer issues a hearing decision adverse to the member ◆ The time period or service limits of a previously authorized service has been met	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
	Findings: The Clinical Appeal Process policy did not accurately address continuation of benefits. This requirement language was inaccurately placed under the resolution letter time frames. The appeal record review contained no cases that involved the termination or suspension of services. The member handbook did not address how long benefits would continue. The notice of action and appeal resolution letters also did not inform members of how long benefits may continue.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
	Required Actions: CHP must revise applicable policies and other applicable materials to describe how long benefits may continue if requested by the member during an appeal or State fair hearing.	
42CFR438.420(d) Contract: Exhibit G—8.209.4.U	21. If the final resolution of the appeal is adverse to the member—that is, it upholds the Contractor's action—the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this rule.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The required provision was found in the Clinical Appeal Process policy. There were no examples of this type of appeal during the review period.	
	Required Actions: None	
42CFR438.424 Contract: Exhibit G—8.209.4.V	22. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The required provision was found in the Clinical Appeal Process policy. There were no examples of this type of appeal during the review period.	
	Required Actions: None	
42CFR438.424 Contract: Exhibit G—8.209.4.W	23. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The required provision was found in the Clinical Appeal Process policy. There were no examples of this type of appeal during the review period.	
	Required Actions: None	

Results for Appeals							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	4	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	Not Applicable or Not Scored	=	1	X	N/A	=	N/A
Total Applicable		=	22	**Total Score**		=	16

Total Score ÷ Total Applicable	=	73%

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
42CFR438.240(b)(3) Contract: II.I.e	1. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Quality Management/Utilization Management Program Description listed review-of-care patterns with the goal of identifying over- and underutilization in the description of activities performed by the Quality of Care Committee. Data reports used to detect over- and underutilization were trend reports for admissions/1,000 and reports of readmission rates and emergency room utilization. Data was also analyzed per CMHC. The Top Five Diagnoses report included results of studies to examine outpatient treatment patterns for members with one of the top five diagnoses for adults and for children. Results of this report were discussed in the Quality of Care Committee meetings (as documented in the October 15, 2008, meeting minutes), with follow-up actions/studies.	
	Required Actions: None	
UM Criteria – Section IV	2. The Contractor has policies and procedures outlining the activities undertaken to specifically identify and address underutilization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Key Performance Indicators policy (3.01) and the Quality of Care Issues and Outliers Practice Patterns policy (3.09) described the processes for identifying indicators of over- and underutilization. CHP staff reported quality projects such as analysis of practice patterns for high-volume providers and comparing average numbers of sessions per type of treatment to identify outliers (for both under- and overutilization). Another project was a performance improvement project designed to analyze and increase the participation of members 60 years of age and older. Staff reported that quality program staff members are developing processes to respond to the findings of these studies.	
	Required Actions: None	

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
UM Criteria – Section IV	3. The Contractor's policies and procedures include the mechanism for routine trending and analysis of data by levels of care and by provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Key Performance Indicators policy described the data reports used for routine trending and analysis of data by level of care and provider. The reports, for example, addressed bed days, admissions, emergency room visits, admissions/1,000, and the top five diagnoses. The reports trended data by provider in the external provider network and compared the CMHCs (as single, organizational providers).	
	Required Actions: None	
UM Criteria – Section IV	4. Trending includes services prior authorized and not prior authorized.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The ECM/HVP Report compared CMHC and non-CMHC service patterns (outpatient services provided through the CMHCs were not authorized). The Top Five Diagnoses Report analyzed data by type of treatment (e.g., case management, medication management, psychotherapy, recovery/prevention, and vocational services), including authorized and non- authorized services. In addition, there were specific studies that analyzed emergency services (not authorized). All services provided by the external provider network required authorization and were trended and analyzed.	
	Required Actions: None	

Results for Underutilization							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	0	X	N/A	=	N/A
Total Applicable		=	4	**Total Score**		=	4

Total Score ÷ Total Applicable	=	100%

Appendix B. Notice of Action Record Review Tool for Colorado Health Partnerships, LLC

The completed notice of action record review tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Colorado Health Partnerships, LLC

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	February 17, 2009
Reviewer:	Barbara McConnell
Participating BHO Staff Member:	Amie Adams

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision and Notice	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons Were Easy to Understand	Decision Made by Qualified Clinician	Notice Included all Required Content
Comments pertaining to notice-of-action templates: There was language in the templates that related to specific requirements and were inaccurate and incomplete. Because the templates were used and addressed the requirement, this record review received a Met score. Scoring pertaining to the global template being incorrect is in the monitoring tool (Appendix A – Component 1).										
1	XXXXX	1/18/08	1/18/08	0	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a new request for admission to a residential treatment center (RTC) facility directly from an inpatient facility. The member did not meet medical necessity criteria for an RTC and was refusing RTC treatment. CHP's template letter was used and addressed all of the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										
2	XXXXX	7/16/07	7/25/07	9	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a new request for outpatient treatment and play therapy to determine if the child was sexually abused. An assessment session revealed that no mental illness was present. Continued treatment to determine environmental factors and, therefore, appropriateness of placement (rather than for treatment of a mental illness) was deemed a noncovered service. The notice of action referred the member to Medicaid to determine if the services were covered through another Medicaid program or payment source. CHP's template letter was used and addressed all of the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										
3	XXXXX	Retro review decision 5/29/08	6/2/08	4 days from decision affecting claim to the notice date	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: This was a retroactive review that denied payment of part of a hospitalization. The hospitalization was September 12, 2007, to October 12, 2007. Payment was approved for September 12, 2007, through October 6, 2007. Payment was denied for October 7, 2007, through October 12, 2007, due to lack of medical necessity and not meeting continued-stay criteria. The denial letter was sent within four days of the decision affecting the claim. The letter incorrectly stated that the action was a denial of treatment. The action was a denial of payment for treatment previously received. By using the template, the letter met the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Colorado Health Partnerships, LLC

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision and Notice	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons Were Easy to Understand	Decision Made by Qualified Clinician	Notice Included all Required Content
4	XXXXX	Retro review decision 3/5/08	3/5/08	0	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☐ N ☒
Comments: This was a retroactive review of a hospitalization November 9, 2007, through November 12, 2007, for the treatment of delirium. Payment was denied based on delirium being deemed a noncovered service. The notice of action referred the member to Medicaid to determine if the services were covered through another Medicaid program or payment source. The denial letter was sent the same day as the decision affecting the claim. The letter incorrectly stated that the action was a denial of treatment. The action was a denial of payment for treatment previously received. By using the template, the letter met the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										
5	XXXXX	8/22/07	8/22/07	0	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a new request for day treatment. The request was denied for lack of medical necessity for this level of care. CHP worked with the school and the CMHC to provide an alternative level of care based on the member's acuity of symptoms. CHP's template letter was used and addressed all of the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										
6	XXXXX	3/5/08	3/5/08	0	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a new request for continued hospitalization. The initial authorization period was complete. Continued hospitalization was denied based on lack of medical necessity. CHP's template letter was used and addressed all of the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										
7	XXXXX	6/17/08	6/17/08	0	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a new request for inpatient hospitalization. The service was denied based on lack of medical necessity for inpatient care. CHP's template letter was used and addressed all of the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Colorado Health Partnerships, LLC

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision and Notice	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons Were Easy to Understand	Decision Made by Qualified Clinician	Notice Included all Required Content
8	XXXXX	Retro review decision 7/18/08	7/19/08	1 day from date of decision affecting claim to the date of notice	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a review of a request for payment for services at a therapeutic boarding school starting June 11, 2007. CHP was a secondary payor. The primary insurance had denied payment due to lack of compliance with authorization requirements. CHP denied payment due to boarding school services being deemed a noncovered service, and because Medicaid, as a secondary payor, could not be accessed if the member did not follow the preauthorization guidelines of the primary payor. The facility was in the State of Utah and was not a licensed psychiatric residential treatment center (PRTC). CHP offered a team review to determine medical necessity for a PRTC in the State of Colorado. The parent declined, stating that the member needed to stay at the facility in Utah. CHP's template letter was used and addressed all of the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										
9	XXXXX	11/30/07	11/30/07	0	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a new request for residential services following inpatient hospitalization. The request was denied for not having tried lower levels of care interventions. CHP's template letter was used and addressed all of the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										
10	XXXXX	10/22/07	10/23/07	1	M ☒ N ☐ N/A ☐	N/A	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: This was a new request for residential services. The member was in day treatment. The request was denied based on lower levels of treatment not having been tried. CHP authorized two more weeks of day treatment and additional outpatient services at the CMHC. CHP's template letter was used and addressed all of the requirements. See the compliance monitoring tool for the BHO's performance on each requirement.										
# Applicable Elements					10		0	10	10	10
# Compliant Elements					10		N/A	10	10	8
Percent Compliant										

Legend:
M = Met
N = Not met
N/A = Not applicable

Total Applicable Elements:	**40**
Total # Compliant Elements:	**38**
Total Percent Compliant:	**95%**

Appendix C. Appeals Record Review Tool for Colorado Health Partnerships, LLC

The completed appeals record review worksheet follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix C. Colorado Behavioral Health Organization (BHO) Appeals Record Review Tool *for* Colorado Health Partnerships, LLC

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	February 17, 2009
Reviewer:	Barbara McConnell
Participating BHO Staff Member:	Amie Adams and Mary Jane Horgan

1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	**Member ID**	**Date Appeal Received**	**Evidence of Reasonable Assistance**	**Date of Acknow-ledgment Letter**	**Acknow-ledgment Within 2 Working Days**	**Decision-maker—Previous Level**	**Decision-maker—Clinical Expertise**	**Expedited**	**Time Frame Extended**	**Date Resolution Letter Sent**	**Resolved in Time Frame**	**Resolution Notice Included Required Content**	**Resolution Notice Was Easy to Understand**
1	XXXXX	2/4/08	M☒ N☐ U☐	2/4/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	2/6/08	M☒ N☐	M☒ N☐	M☒ N☐
Comments: This was an appeal of a denial of residential services. The appeal was filed orally (via telephone). While the electronic record indicated that the customer service representative explained that an independent doctor would review the case, the same doctor signed the notice of action, the appeal acknowledgment letter, and the appeal resolution letter. There was no indication in the letters who actually reviewed the case other than the doctor who signed the letters. The record indicated that Dr. D. made the denial decision, yet the denial notice was signed by Dr. H. The appeal record indicated that Dr. H. reviewed the appeal and signed the appeal resolution letter, which was resolved in favor of the member. The original denial was based on having the member's needs met at another level of care.													
2	XXXXX	11/19/07	M☐ N☐ U☒	11/19/07	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	11/27/07	M☒ N☐	M☒ N☐	M☒ N☐
Comments: This was an appeal of a denial for dialectical behavioral therapy (DBT). The appeal was received via e-mail from the mother (very articulate) to Dr. H. The denial record indicated that the denial decision was made by Dr. D., even though the letter was signed by Dr. H. The appeal record indicated that the appeal decision was made by Dr. H. Dr. H. also signed the appeal resolution letter. The original denial was based on lack of medical necessity. The appeal was resolved in favor of the member, stating that the DBT group at the CMHC was now available.													
3	XXXXX	8/17/07	M☒ N☐ U☐	N/A	M☐ N☐ N/A ☒	M☒ N☐ U☐	M☒ N☐ U☐	Y☒ N☐	Y☒ N☐	8/24/07	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The member requested an expedited appeal. There was no acknowledgment letter in the record, but the letter is not required for an expedited appeal. The original denial was based on lack of medical necessity for the level of care requested, and CHP provided therapy at another level of care. The record indicated that the decision was made by Dr. D., but the notice of action was signed by Dr. H. The member requested an extension to allow her to provide additional information. An independent physician at ValueOptions corporate offices (Dr. Z.) reviewed and upheld the original decision. The resolution letter was signed by Dr. H.													
	# Applicable Elements		2		2	3	3				3	3	3
	# Compliant Elements		2		2	3	3				3	3	3
	Percent Compliant												

Legend:
M = Met
N = Not met or No
U = Unable to determine
Y = Yes

Total # Applicable Elements	**19**
Total # Compliant Elements	**19**
Total Percent Compliant	**100%**

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

Table D-1 lists the participants in the FY 2008–2009 site review of **CHP**.

Table D-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Rachel Henrichs	Project Coordinator
CHP Participants	**Title**
Amie Adams	Call Center Manager
Erica Arnold-Miller	Director of Quality Management
Sheila Bowlin	Clinical/Quality Assistant
Haline Grublak	Director of Office of Consumer and Family Affairs
Steve Holsenbeck, MD	Chief Medical Officer
Mary Jane Horgan	Director of Clinical Services
Chris Jacobson	Quality Management Specialist
Dave Lockert	Consumer and Family Advocate
Tammy Ryder	Clerk, Office of Consumer and Family Affairs
Arnold Salazar	Chief Executive Officer
Maggie Tilley	Compliance/Human Resources
Charlotte Yianakopulos-Veatch	Clinical Director
Department Observers	**Title**
Jerry Ware	Quality Compliance Specialist
Marceil Case	Behavioral Health Specialist

Appendix E. Corrective Action Plan Process for FY 2008–2009 for Colorado Health Partnerships, LLC

CHP is required to submit to the Department a CAP for all elements within each component scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the health plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. Supporting documents should not be submitted and will not be considered until the plan has been approved by the Department. Following Department approval, the BHO must submit documents per the timeline that was approved.

Table E-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	Each BHO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or the file transfer protocol (FTP) site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must address the planned intervention(s) to complete the required actions, and the timeline(s) for the intervention(s).
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, the BHO must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	The Department will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan, or ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the plan, the BHO should implement all the planned interventions and submit evidence of such intervention to HSAG via e-mail or the FTP site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table E-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department 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 CAP follows.

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
2. Notices of Action 1. The Contractor defines action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals. **Findings:** CHP's definition was incomplete. "The denial, in whole or in part, of payment for a requested service" was	CHP must revise applicable policies and other documents to include an accurate and complete definition of action.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
missing from CHP's definition in policies and in the member handbook. In addition, CHP's definition in the Grievance Process policy included "the failure to act within the timeframes provided below" (with no time frames listed in the same or next section of the policy), instead of "the failure to provide services in a timely manner" and "the failure to act within the time frames for resolution of grievances and appeals." The member handbook included "failure of provider to act within approved timeframes" instead of "the failure to provide services in a timely manner" and "the failure to act within the time frames for resolution of grievances and appeals." Neither the Appeals Process policy nor the Clinical Appeals policy included a definition of "action."				

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
2. Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding. **Findings:** The notice-of-action template was written in language that was easy to understand; however, as the templates were applied and used for specific member situations, the notices of action actually sent were confusing. Notices of action were sent to members that included information about continuing benefits (services) when the requirements were not met and the member would not be eligible to request continued services.	CHP must ensure that each notice of action sent to members is easy to understand. CHP may consider developing additional templates that apply to other notice situations.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within 10 calendar days, on the date the time frames expire ◆ For expedited service authorization	CHP must revise its applicable policies and processes to ensure that notices of action related to the termination, suspension, or reduction of previously authorized services are sent within the required time frames.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
decisions, within three days **Findings:** Neither the Medical Necessity Determination, Lack of Information, and Notification Timelines policy nor the Clinical Appeal Process policy included the time frame for mailing notices of action related to standard and expedited service authorization decisions for the denial or limited authorization of a requested service. The on-site record review contained no notices of action related to the termination, suspension, or reduction of previously authorized services. The time frames required for notices of action regarding termination, suspension, or reduction of a previously authorized service were found in the Clinical Appeal Process policy as the time frames required for mailing the appeal resolution notice.				

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
5. If the Contractor extends the time frame for authorization decisions (see Standard I) it provides the member: ◆ Written notice of the reason for the decision to extend the time frame. ◆ The right to file a grievance if the member disagrees with the decision. ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires. **Findings:** The Clinical Appeal Process policy included language about notification to members if CHP extended the time frame for making authorization decisions; however, the language was inappropriately placed within a section that addressed the mailing of the resolution notice.	CHP must revise its applicable policies to accurately address the time frames for extension of authorization decisions.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
3. Appeals 1. The Contractor has a system in place that includes an appeal process and access to the State fair hearing process. **Findings:** Page 6 of the Clinical Appeal Process policy indicated that members are not provided access to the State fair hearing process if the provider requested the appeal.	CHP must clarify its applicable policies to ensure members' access to the State fair hearing process.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
11. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, 10 working days from the day the Contractor receives the appeal ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal **Findings:** The Clinical Appeal Process policy did not include the time frames for notifying members of the disposition of the appeal. The resolution notice section of the policy included the time frames for making authorization decisions (which were misplaced in the policy).	CHP must revise its applicable policies to reflect accurate time frames for resolving appeals and providing notice to the member.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
12. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if either: ◆ The member requests the extension. ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest. One section of the Clinical Appeal Process policy indicated that the extension was related only to standard appeals and not to expedited appeals. In addition, this section contradicted an earlier section in the policy that did not indicate the option for an extension: "should the requested information not be received within the decision time frame, the appeal is conducted based on whatever information is available and a decision is rendered within appropriate timeframes." The	CHP must revise applicable policies and member materials to include complete and accurate information regarding the extension of appeal resolution time frames.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
member handbook informed members that CHP will send a letter if CHP needs more time; however, the handbook did not inform members that they may ask for more time.				
14. For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution. **Findings:** The Clinical Appeal Process policy did not address oral notice of resolution for expedited appeals.	CHP must revise applicable policies to reflect compliance with BBA requirements regarding oral notice for expedited appeals, and to be consistent with CHP practice.			
19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action ▪ The intended effective date of	CHP must revise applicable policies and other applicable materials to describe the requirements for continuation of benefits during the appeal or State fair hearing processes.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. **Findings:** The Clinical Appeal Process policy did not accurately address continuation of benefits. This requirement language was inaccurately placed under the resolution letter time frames.				

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
20. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal ◆ Ten days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached ◆ A State fair hearing officer issues a hearing decision adverse to the member ◆ The time period or service limits of a previously authorized service has been met	CHP must revise applicable policies and other applicable materials to describe how long benefits may continue if requested by the member during an appeal or State fair hearing.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* CHP				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
Findings: The Clinical Appeal Process policy did not accurately address continuation of benefits. This requirement language was inaccurately placed under the resolution letter time frames. The member handbook did not address how long benefits would continue. The notice of action and appeal resolution letters also did not inform members of how long benefits may continue.				

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

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

Table F-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 on October 3, 2008, for the BHO and the Department to preview the FY 2008–2009 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. ◆ HSAG provided a presentation to the Department and the BHOs on January 27, 2009, titled "Developing and Implementing Corrective Action Plans." In this presentation, HSAG reviewed the timeline and requirements for the corrective action plan process. ◆ 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 the BHO's 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 BHO's contract, dated March 1, 2007, to develop the 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 four components. ◆ Documents requested included applicable policies and procedures, minutes of key BHO committee or other group meetings, reports, logs, and other documentation.

Table F-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents needed that HSAG identified during its desk audit. ◆ HSAG requested and reviewed additional documents needed that HSAG identified 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 2008–2009 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 required of the BHO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2008–2009 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.