

Colorado Medicaid
Community Mental Health Services Program

FY 2009–2010 SITE REVIEW REPORT
for
Colorado Health Partnerships, LLC

June 2010

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



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1. Executive Summary

for Colorado Health Partnerships, LLC

Overview of FY 2009–2010 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 (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements, and each state's quality strategy. The Colorado 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 sixth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2009–2010 site review process, the Department requested a review of seven areas of performance. For its review of **Colorado Health Partnerships, LLC (CHP)**, HSAG developed a review strategy consisting of seven standards that it had not reviewed within the previous two fiscal years. The areas chosen for review were Standard I—Emergency and Poststabilization Services (a subset of Standard I—Coverage and Authorization of Services); Standard IV—Member Rights and Protections; Standard VI—The Grievance System (Grievances Only); Standard VII—Provider Participation and Program Integrity; Standard VIII—Credentialing and Recredentialing; Standard IX—Subcontracts and Delegation; and Standard X—Quality Assessment and Performance Improvement. Compliance with federal regulations was evaluated through review of the seven standards. This report documents results of the FY 2009–2010 site review activities for the review period—July 1, 2009, through March 16–17, 2009 (the date of the on-site review). Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Appendices A and B contain details of the findings.

Methodology

In developing the data collection tools and in reviewing the seven standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions that were issued June 14, 2002, and were effective August 13, 2002. To determine compliance, HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key BHO personnel. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. Details of the review of the seven standards are in Appendix A. Details of the on-site grievance record review are in Appendix B.

The seven standards chosen for the FY 2009–2010 site reviews represent a portion of the requirements based on Medicaid managed care requirements. The remainder of Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination of Care, Standard V—Member Information, and the remainder of Standard VI—the Grievance System, will be reviewed in subsequent years.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*. Appendix E contains a detailed description of HSAG’s site review activities by activity, as outlined in the CMS final protocol.

Objective of the Site Review

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

- ◆ The BHO’s compliance with federal regulations and contract requirements in the seven areas of review.
- ◆ Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal health care regulations in the standard areas reviewed.
- ◆ The quality and timeliness of, and access to, 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

Based on the results from the Compliance Monitoring Tool and conclusions drawn from the review activities, HSAG assigned each element within the standards in the Compliance Monitoring Tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual element within the Compliance Monitoring Tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations to enhance some elements, regardless of the score. While HSAG provided recommendations for enhancement of BHO processes based on these identified opportunities for improvement, for requirements that may have been scored *Met*, these recommendations do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **CHP** for each of the standards. Details of the findings for each standard are in Appendix A.

Table 1-1—Summary of Scores for the Standards								
Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I	Emergency and Poststabilization Services	9	9	9	0	0	0	100%
IV	Member Rights and Protections	6	6	6	0	0	0	100%

Table 1-1—Summary of Scores for the Standards								
Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
VI	The Grievance System (Grievances Only)	13	13	13	0	0	0	100%
VII	Provider Participation and Program Integrity	8	8	8	0	0	0	100%
VIII	Credentialing and Recredentialing	39	39	39	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
X	Quality Assessment and Performance Improvement	12	12	12	0	0	0	100%
Totals		93	93	93	0	0	0	100%

2. Summary of Performance Strengths and Required Actions

for Colorado Health Partnerships, LLC

Overall Summary of Performance

For all seven of the standards HSAG reviewed, **CHP** received percentage-of compliance scores of 100 percent, indicating a comprehensive understanding of the managed care requirements of the BBA. **CHP**'s policies and procedures were comprehensive, easy to understand, and presented in an organized manner. During the on-site interviews, **CHP** staff members were able to clearly articulate procedures followed, which corroborated the written policies and procedures.

Standard I—Emergency and Poststabilization Services

Summary of Findings and Opportunities for Improvement

CHP received an overall score of 100 percent compliance with the emergency and poststabilization services standard. **CHP** delegated utilization management, including the authorization and adjudication of emergency and poststabilization services, to ValueOptions (VO). VO had comprehensive policies and procedures in place that were consistent with the BBA provisions. **CHP** demonstrated that its policies were in practice and effective in ensuring that members were not held liable for payment for emergency behavioral health care. The **CHP** member handbook contained clear and concise verbiage pertaining to the availability of emergency and poststabilization services.

Summary of Strengths

VO had comprehensive documentation in place—including policies, the **CHP** member handbook, and the provider handbook—to provide the applicable audience with clear information pertaining to the provision of emergency and poststabilization services. In addition, **CHP** disseminated user-friendly information in the **CHP** member handbook addressing how to access crisis care available to members.

Summary of Required Actions

There were no required actions for this standard.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

CHP received an overall score of 100 percent compliance with the member rights and protections standard. **CHP** delegated the management of member rights to VO. The **CHP** Member Information Requirements Delegation policy detailed the provisions pertaining to member rights and protections. The policy delineated the means by which members were notified of their rights and the means by which the BHO ensured that member rights were protected. The policy contained each element included in the scope of this review and demonstrated a comprehensive policy that was in consort with the Code of Federal Regulations (CFR) at 42 CFR 438. **CHP** ensured that its providers were trained in the area of member rights and protections and monitored their compliance with provisions through various means, including the Office of Member and Family Affairs (OMFA) and contract compliance reviews of providers. OMFA played a key role in ensuring that member rights and protections were the BHO's priority. In addition, **CHP** considered trends in grievances and appeals data related to member rights and protections through **CHP**'s quality improvement process.

Summary of Strengths

CHP closely monitored providers to ensure that they were trained in the area of member rights. **CHP** used diverse venues and presentation methods to ensure that members, providers, and the community at large were aware of member rights and protections. The **CHP** training program demonstrated a comprehensive and diverse set of materials. In addition, OMFA, along with peer specialists located at the community mental health centers (CMHCs), provided advocacy pertaining to member rights and protections.

Summary of Required Actions

There were no required actions for this standard.

Standard VI—The Grievance System (Grievances Only)

Summary of Findings and Opportunities for Improvement

The **CHP** Grievance Delegation policy detailed **CHP**'s delegation of the grievance process to VO. The VO grievance policies and procedures clearly defined the process by which a member or his or her designated representative may file grievances orally and in writing. The **CHP** member handbook and **CHP** provider handbook demonstrated **CHP**'s communication of the grievance process, methods by which members may file grievances, required time frames for filing grievances, and members' rights as they pertain to grievances and State fair hearings to members and providers.

The VO grievance policies described the BHO's procedures for processing grievances within the required time frames. The grievance file review of 10 grievance files provided evidence that: VO provided written acknowledgment of a grievance to the member within two working days of receipt of the grievance for all grievances, VO staff members who processed grievances were not involved in any previous level of the review, VO staff members had the appropriate clinical expertise in treating the member's condition for the three grievances that involved a clinical issue, VO provided written disposition of a grievance to the member within 15 working days from the date the grievance was received, and when staff required additional time to collect information for a grievance, which was in the member's best interest, VO staff notified the member in writing of the extended timeline to resolve the grievance. The notice of extension contained the reason for the delay and the new date that the grievance would be resolved.

Summary of Strengths

The grievance policies detailed the comprehensive grievance system, and the policies contained all of the required information. The grievance files reviewed were well organized, contained all of the required content, and provided evidence that staff adhered to the policies and associated time frames when processing grievances. The grievance database captured all of the required elements, and database demonstrations provided by staff provided evidence that staff members were able to retrieve grievance information quickly.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

CHP received an overall score of 100 percent compliance with provider participation and program integrity standard. The **CHP** Provider Network Delegation policy detailed the delegation of provider networking and contracting from **CHP** to VO. The policies and procedures, provider agreements, and contract amendments contained the required provisions that the BHO would not prohibit, or otherwise restrict, a health care professional from advising or advocating on behalf members; that members may not be held liable for payments to providers; and that the BHO did not contract with providers who were sanctioned, debarred, or excluded from participation in federal health care programs. The **CHP** member handbook contained the provision that **CHP** did not deny services based on moral or religious grounds. The **CHP** Compliance Plan and related policies demonstrated **CHP**'s administrative procedures to guard against fraud and abuse. The **CHP** Compliance Plan and policies contained all of the required provisions for designating a compliance officer, compliance officer training, compliance training for staff, internal monitoring and reporting, and **CHP**'s process for responding to detected offenses.

Summary of Strengths

The **CHP** compliance education materials presented a comprehensive overview of the type of information used to educate and train **CHP** associates on the compliance program. The **CHP** compliance education materials included information regarding standards of conduct, designation of a compliance officer, lines of communication between the compliance officer and **CHP** associates, disciplinary guidelines, and **CHP**'s provision for prompt response to detected offenses and corrective action initiatives related to the Medicaid managed care contract.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

CHP received an overall score of 100 percent compliance with credentialing and recredentialing standard. The **CHP** Credentialing and Recredentialing Delegation policy described **CHP**'s delegation of credentialing and recredentialing activities to VO. The **CHP** Credentialing and Recredentialing Delegation policy also described **CHP**'s oversight of VO's credentialing and recredentialing program, which included verifying that VO maintained a well-defined credentialing and recredentialing process to evaluate contracting with licensed practitioners to provide services to members.

VO's credentialing and recredentialing policies described the process for evaluating and selecting providers to participate in the network and notifying providers of credentialing decisions within the required time frames. The credentialing and recredentialing process included the use of an application completed by the practitioner, attestation from the practitioner, primary source verification, and recommendations to the medical director to approve credentialing or recredentialing of practitioners who completed the credentialing or recredentialing process and whose files met all of the credentialing and recredentialing requirements. The BHO's credentialing and recredentialing policies also described the use of the Colorado Local Credentialing Committee (CLCC), which consisted of a multidisciplinary group of peers who reviewed and made recommendations for approval or denial of credentialing and recredentialing files to the National Credentialing Committee (NCC) prior to the NCC's review of credentialing and recredentialing files.

The BHO's credentialing and recredentialing policies listed providers' rights related to the credentialing and recredentialing process. The provider credentialing application also provided evidence that providers were notified of their rights at the time they completed the application for credentialing or recredentialing.

Summary of Strengths

The on-site demonstration of the VO credentialing database demonstrated the comprehensive organization and capabilities of the database, which allowed staff to access provider credentialing and recredentialing information quickly. Meeting minutes of both the NCC and CLCC were comprehensive and well organized and provided evidence of thorough review of practitioner credentialing and recredentialing files by the two credentialing committees.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

CHP received an overall score of 100 percent compliance with the subcontracts and delegation standard. **CHP** delegated several managed care functions to VO, including claims, credentialing, information technology/health information systems, grievances, member and family affairs, provider relations, quality management, utilization management, and compliance. The terms and conditions of the delegation, including a list of delegated responsibilities and reporting requirements, were detailed in the Agreement to Delegate and the Management Services Agreement between **CHP** and VO. **CHP** conducted ongoing monitoring and annual assessment of all delegated activities.

Summary of Strengths

The **CHP** Agreement to Delegate and the Management Services Agreement were consistent with the applicable National Committee for Quality Assurance (NCQA) and BBA requirements. The agreements included a description of all delegated activities and detailed monitoring activities to be conducted by **CHP** to ensure compliance. **CHP** demonstrated that it closely monitored performance of each delegated activity on an ongoing and annual basis.

Summary of Required Actions

There were no required actions for this standard.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

CHP received an overall score of 100 percent compliance with the quality assessment and performance improvement (QAPI) standard. **CHP** delegated quality management functions to VO. The **CHP** Quality Improvement and Utilization Management Program description detailed the structure and goals of the quality program. **CHP** demonstrated that comprehensive mechanisms were in place to ensure the quality and appropriateness of care provided to members through the analysis of utilization data, grievance and appeal data, performance improvement projects (PIPs), and member surveys. The quality program was reviewed on an ongoing and annual basis through the Quality Improvement/Utilization Management (QI/UM) Committee. The Quality Management and Utilization Management Program Evaluation for FY 2009 demonstrated annual, formal assessment of the program.

Summary of Strengths

CHP had an ongoing and comprehensive quality assessment and performance improvement program in place. The program included mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs. **CHP** had data systems in place to collect, analyze, integrate, and report data in support of the program. **CHP** had processes in place to detect over- and underutilization through innovative data integration and report development.

Summary of Required Actions

There were no required actions for this standard.

3. Follow-up on FY 2008–2009 Corrective Action Plan for Colorado Health Partnerships, LLC

Methodology

As a follow-up to the FY 2008–2009 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all components for which the BHO 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 2008–2009 compliance monitoring site review, or until the time of the on-site portion of the BHO's FY 2009–2010 site review.

Summary of 2008–2009 Required Actions

Based on the 2008–2009 compliance review, **CHP** was required to submit a CAP that addressed elements of noncompliance related to notices of action and appeals. Required actions included:

- ◆ Revising applicable policies and related materials to include an accurate and complete definition of an action.
- ◆ Ensuring that each notice of action sent to a member is easy to understand.
- ◆ Review and revising all applicable policies to ensure they contain 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 process.
- ◆ Clarifying applicable policies to ensure member access to the State fair hearing process.
- ◆ Revising applicable policies to reflect compliance with BBA requirements regarding oral notice for expedited appeals and to be consistent with **CHP**'s practices.

Summary of Corrective Action/Document Review

CHP submitted its CAP to HSAG and the Department in June 2009. After careful review, HSAG determined that the CAP was not specific enough to adequately address all required actions. HSAG and the Department participated in a conference call with **CHP** in August 2009 to answer **CHP** staff members' questions regarding requirements of the BBA and to outline the necessary components of a comprehensive plan. HSAG and the Department continued to work with **CHP** until HSAG determined that **CHP** had successfully completed all required actions.

Summary of Continued Required Actions

CHP successfully addressed all FY 2008–2009 required actions.

Appendix A. **Compliance Monitoring Tool** *for* **Colorado Health Partnerships, LLC**

The completed compliance monitoring tool follows this cover page.

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Colorado Health Partnerships, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.114(a)	1. The Contractor defines Emergency Medical Condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ◆ Serious impairment to bodily functions ◆ Serious dysfunction of any bodily organ or part	Documents Submitted/Location Within Documents: 1. CHP Utilization Management Delegation Policy – Entire policy 2. 270L Emergency and Post-Stabilization Services Policy – Pages 2-3, Section IV.A defines Emergency Medical Condition. 3. Member Handbook (Misc folder) – Page 7, 11 provides definition of emergency medical condition and instructs members on how to access emergency services. 4. C214 Member Request Policy – Pages 2-5, Section V.B.1-5, and V.C.1 discusses protocols for VO staff to direct members to the nearest facility to obtain services in any life-threatening emergency. 5. Provider Handbook (Misc folder) – Page 14 of the .pdf file defines Emergency Medical Condition for providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: CHP delegated utilization management activities, which consisted of utilization management of emergency and poststabilization services, to VO. The CHP Utilization Management Delegation policy described the delegation terms between the two parties. VO's policy, Emergency and Poststabilization Services, contained a definition of an emergency medical condition, which was consistent with the verbiage in this requirement. In addition, a definition of emergency services was located in the CHP member handbook and in the provider handbook. The provider handbook was applicable to each of the VO partnership BHOs.		
	Required Actions: None		

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FY 2009–2010 Compliance Monitoring Tool
for Colorado Health Partnerships, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.114(a)	2. The Contractor defines Emergency Services as follows: - Services furnished by a provider that is qualified to furnish these services under this title - Needed to evaluate or stabilize an emergency medical condition	Documents Submitted/Location Within Documents: - CHP Utilization Management Delegation Policy - Entire policy 270L Emergency and Post-Stabilization Services Policy – Page 3, Section IV.C.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The definition of emergency services was delineated in VO's Emergency and Poststabilization Services policy and contained verbiage that was consistent with this requirement. The definition of emergency services was also detailed in the CHP member handbook and in the provider handbook.		
	Required Actions: None		
42CFR438.114(a)	3. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition.	Documents Submitted/Location Within Documents: - CHP Utilization Management Delegation Policy - Entire policy 270L Emergency and Post-Stabilization Services Policy – Page 3, Section IV.D.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO policy, Emergency and Poststabilization Services, contained a definition of poststabilization services that was consistent with this requirement. In addition, the policy delineated that poststabilization services end when a member is transferred from an emergency room to a psychiatric inpatient setting or is discharged from an emergency room to a lower level of care.		
	Required Actions: None		

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Colorado Health Partnerships, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.114(c)(1)	4. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.	Documents Submitted/Location Within Documents: 1. CHP Utilization Management Delegation Policy - Entire policy 2. CHP Claims Delegation Policy – Entire policy 3. 270L Emergency and Post-Stabilization Services Policy – Page 1, Section III.A. 4. Procedure for Handling Emergency Room and Outpatient Lab Charges – Page 1, Procedure.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO policy, Emergency and Poststabilization Services, contained the provision that VO covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with VO. In addition, VO's policy, Handling Emergency Room and Outpatient Lab Charge Claims, stated that members may access emergency services from both in-network and out-of-network providers without prior authorization.		
	Required Actions: None		
42CFR438.114(c)(1)	5. The Contractor may not deny payment for treatment obtained under either of the following circumstances: ◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would <i>not</i> have had the following outcomes ▪ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ▪ Serious impairment to bodily functions ▪ Serious dysfunction of any bodily organ or part ◆ A representative of the Contractor's organization instructed the member to seek emergency services	Documents Submitted/Location Within Documents: 1. CHP Utilization Management Delegation Policy - Entire policy 2. CHP Claims Delegation Policy – Entire policy 3. 270L Emergency and Post-Stabilization Services Policy – Pages 1-2, Section III. B & C. 4. Procedure for Handling Emergency Room and Outpatient Lab Charges – Page 1, Procedure. 5. Provider Handbook (Misc folder) – Page 14 of 110	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Colorado Health Partnerships, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
	Findings: The VO policy, Emergency and Poststabilization Services, contained the provision that VO did not deny payment of services for emergency medical conditions, as per language consistent with the requirement, or if a representative of VO instructed the member to obtain emergency services. In addition, VO's policy, Handling Emergency Room and Outpatient Lab Charge Claims, stated that members may access emergency services from both in-network and out-of-network providers without prior authorization. During the on-site audit, staff members reported that emergency claims were not denied for a psychiatric diagnosis. Required Actions: None		
42CFR438.114(d)(1)	6. The Contractor does not: ♦ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms ♦ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services	Documents Submitted/Location Within Documents: 1. CHP Utilization Management Delegation Policy - Entire policy 2. CHP Claims Delegation Policy – Entire policy 3. 270L Emergency and Post-Stabilization Services Policy – Page 2, Section III.C. 4. Procedure for Handling Emergency Room and Outpatient Lab Charges – Page 1, Procedure.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO policy, Emergency and Poststabilization Services, contained the provision that VO did not limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms and did not refuse to cover emergency services if the provider failed to notify the member's primary care provider (PCP), VO, or the Department within 10 days of presentation for emergency care. Required Actions: None		

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.114(d)(2)	7. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Documents Submitted/Location Within Documents: 1. CHP Utilization Management Delegation Policy - Entire policy 2. CHP Claims Delegation Policy – Entire policy 3. 270L Emergency and Post-Stabilization Services Policy – Page 2, Section III.D. 4. CHP Member Handbook (Misc folder) – Page 13 informs members that they are not responsible for payment of services (any services) covered by Medicaid.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO policy, Emergency and Poststabilization Services, contained the provision that VO did not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member. In addition, the CHP member handbook informed members that they were not responsible for the payment of any Medicaid-covered service and instructed them to contact the BHO if they received a bill.		
	Required Actions: None		
42CFR438.114(d)(3)	8. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.	Documents Submitted/Location Within Documents: 1. CHP Utilization Management Delegation Policy - Entire policy 2. CHP Claims Delegation Policy – Entire policy 3. 270L Emergency and Post-Stabilization Services Policy – Page 2, Section III.E.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO policy, Emergency and Poststabilization Services, contained the provision that allowed the attending emergency physician or other provider treating the member to determine when the member was sufficiently stabilized for transfer or discharge. In addition, the policy detailed that the provider’s determination was binding on VO, which was responsible for payment.		
	Required Actions: None		

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Colorado Health Partnerships, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.10(f)(6)(viii)(B)	9. The Contractor does not require prior authorization for emergency services.	Documents Submitted/Location Within Documents: 1. CHP Utilization Management Delegation Policy - Entire policy 2. 270L Emergency and Post-Stabilization Services Policy – Page 2, Section III.F. 3. Procedure for Handling Emergency Room and Outpatient Lab Charges – Page 1, Procedure. 4. Provider Handbook (Misc Folder) – Page 14 of 110 5. CHP Member Handbook (Misc folder) – Page 11	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO policy, Emergency and Poststabilization Services, contained the provision that VO did not require prior authorization for emergency services. The VO policy, Procedure for Handling Emergency Room and Outpatient Lab Charge Claims, provided additional evidence that members can access emergency room services without prior authorization. In addition, the member handbook and provider handbook informed readers that prior authorization was not required for emergency services.		
	Required Actions: None		

Results for Standard I—Emergency and Poststabilization Services

Total	Met	=	<u>9</u>	X	1.00	=	<u>9</u>
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>
Total Applicable		=	<u>9</u>	Total Score	=	<u>9</u>	

Total Score ÷ Total Applicable		=	<u>100%</u>
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Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.100(a)(1)	1. The Contractor has written policies regarding member rights.	Documents Submitted/Location Within Documents: 1. CHP Member Information Requirements Delegation Policy – Entire policy. 2. 304L Member Rights and Responsibilities Policy – Entire policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: CHP delegated the management of member rights and responsibilities to VO. The VO Member Rights and Responsibilities policy detailed the provisions related to member rights in accordance with federal regulations. In addition, the CHP Member Information Requirements Delegation policy outlined the oversight methods used to ensure that services were provided in a manner consistent with applicable requirements.		
	Required Actions: None		
42CFR 438.100(a)(2)	2. The Contractor ensures that its staff and affiliated providers take member rights into account when furnishing services to members.	Documents Submitted/Location Within Documents: 1. CHP Member Information Requirements Delegation Policy – Entire policy. 2. Provider Handbook (Misc folder) – Page 90, OMFA Section. 3. Provider Forum Training Presentation – Pages 76-82. 4. CHP Member Rights PowerPoint training 5. CHP contract compliance audit tool – lines 5-33 CHP website http://www.coloradohealthpartnerships.com/members/mbr_your_rights.htm	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Provider Forum Training Presentation contained a training component addressing member rights and responsibilities. The CHP Member Rights PowerPoint training provided evidence of a comprehensive training program on the topic of member rights. The provider handbook contained information regarding the OMFA and described its role in member rights and individual grievance review. During the on-site interview, staff members described various types of training venues for providers, including provider forums, Web trainings, and the provider handbook and described the monitoring mechanisms in place through OMFA and contract compliance audits to ensure that providers are compliant with provisions pertaining to member rights. Staff members described the process by		

Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
	which individual grievances and trends related to member rights were addressed and resolved. Last, staff members described mechanisms to review grievance data and identify trends.		
	Required Actions: None		
42CFR438.100(b)(2) & (3)	3. The Contractor ensures that members have the right to: ◆ Receive information in accordance with information requirements (42CFR438.10) ◆ Be treated with respect and with due consideration for his or her dignity and privacy ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45CFR164.524 and 164.526 ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210)	Documents Submitted/Location Within Documents: 1. CHP Member Information Requirements Delegation Policy – Entire policy. 2. 304L Member Rights and Responsibilities Policy – Entire policy. 3. CHP Member Handbook (Misc folder) – Page 14. 4. Provider Handbook (Misc folder) – Pages 90-97 of 110. 5. CHP website (www.ColoradoHealthPartnerships.com) – web version of member handbook. 6. CHP Enrollment Letter. 7. CHP Enrollment Letter - Spanish 8. Contract compliance audit tool	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
	Findings: CHP and VO communicated information regarding member rights, including those required by the BBA, in their member handbook and provider handbook and in the VO’s Member Rights and Responsibilities policy. Information regarding member rights was included on the CHP Web site and in the BHO’s member enrollment letter. Contracted providers were required to post a copy of member rights and responsibilities in their offices. Member rights requirements were monitored through contract compliance audits. During the on-site review, staff members described the role of peer specialists in the CMHCs acting as member advocates and coaches in the area of member rights. Required Actions: None		
42CFR438.100(c)	4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor treats the member. Findings: VO’s policy, Member Rights and Responsibilities, contained information regarding the right of members to express their dissatisfaction without causing any adverse effects on the provision of covered services. In addition, the CHP member handbook, provider handbook, and Web site contained this provision. During the on-site audit, staff members described the role of OMFA, provider relations, the Quality of Care Committee, and the Compliance Committee in overseeing corrective action if a violation were to occur. Required Actions: None	Documents Submitted/Location Within Documents: 1. CHP Member Information Requirements Delegation Policy – Entire policy/ section V.A.2. 2. 304L Member Rights and Responsibilities Policy – Entire policy. 3. Provider Handbook (Misc folder) – Page 96 of 110. 4. CHP Member Handbook (Misc folder) – Page 14.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.100(d)	5. Contractor complies with any other federal and State laws (such as Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and Titles II and III of the Americans with Disabilities Act and other laws regarding privacy and confidentiality).	Documents Submitted/Location Within Documents: 1. CHP Member Information Requirements Delegation Policy – Entire policy. 2. ValueOptions® Non-Discrimination of Members Policy – Entire policy. 3. Provider Handbook (Misc folder) – Page 8 and 86-88 of 110. 4. CHP Provider Handbook (Misc folder) – Inside cover page and pg. 14.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO policy, Member Rights and Responsibilities, provided evidence of provisions related to State and federal laws. Specifically, the policy addressed provisions pertaining to the right of members to be free from discrimination based on race, age, and disability. VO's Member Rights and Responsibilities policy also addressed provisions pertaining to members' protected health information (PHI). During the on-site interview, staff members stated that staff received training in this area. A list of training elements that referenced the applicable law was provided as evidence.		
	Required Actions: None		
42CFR438.224	6. The Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.	Documents Submitted/Location Within Documents: 1. CHP Member Information Requirements Delegation Policy – Entire policy. 2. 104LC ValueOptions® Compliance Department Confidentiality Policy – Entire policy 3. 104LCA ValueOptions® Confidentiality Non-Disclosure Agreement – Entire policy 4. 304L Member Rights and Responsibilities Policy – Entire policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO policy, National Compliance Department Confidentiality, and the corresponding employee confidentiality agreement described the types of protected information. The VO policy, Member Rights and Responsibilities, detailed the provisions pertaining to adherence to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).		
	Required Actions: None		

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Results for Standard IV—Member Rights and Protections									
Total	Met	=	<u>6</u>	X	1.00	=	<u>6</u>		
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>		
Total Applicable		=	<u>6</u>		Total Score	=	<u>6</u>		
Total Score ÷ Total Applicable						=	<u>100%</u>		

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Standard VI—The Grievance System (Grievances Only)			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.402(a) Volume 8 8.209.1	1. The Contractor has a system in place that includes a grievance process.	Documents Submitted/Location Within Documents: 1. CHP Grievance Delegation Policy (entire policy) 2. CHP_304_Grievance Process.pdf (entire policy) 3. Grievance section of staff training. (ppt) 4. CHP Advocates list 5. CHP grievance flow chart	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Grievance Delegation policy detailed its delegation of the grievance process to VO. VO was responsible for the operational activities and maintenance of the grievance system, which included receiving oral and written grievances and processing grievances according to federal and State guidelines. VO was responsible for maintaining grievance policies, which described the process. The CHP Grievance Delegation policy described the oversight functions provided by CHP to ensure that the delegate maintained an adequate grievance process. The VO Grievance Process policy detailed the processes by which members may file a grievance, the procedures used for processing member grievances, and the process by which grievances were received and processed by VO.		
	Required Actions: None		
42CFR438.400(b) Volume 8 8.209.2	2. The Contract defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or an employee, or failure to respect the member's rights.	Documents Submitted/Location Within Documents: 1. CHP_304_Grievance Process.pdf, pg. 3 Section, IV D 2. Member handbook, page 16 (misc folder) 3. CHP web site Member Handbook screen shot: http://www.coloradohealthpartnerships.com/members/mbr_hbk.htm	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy defined a grievance as “an oral or written expression of dissatisfaction about any matter other than an Action, including but not limited to quality of care or services provided, and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights.” The CHP member handbook and the CHP provider handbook provided evidence that the BHO communicated this definition of a grievance to members and providers via the respective handbooks.		
	Required Actions: None		

Standard VI—The Grievance System (Grievances Only)			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.402(b)(1) Volume 8 8.209.1	3. The Contractor has provisions for who may file grievances: ◆ A member may file a grievance (or his or her authorized representative), ◆ A provider may file a grievance on behalf of a member (Colorado permits the provider to act as the member's authorized representative)	Documents Submitted/Location Within Documents: 1. ValueOptions® Designated Client Representative Form 2. CHP_304_Grievance Process.pdf (section IV.c. -designated client representative) 3. Screen shot grievance data base DCR	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy detailed VO's provision for who may file a grievance. The policy stated that a member may file either a written or verbal grievance and that a member may designate a representative to file a grievance on his or her behalf. The VO Designated Client Representative form provided evidence that the BHO maintained a form for members to complete if they wished to designate a representative to file a grievance on their behalf. The CHP member handbook and CHP provider handbook provided evidence that the BHO communicated who may file a grievance on a member's behalf to members and providers.		
	Required Actions: None		
42CFR438.402(b)(3) Volume 8 8.209.5.D	4. The Contractor accepts grievances orally or in writing.	Documents Submitted/Location Within Documents: 1. CHP_304_Grievance Process.pdf, Section, III.c. 2. Member handbook page 17	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy provided evidence of VO's provision for accepting grievances orally or in writing. The CHP member handbook and CHP provider handbook stated that a member may file a grievance or designate a representative—such as a friend, family member, or provider—to file a grievance on the member's behalf, either orally or in writing. The on-site grievance file review provided evidence that the BHO accepted grievances orally and in writing from members.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.402(b)(2) Volume 8 8.209.5.A	5. The member has 20 calendar days from the date of the incident to file a grievance.	Documents Submitted/Location Within Documents: 1. Member handbook, page 17 (Misc Folder) 2. CHP Web Site Member Rights Screen Shot http://www.coloradohealthpartnerships.com/members/mbr_your_rights.htm	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy detailed VO's provision that a member has 20 calendar days from the date of an incident to file a grievance. The CHP provider handbook detailed the provision that all grievances must be filed within 20 calendar days from the day of the occurrence. The CHP member handbook provided evidence that CHP informed members that they have 20 calendar days from the time of the event to file a grievance.		
	Required Actions: None		
42CFR438.406(a) Volume 8 8.209.4.C	6. In handling grievances, 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.	Documents Submitted/Location Within Documents: 1. Member handbook, Page 10 – interpreter services (Misc Folder)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Grievance Delegation policy stated that the delegated entity would provide reasonable assistance in completing forms and taking other procedural steps, including providing interpreter services and toll-free telephone numbers with an adequate teletype/telecommunications device for the deaf (TTY/TDD) and interpreter capability for members who file a grievance. The VO Grievance Process policy detailed the provision for assisting members with filing a grievance. The CHP member handbook included information to members that assistance was available to members who file a grievance. CHP staff stated that OMFA staff assisted members with filing a grievance orally and in writing. For individuals who were deaf or hard of hearing, CHP staff stated that staff used Relay Colorado to communicate with them about their grievance. For Spanish-speaking members, CHP staff stated that a grievance would be routed to the clinical department first, where clinical staff would access the Language Line. Language Line representatives would provide interpretation with clinical staff present so that clinical staff could determine if the grievance involved a clinical issue. If the grievance involved a clinical issue, clinical staff would remain on the line to process and potentially resolve the grievance. If it was determined that the grievance did not involve a clinical issue, CHP staff stated that VO employed Spanish-speaking staff to receive the		

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References	Requirement	Evidence Submitted by the BHO	Score
	grievance or translate on the member's behalf. CHP staff members also stated that staff members who received and processed grievances were trained in accessing the Language Line for members with limited English proficiency.		
	Required Actions: None		
42CFR438.406(a) Volume 8 8.209.5.B	7. The Contractor acknowledges each grievance in writing within two working days of receipt.	Documents Submitted/Location Within Documents: 1. CHP_304_Grievance Process.pdf , Section V.a.4 2. Member handbook page 17 (Misc Folder) 3. CHP website http://www.coloradohealthpartnerships.com/members/mbr_hbk.htm 4. CHP grievance acknowledgement letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy detailed VO's provision for acknowledging grievances within two working days of receipt of a grievance, and within one day for urgent care grievances. Of the 10 grievance files reviewed, all 10 grievances were acknowledged within two working days of receipt.		
	Required Actions: None		
42CFR438.406(a) Volume 8 8.209.5.C	8. The Contractor ensures that the individuals who make decisions on grievances are individuals who: ◆ Were not involved in any previous level of review or decision-making ◆ If deciding a grievance regarding the denial of expedited resolution of an appeal, or a grievance that involves clinical issues, has the appropriate clinical expertise in treating the member's condition or disease.	Documents Submitted/Location Within Documents: 1. CHP_304_Grievance Process.pdf, Section V.A.9 2. Member handbook, page 17 3. CHP website http://www.coloradohealthpartnerships.com/members/mbr_hbk.htm	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy detailed VO's provision that individuals who make decisions about grievances are not involved in any previous level of review or decision making and have the appropriate clinical expertise in treating the client's condition if they are		

Standard VI—The Grievance System (Grievances Only)			
References	Requirement	Evidence Submitted by the BHO	Score
	deciding a grievance that involves clinical issues. Of the 10 grievance files reviewed, all 10 files provided evidence that staff members who resolved the grievances were not involved in any previous level of review or decision making. Of the 10 grievance files reviewed, 3 files involved a clinical issue, and all three files provided evidence that staff members who were involved in resolving the grievance had the appropriate clinical expertise in treating the member's condition or disease. Required Actions: None		
42CFR438.408(b)&(d) Volume 8 8.209.5.D &F	9. The Contractor must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the Contractor receives the grievance. The notice includes: ◆ The results of the disposition/resolution process ◆ The date it was completed	Documents Submitted/Location Within Documents: 1. CHP_304_Grievance Process.pdf. Section V.A.10,11 2. Grievance resolution letter template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy detailed VO's provision that written resolution of a grievance will occur as expeditiously as the member's health condition requires, but will not exceed 15 working days from the day the grievance was received. All 10 of the grievance files reviewed provided evidence that grievances were resolved within the required time frame and that letters of disposition contained the required content.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.408(c) Volume 8 80209.5.E	10. The Contractor may extend the timeframes for resolution of grievances by up to 14 calendar days if: ◆ The member requests the extension, or ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest	Documents Submitted/Location Within Documents: 1. CHP_304_Grievance Process.pdf , Section V.A.12 2. CHP delay template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy stated that the time frame for resolution of a grievance may be extended by up to 14 calendar days if the member requests the extension or if a review of the grievance determines the need for additional information and that a delay is in the member's best interest. Of the 10 grievance files reviewed, one grievance was extended. The file contained evidence that the BHO notified the member of the need to extend the grievance prior to the original due date for disposition of the grievance. The letter of extension contained the reason for the delay, which was in the member's best interest to resolve the grievance.		
	Required Actions: None		
42CFR438.408(c)(2) Volume 8 80209.5.E	11. If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.	Documents Submitted/Location Within Documents: 1. CHP_304_Grievance Process.pdf, Section V.A.12 2. CHP delay template	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy detailed VO's provision for giving the member prior written notice of the reason for the delay if the time frame is extended. The CHP Delay in Resolution Letter template provided evidence of the BHO's mechanism for informing members in writing of the reason for the delay to resolve the grievance. Of the 10 grievance files reviewed, 1 grievance was extended. The file contained evidence that prior to the original due date for resolution of the grievance, the BHO notified the member in writing of the need to extend the grievance. The letter of extension contained the reason for the delay, which was in the member's best interest to resolve the grievance.		
	Required Actions: None		

Standard VI—The Grievance System (Grievances Only)			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.414 Volume 8 8.209.3.B	12. 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 timeframes 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 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 ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service	Documents Submitted/Location Within Documents: 1. Provider Handbook (Misc folder) – Pages 30-33 and 91-92 of 110. 2. Screenshot provider handbook web page	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—The Grievance System (Grievances Only)			
References	Requirement	Evidence Submitted by the BHO	Score
	Findings: As part of its delegated functions, VO provided the grievance system information specified in 42 CFR 438.10 to providers as part of their approved credentialing packet when they enter into a provider contract with VO. The information was provided in the provider handbook and member handbook, both of which were available online. The CHP provider handbook provided evidence that providers were informed of the following member grievance information: the right to file grievances; the toll-free telephone numbers to file a grievance orally; 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 a State fair hearing; the availability of assistance with filing a grievance, an appeal, or requesting a State fair hearing; and 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 CHP member handbook and CHP provider handbook also listed all of the avenues by which members may file a grievance and included the toll-free telephone numbers available to members to file a grievance orally with the plan. The CHP member handbook contained the provision that if benefits continue during the appeal or State fair hearing processes, 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. The CHP member handbook and CHP provider handbook contained the provision that providers may serve as a member's designated representative and file an appeal on the member's behalf with the written permission of the member.		
	Required Actions: None		
42CFR438.416 Volume 8 8.209.3.C	13. The Contractor maintains records of all grievances, and submits quarterly reports to the Department.	Documents Submitted/Location Within Documents: 1. 304 Grievance Process Policy – Page 11 of 12. 2. Screen shot grievance data base home page 3. Screen shot grievance data base report page	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Grievance Process policy described VO's processes for maintaining records of all grievances and submitting quarterly reports to the Department on the last day of the month following each quarter. The CHP Grievance Database screen print provided evidence of the types of grievance information collected and stored in the database. The CHP Grievance Delegation policy detailed the BHO's provision for monitoring the scope and activities of VO's grievance system.		
	Required Actions: None		

Results for Standard VI—The Grievance System (Grievances Only)									
Total	Met	=	13	X	1.00	=	13		
	Partially Met	=	0	X	.00	=	0		
	Not Met	=	0	X	.00	=	0		
	Not Applicable	=	0	X	NA	=	0		
Total Applicable		=	13		Total Score	=	13		
Total Score ÷ Total Applicable						=	<u>100%</u>		

Standard VII—Provider Participation and Program Integrity			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.102(a)	1. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient for the following: ◆ The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered ◆ Any information the member needs in order to decide among all relevant treatment options ◆ The risks, benefits, and consequences of treatment or non-treatment ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions	Documents Submitted/Location Within Documents: 1. CHP Provider Network Delegation Policy – entire policy 2. Provider Contract Colorado Medicaid Provider Addendum – Page 1, Section B.6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Provider Network Delegation policy stated that the CHP delegated operational responsibility for provider networking and contracting to VO. The Provider Contract Colorado Medicaid Provider Addendum detailed VO's provisions for not prohibiting or restricting health care professionals from advising or advocating on behalf of a member who is the provider's patient.		
	Required Actions: None		

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Standard VII—Provider Participation and Program Integrity			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.102(b)	2. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: ◆ To the State ◆ To member before and during enrollment ◆ To members within 90 days after adopting the policy with respect to any particular service (consistent with the format provisions in 42CFR438.10) (The Contractor need not furnish information on how and where to access the service.)	Documents Submitted/Location Within Documents: 1. CHP Provider Network Delegation Policy – entire policy 2. CHP Member Handbook (Misc folder) –Page 9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings:		
	The CHP member handbook contained the provision that CHP and VO did not deny services based on moral or religious grounds.		
	Required Actions: None		

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Standard VII—Provider Participation and Program Integrity			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.12(a)(1) 42CFR438.214(c)	3. The Contractor does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and does not discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Documents Submitted/Location Within Documents: 1. CHP Provider Network Delegation Policy – entire policy 2. N401 Primary Source Verification Policy – Pages 1-2, Sections A.1-11 and IV.G	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Primary Source Verification policy detailed VO's nondiscriminatory provisions that providers were not discriminated against based on their specialty, license or certification, or the population to which they provide services.		
	Required Actions: None		

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Standard VII—Provider Participation and Program Integrity			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.12(a)(1)	4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.	Documents Submitted/Location Within Documents: 1. CHP Provider Network Delegation Policy – entire policy 2. N201 Practitioner Credentialing Process Policy – Page 4, Section H.2 3. Provider Program Participation Denial Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing Process policy provided evidence that VO maintained provisions for declining to include providers in its network as a result of the credentialing process. The policy stated that recommendations to deny participation in the network were forwarded to the VO NCC for review and a determination of network participation. If the VO NCC's recommendation was to deny credentialing, the practitioner was notified in writing within five business days of the date of the decision the reason(s) for the denial. The practitioner was also notified of his or her rights to appeal to the VO Provider Appeals Committee within 30 calendar days from the date on the letter of notification. The VO Provider Program Participation Denial Letter template provided evidence of the type of communication sent to providers if the VO declined a provider or group of providers participation in the provider network. For cases in which there was no defined network need to include a new provider, VO staff stated that the provider would receive a letter of denial. During the on-site review, VO staff produced a letter of denial that was sent to a practitioner. The letter included the reason for the denial, which was that network capacity did not warrant a new practitioner with that particular specialty.		
	Required Actions: None		

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Standard VII—Provider Participation and Program Integrity			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.106	5. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor’s debts in the event of the Contractor’s or subcontractor’s insolvency ◆ Covered services provided to the member for which the State does not pay the Contractor ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider that provides the services under a contractual, referral, or other arrangement ◆ Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly	Documents Submitted/Location Within Documents: 1. CHP Provider Network Delegation Policy – entire policy 2. Provider Contract Colorado Medicaid Addendum – Page 3, Section H.3 3. ValueOptions® Practitioner Agreement – Pages 4-5 4. ValueOptions® Facility Agreement – Page 5	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Provider Contract Colorado Medicaid Addendum contained provisions that Medicaid members were not held liable for payments of covered services that were the legal obligation of VO and/or the payor in instances including the insolvency of a payor or VO, breach of an agreement by VO, and/or nonpayment for covered services. The VO Practitioner Agreement and VO Facility Agreement provided evidence of VO’s provision that a practitioner or facility may not in any event—including nonpayment by VO or the payor, insolvency of VO or the payor, or breach of the agreement—bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a member, subscriber, enrollee person to whom health care services have been provided, or person acting on behalf of the member for whom health care services were provided pursuant to the agreement.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.214(d)	6. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act.	Documents Submitted/Location Within Documents: 1. CHP Network Delegation Policy- entire policy 2. CHP Credentialing & Recredentialing Delegation Policy – entire policy 3. N401 Primary Source Verification Policy– Page 4 4. N401H Sanction Notification Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: CHP Credentialing & Recredentialing Delegation policy detailed CHP’s provisions for delegating the operational responsibilities of credentialing and recredentialing to VO. The policy also detailed the BHO’s provisions for conducting annual reviews prior to the automatic renewal of a delegation agreement to ensure that VO maintained compliance with all applicable credentialing and recredentialing standards and regulations such that the delegate did not employ or contract with providers excluded from participation in federal health care programs under Title XI of the Social Security Act, Sections 1128 and 1128A. The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source a provider’s credentials, licenses, and applicable education and experience as part of the credentialing and recredentialing processes. The policy listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities. The decision to deny credentialing or participation in the network based on information found during the primary source verification was maintained by the VO NCC.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.608	7. The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: ♦ Written policies and procedures and standards of conduct that articulate the Contractor’s commitment to comply with all applicable federal and State standards ♦ The designation of a compliance officer and a compliance committee that are accountable to senior management ♦ Effective training and education for the compliance officer and the Contractor’s employees ♦ Effective lines of communication between the compliance officer and the Contractor’s employees ♦ Enforcement of Standards through well publicized disciplinary guidelines ♦ Provision for internal monitoring and auditing ♦ Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Medicaid managed care contract requirements	Documents Submitted/Location Within Documents: 1. CHP Management Service Agreement -entire document 2. CHP Compliance Plan - entire document 3. CHP Fraud & Abuse Policy - entire document 4. CHP Re view & Monitoring of Fraud & Abuse - entire document 5. 2009 Compliance Training Attendance Sheet 6. 2009 Compliance Training PowerPoint 7. COG Minutes April 2009 dedicated to training 8. CHP Code of Conduct	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Compliance Plan and the Fraud and Abuse policy detailed the BHO’s provisions and policies for complying with all applicable federal and State standards and warding against fraud and abuse. The Compliance Plan stated that the CHP Class A Board of Managers delegated oversight of the compliance program to the CHP Compliance Oversight Group. Membership of		

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	the Compliance Oversight Group included representatives from VO, representatives from each partner LLC, and the executive director of CHP. The Compliance Plan also stated that the CHP executive director served as the compliance officer and was responsible for reporting compliance-related issues to the Class A Board. The Compliance Plan detailed the type and frequency of compliance trainings for officers, managers, employees, and contractors. The Compliance Plan also detailed the provision for internal monitoring and auditing, enforcement of standards through disciplinary guidelines, and prompt response to detected offenses, including the development of corrective actions or engaging legal counsel as necessary. The CHP Fraud and Abuse policy detailed the types of penalties for confirmed fraud or abuse. The Review and Monitoring of Fraud and Abuse policy described CHP’s internal monitoring and auditing for fraud and abuse. The Compliance Training PowerPoint provided evidence of the information presented to employees for compliance training, and the Compliance Training Attendance Sheet provided evidence that employees attended the required compliance training.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.610	8. The Contractor may not knowingly have a director, partner officer, employee, subcontractor, or owner (owning 5 percent or more of the entity) who is debarred, suspended or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549. Findings: The CHP Provider Contract Colorado Medicaid Addendum contained the provisions that providers may not employ or contract with any individuals or entities who have been disbarred, suspended, or otherwise excluded from participation in any government-sponsored health care program, including, without limitation, the Colorado Medicaid program or the federal Medicare program. The CHP Management Services Agreement with VO included a certification clause in which VO certified that neither it nor its principles were debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from providing services required by the Medicaid contract by any federal department or agency. CHP staff stated that CHP conducted a monthly review of the Office of Inspector General (OIG) database to verify that Class A and Class B board members, which included CHP and partner staff, were not debarred, suspended, or otherwise excluded from participation in any government-sponsored health care program. The monthly OIG reports provided evidence that CHP staff conducted the review. Required Actions: None	Documents Submitted/Location Within Documents: 1. CHP Management Service Agreement, page 8, section 8.7 2. CHP OIG Results 3. Provider Contract Colorado Medicaid Addendum, page 2, D.1.a-d	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Results for Standard VII—Provider Participation and Program Integrity									
Total	Met	=	<u>8</u>	X	1.00	=	<u>8</u>		
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>		
Total Applicable		=	<u>8</u>	Total Score	=	<u>8</u>			

Total Score ÷ Total Applicable = 100%

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References	Requirement	Evidence Submitted by the BHO	Score
NCQA—CR1	1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. CHP Management Services Agreement – entire agreement 3. CHP Delegation Agreement – entire agreement 4. N101 Overview of National Networks Policy – entire policy 5. N201 Practitioner Credentialing Process – entire policy 6. N203 Facility Provider Credentialing Process – entire policy 7. N501 Practitioner Recredentialing Process – entire policy 8. N502 Facility Program Clinic Recredentialing Process – entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Credentialing and Recredentialing Delegation policy described CHP’s delegation of credentialing and recredentialing activities to VO. The CHP Credentialing and Recredentialing Delegation policy also described CHP’s oversight of VO’s credentialing and recredentialing program, which included verifying that VO maintained a well-defined credentialing and recredentialing process for evaluating contracting with licensed practitioners to provide services to members. The VO Practitioner Credentialing Process and Facility Provider Credentialing Process policies described VO’s credentialing process for evaluating and selecting providers to participate in the network and provide services to members. VO’s process for credentialing practitioners included the use of an application completed by the practitioner, attestation from the practitioner, primary source verification, and recommendations to the medical director to approve credentialing of practitioners who completed the credentialing process and whose files were considered “clean” and did not contain any information that would lead to a denial of credentialing of the practitioner. The VO Facility/Provider Credentialing Process policy described VO’s credentialing process for facilities and stated that all facilities must complete the credentialing process and be approved by the VO NCC prior to the execution of an agreement with VO. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of credentialing files to the NCC prior to the NCC’s review of credentialing files.		

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	The VO Practitioner Recredentialing Process policy and the Facility Provider Recredentialing Process policy described VO’s process for recredentialing providers who participated in the network and provided services to members. VO’s process for recredentialing practitioners included the use of an application completed by the practitioner, attestation from the practitioner, primary source verification, and recommendations to the medical director to recredential practitioners whose files were considered “clean” and did not contain any information that would lead to a denial of recredentialing of the practitioner. The VO Facility/Provider Recredentialing Process policy described VO’s recredentialing process for facilities and stated that all facilities must complete the recredentialing process and be approved by the VO NCC. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of recredentialing files to the NCC prior to the NCC’s review of recredentialing files. Required Actions: None		
NCQA CR1— Element A Element B NCQA CR9— Element A NCQA CR10— Element A Element B Element C 42CFR438.214(a) NCQA CR1— Element A and B NCQA CR9 CR10-Element A and C	2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers, psychiatric nurse specialist, and or licensed professional counselors.	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N205 Discipline Specific Credentialing Criteria for Practitioners – entire policy 3. N301 Development of Credentialing Criteria – entire policy 4. N410 Acceptable State Licensure for Practitioner Participation – entire policy 5. N410A State Licensure Grid 6. N410B Advanced Practice Nurse (APN) Standards 7. Provider Credentialing Criteria Checklist	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Discipline Specific Credentialing Criteria for Practitioners policy specified the types of practitioners that VO credentialed and recredentialed, including all physicians, such as psychiatrists, and nonphysician practitioners, such as clinical social workers and licensed professional counselors, who had an independent relationship with VO. The VO Applicable State Licensure Grid detailed the applicable state licenses for all physician and nonphysician providers by state, which included Colorado. The VO Provider Credentialing Criteria Checklist contained the specific criteria and checklist, by provider specialty, of documents and information that must be sent to VO prior to processing the credentialing application for each practitioner. The VO Provider Data Sheet, which was generated from the VO NetworkConnect online provider credentialing and recredentialing database, contained evidence of the types of practitioners that were to be credentialed or recredentialed.		

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	Required Actions: None		
	2.B. The verification sources used	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N401 Primary Source Verification Policy – entire policy 3. N401A Primary Source Verification Report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source a provider’s credentials, licenses, and applicable education and experience as part of the credentialing and recredentialing processes. The policy listed the types of primary source databases used, such as the National Practitioner Data Bank (NPDB), OIG reports, and the National Student Clearinghouse, to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities.		
	Required Actions: None		
	2.C. The criteria for credentialing and recredentialing	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N201 Practitioner Credentialing Process – entire policy 3. N203 Facility Provider Credentialing Process – entire policy 4. N401 Primary Source Verification Policy – entire policy 5. N205 Discipline Specific Credentialing Criteria for Practitioners – entire policy 6. N206 Credentialing Criteria for Facility Organizational Providers – entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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References	Requirement	Evidence Submitted by the BHO	Score
		7. N501 Practitioner Recredentialing Process – entire policy 8. N502 Facility Program Clinic Recredentialing Process – entire policy	
	Findings: The VO Practitioner Credentialing Process policy and the Facility Provider Credentialing Process policy described VO’s credentialing criteria for evaluating and selecting providers to participate in the network and provide services to members. VO’s criteria for credentialing practitioners included the provision that practitioners submit a completed application and attestation form so VO may complete primary source verification of all licenses, certifications, and educational and employment experience; clinical privileges, if applicable; malpractice history; evidence that the applicant was not excluded from participation in federally funded programs, including Medicare and Medicaid; and criminal background or criminal record. The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source a provider’s credentials, licenses, and applicable education and experience as part of the credentialing processes. The policy listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities. The VO Credentialing Criteria for Facility/Organizational Provider policy detailed the program-specific criteria that must be met for VO to approve credentialing of a facility. The VO Facility/Provider Credentialing Process policy described VO’s credentialing criteria for facilities and stated that all facilities must complete the credentialing process and be approved by the VO NCC prior to the execution of an agreement with VO. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of credentialing files to the NCC prior to the NCC’s review of credentialing files. The VO Practitioner Recredentialing Process policy and the Facility Provider Recredentialing Process policy described VO’s criteria for recredentialing providers who participated in the network and provided services to members. VO’s criteria for recredentialing practitioners included the requirement for practitioners to submit a completed application and attestation form. The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source a provider’s credentials, licenses, and applicable education and experience as part of the recredentialing processes. The VO Facility/Provider Recredentialing Process policy described VO’s recredentialing criteria for facilities and stated that all facilities must complete the recredentialing process and be approved by the VO NCC. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of recredentialing files to the NCC prior to the NCC’s review of recredentialing files.		
	Required Actions: None		

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	2.D. The process for making credentialing and recredentialing decisions	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N101 Overview of National Networks Policy – Entire policy 3. N201 Practitioner Credentialing Process – Entire policy 4. N501 Practitioner Recredentialing Process - Entire policy 5. N203 Facility Provider Credentialing Process – Entire policy 6. N502 Facility Program Clinic Recredentialing Process – Entire policy 7. N601 Role of National Credentialing Committee – Entire policy 8. N604 Role of Local Credentialing Committee – Entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing Process policy and the Facility Provider Credentialing Process policy described VO’s process for making credentialing decisions and selecting providers to participate in the network. VO’s process for credentialing practitioners included the use of an application completed by the practitioner, attestation from the practitioner, and primary source verification. The policies described the process by which “clean” files with recommendations for approval were forwarded to the VO medical director, who acted on behalf of the VO NCC, to approve clean credentialing files. The VO Role of Colorado Local Credentialing Committee policy detailed the roles and responsibilities of the CLCC for reviewing and rendering credentialing and recredentialing decisions. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of credentialing files to the NCC prior to the NCC’s review of credentialing files. Recommendations to deny credentialing applications were forwarded to the NCC for review and determination of network participation. The VO Practitioner Recredentialing Process policy and the Facility Provider Recredentialing Process policy described VO’s criteria for recredentialing providers who participated in the network and provided services to members. VO’s criteria for recredentialing practitioners included the requirement for practitioners to submit a completed application and attestation form. The		

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	VO Primary Source Verification policy detailed VO's process for verifying at the primary source a provider's credentials, licenses, and applicable education and experience as part of the recredentialing processes. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of recredentialing files to the NCC prior to the NCC's review of recredentialing files. The VO Facility/Provider Recredentialing Process policy described VO's recredentialing criteria for facilities and stated that all facilities must complete the recredentialing process and be approved by the VO NCC. Required Actions: None		
	2.E. The process for managing credentialing/recredentialing files that meet the Contractor's established criteria	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N202 Organization of Practitioner Credentialing & Recredentialing File – Entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Organization of Practitioner Credentialing & Recredentialing File policy described VO's use of a proprietary electronic database for storing and managing credentialing and recredentialing files for practitioners and facilities. According to the criteria established by policy, the credentialing database stored the following: provider agreements, applications, compliance documents, correspondence, credentialing/recredentialing information, disenrollment, education, foreign network documentation, invalid documents, legal documents, licensure, malpractice insurance, primary source verification documents and results, resumes, and other documents. Required Actions: None		
	2.F. The process for delegating credentialing or recredentialing (if applicable)	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. CHP Management Services Agreement – entire policy 3. CHP Delegation Agreement – entire policy 4. N201 Practitioner Credentialing Process – Entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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		5. N501 Practitioner Recredentialing Process - Entire policy 6. N203 Facility Provider Credentialing Process – Entire policy 7. N502 Facility Program Clinic Recredentialing Process – Entire policy	
	Findings: The CHP Credentialing and Recredentialing Delegation policy described CHP’s delegation of credentialing and recredentialing activities to VO. The CHP Credentialing and Recredentialing Delegation policy described CHP’s oversight of VO’s credentialing and recredentialing program, which included verifying that VO maintained a well-defined credentialing and recredentialing process for evaluating contracting with licensed practitioners to provide services to members. The CHP Credentialing Delegation Oversight Monitoring Report, which was presented to the Class A Board of Managers, provided evidence of CHP’s oversight monitoring of VO credentialing and recredentialing activities. The report detailed the results of the credentialing and recredentialing file review conducted by CHP, which occurred February 3 and 4, 2010, and a summary that VO’s credentialing and recredentialing processes and procedures were in compliance with CHP requirements.		
	Required Actions: None		
	2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes)	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N101 Overview of National Networks Policy – entire Policy 3. N201 Practitioner Credentialing Process – Page 2, Section IV.D	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing policy described VO’s process for credentialing providers who sought to participate in the network. The policy contained VO’s nondiscriminatory clause that VO did not make credentialing decisions based on an applicant’s race, ethnic/national identity, gender, age, or sexual orientation, or based on the type of procedure or patient in which the		

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	practitioner specialized. The VO Practitioner Recredentialing Process policy described VO's process for recredentialing providers who participated in the network. The policy contained VO's nondiscriminatory clause that VO did not make recredentialing decisions based on an applicant's race, ethnic/national identity, gender, age, or sexual orientation, or based on the type of procedure or patient in which the practitioner specialized. The VO Overview of National Networks policy contained the provision that the NCC was made up of a diverse group of peers who were required to sign statements of nondiscrimination to participate on the panel. The policy described the steps the NCC took to ensure that credentialing and recredentialing activities occurred in a nondiscriminatory manner, which included an annual evaluation of network policies to ensure that practices did not occur in a nondiscriminatory manner and a bi-annual audit of 15 practitioner files to review credentialing activity for potential discrimination. The Bi-Annual Audit Report for July through December 2009 contained evidence of VO's review of credentialing files to determine that discrimination did not occur during the credentialing and recredentialing process. The VO Overview of National Networks policy described the process by which the credentialing director reviewed quarterly reports that captured all documented telephone calls or letters from providers alleging discrimination.		
	Required Actions: None		
	2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N207 Practitioner Rights and Notification Policy – Page 3, Section V.B.1-2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Rights and Notification policy described VO's process for notifying practitioners if information obtained during the credentialing and recredentialing process varied from the information provided to VO by the practitioner. The policy stated that VO credentialing staff notified the practitioner within five business days if there was a discrepancy between information presented by the practitioner and what was discovered during the primary source verification process. VO staff stated that if information reported by the practitioner on the application differed from the information obtained from primary source verification, VO notified the practitioner by telephone, e-mail, or fax of the differing information prior to issuing the formal letter. The VO Practitioner Rights and Notification policy further stated that the applicant had 10 business days to submit clarification and/or provide supporting documentation to resolve the conflict and continue the review process. The policy included provisions in		

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	the event practitioners did not respond to the request for clarification, at which time the credentialing administrator forwarded the file to the NCC with a recommendation to deny initial credentialing or disenroll the practitioner from the network.		
	Required Actions: None		
	2.I. The process for ensuring that practitioners are notified of the credentialing/recredentialing decision within 60 calendar days of the committee's decision	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N201 Practitioner Credentialing Process – Page 1, Section III.D.5 N601 Role of National Credentialing Committee – Page 1, Section III.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Role of National Credentialing Committee policy included the provision that all practitioners and providers were notified of all favorable network participation/retention decisions within 60 calendar days of the NCC's decision, and that practitioners and providers were notified of all decisions for denial or disenrollment within five business days of the NCC's decision.		
	Required Actions: None		
	2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/recredentialing program	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N601 Role of National Credentialing Committee – Page 1, Section III.C; Page 2, Section IV, Section V.A. and V.F.2 3. N604 Role of Local Credentialing Committee – Page 2, Section V.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Role of National Credentialing Committee policy detailed the roles and responsibilities of the committee. The VO Role of Colorado Local Credentialing Committee policy detailed the roles and responsibilities of the committee. The VO Role of National Credentialing Committee policy described the leadership of the committee, which consisted of two co-chairpersons, the chief medical officer or designated medical director, and the credentialing representative within National Networks. The VO Role of		

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	Colorado Local Credentialing Committee policy described the leadership of the committee, which consisted of the local medical director or designee, who served as the chairperson, and participating practitioner representatives from clinical disciplines, including psychiatry, psychology, nursing, social work, and counseling. The VO Role of Colorado Local Credentialing Committee policy stated that committee membership was also made up of representatives from related local departments, including network management, quality management, provider relations, and clinical services. The NCC and CLCC meeting minutes reviewed on-site provided evidence of the medical director's participation in the credentialing committees.		
	Required Actions: None		
	2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/recredentialing process, except as otherwise provided by law	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N409 Confidentiality of Provider Other Credentialing Information – Page 1, Section III.B	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Confidentiality of Provider Other Credentialing Information policy described VO's provision for maintaining the confidentiality of practitioner information obtained for the purposes of credentialing. The policy detailed the process for ensuring the confidentiality of information, which included: maintaining a secure electronic format or physically secure file cabinet that contained confidential information, requiring credentialing staff to sign a confidentiality and nondisclosure agreement, confirming the practitioner's identify prior to disclosing confidential information telephonically, ensuring that NCC participants sign a confidentiality and nondisclosure agreement on an annual basis, and ensuring that information is not released without prior explicit consent from providers.		
	Required Actions: None		
	2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N412 Provider Directory & Other Enrollee Information – Page 1, Section III	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	Findings: The VO Provider Directory & Other Enrollee Information policy provided evidence of VO’s process to ensure that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. Information listed in the provider directory was derived from the credentialing database, which could not be changed unless authorized by the provider.		
	Required Actions: None		
	2.M. The right of practitioners to review information submitted to support their credentialing/recredentialing application	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N207 Practitioner Rights and Notification Policy – Page 1, Section III.1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Rights and Notification policy detailed VO’s provision for allowing practitioners to review information submitted to support their credentialing and recredentialing applications. The VO Credentialing Application Cover Letter provided evidence that practitioners were notified of their right to review information in their credentialing file and to call VO if they had questions. The provider handbook listed the telephone numbers, fax lines, e-mail address, and physical location address of the VO credentialing department for providers to contact VO to update or modify provider information. Credentialing and recredentialing files reviewed on-site provided evidence that practitioners were notified of their credentialing rights at the time of application.		
	Required Actions: None		
	2.N. The right of practitioners to correct erroneous information	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N207 Practitioner Rights and Notification Policy – Page 1, Section III.3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Rights and Notification policy described VO’s process for notifying practitioners if information obtained during the credentialing and recredentialing process varied from the information provided to VO by the practitioner. The policy stated that applicants had the opportunity to submit clarification and/or provide supporting documentation to resolve the conflicting or erroneous information.		

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References	Requirement	Evidence Submitted by the BHO	Score
	Required Actions: None		
	2.O. The right of practitioners, upon request, to receive the status of their application	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N207 Practitioner Rights and Notification Policy – Page 1	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Rights and Notification policy described the right of practitioners to request information regarding the status of their credentialing and recredentialing applications and be provided that information by credentialing staff. The policy stated that practitioners could request the status of their credentialing or recredentialing application by calling the National Networks Provider Line, the credentialing administrator directly, or by written communication. The credentialing and recredentialing files reviewed on-site provided evidence that VO notified providers at the time of application of the right to request information about the status of the provider’s application.		
	Required Actions: None		
	2.P. The right of the applicant to receive notification of their rights under the credentialing program	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N207 Practitioner Rights and Notification Policy – Page 1, Section III.3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Rights and Notification policy provided evidence of VO’s provision for credentialing and recredentialing applicants to receive notification of their rights under the credentialing program, such as the right to review information in their credentialing application, correct erroneous information, and request information about the status of their application. The VO Credentialing Application Cover Letter, which was sent to providers who requested a credentialing application, provided evidence that practitioners were notified of their rights under the credentialing program at the time of applying for credentialing and inclusion in the network. The credentialing and recredentialing files reviewed on-site provided evidence that the cover letter was submitted to providers with the credentialing application.		
	Required Actions: None		

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	2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions ◆ Collecting and reviewing sanctions or limitations on licensure ◆ Collecting and reviewing complaints ◆ Collecting and reviewing information from identified adverse events ◆ Implementing appropriate interventions when it identified instances of poor quality, when appropriate	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N710 Ongoing Monitoring of Provider Sanctions – Page 1, Section III 3. N710A State Sanctions Log 4. N710C Office of Inspector General Log 5. N703 Involuntary Suspension Quality of Care – Page 1 6. 309 Quality of Care Issues and Outlier Practice Patterns – Entire policy 7. 308 Critical Adverse Incidents Policy – Entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Ongoing Monitoring of Provider Sanctions policy detailed VO’s provision for continually monitoring practitioner sanctions, complaints, and quality issues between recredentialing cycles. The policy stated that it was the responsibility of the credentialing administrator to review disciplinary action/sanction reports to identify any VO-credentialed practitioners or organizational providers sanctioned by Medicare/Medicaid or by a federal or state agency or licensure or certification board. The review also consisted of identifying any practitioners who were excluded from or opted out of the Medicare program. The policy contained the provision that disciplinary action reports must be reviewed within 30 days of their release date by the reporting entity. For any VO provider who was identified on the disciplinary action/sanction report, the credentialing administrator queried the NPDB to obtain additional information on the sanction or disciplinary action. The policy also specified the provision for the credentialing administrator to forward complaints, quality issues, sanctions, or other adverse events to the NCC with the recommendation to review the information and make a decision regarding the practitioner’s participation in the network. The monthly OIG sanction report provided evidence that VO conducted a monthly search of the OIG database for all practitioners.		
	Required Actions: None		

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	2.R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy- entire policy 2. N701 Practitioner and Provider Compliance – Pages 3, Section V.B.8.1-2, C, D and Page 4, Section V.E 3. N703 Involuntary Suspension Quality of Care – Pages 1, Section III and Page 3, Section V.B 4. N705 Practitioner Disenrollments	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner and Provider Compliance policy, the VO Involuntary Suspension Quality of Care policy, and the VO Practitioner Disenrollments policy provided evidence of VO's provision to provide a written warning, suspend, or terminate a practitioner's involvement in the provider network if the provider did not meet VO's standards of quality.		
	Required Actions: None		
	2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N701 Practitioner and Provider Compliance – Pages 3, Section V.B-E 3. N703 Involuntary Suspension Quality of Care – Page 3, Section V.E.2 4. N705 Practitioner Disenrollments – Entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Involuntary Suspension Quality of Care policy described the process by which VO notified the appropriate authorities, such as the NPDB and the appropriate licensing board, when VO took action against a practitioner for quality reasons.		
	Required Actions: None		

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	2.T. A well defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner’s participation based on issues of quality of care or service	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N606 Provider Appeal Process – Entire policy 3. N607 Fair Hearing Process – Entire policy 4. ValueOptions® Practitioner Agreement– Page 4, Section 2.9 and Page 7, Section 6.2	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Provider Appeal Process policy detailed the process by which providers may file an appeal based on issues of quality of care or service. The policy stated that provider appeals were reviewed by the Provider Appeal Committee. The policy specified that the provider may file an appeal with VO or the Department if the provider disagrees with the findings from the Provider Appeal Committee. The VO Practitioner Agreement and CHP provider handbook provided evidence that the provider appeal process was communicated to providers upon enrollment.			
Required Actions: None			
	2.U. How the Contractor makes the appeal process known to practitioners	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. Provider Handbook Network Credentialing (Misc Folder)– Page 5, Appeals 3. ValueOptions® Practitioner Agreement– Page 4, Section 2.9	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Agreement and CHP provider handbook provided evidence that the provider appeal process was communicated to providers upon enrollment.			
Required Actions: None			

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References	Requirement	Evidence Submitted by the BHO	Score
NCQA CR2— Element A	3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners.	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N601 Role of National Credentialing Committee (NCC) – Page 1, Section III.A 3. N604 Role of Local Credentialing Committee (LCC) – Entire policy 4. National Credentialing Committee Minutes November 2009 5. Local Credentialing Committee Minutes November 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Role of National Credentialing Committee policy detailed the roles and responsibilities of the committee and defined the committee as a standing subcommittee of the Quality Council. The policy also stated that the NCC used a peer review process to make decisions. The VO Role of Colorado Local Credentialing Committee policy detailed the roles and responsibilities of the CLCC for reviewing and rendering credentialing and recredentialing decisions. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of recredentialing files to the NCC prior to the NCC’s review of recredentialing files. The NCC and CLCC meeting minutes reviewed on-site provided evidence of the range of representation of persons participating in the committee, such as psychiatrists, psychologists, licensed clinical social workers, and counselors.		
	Required Actions: None		

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NCQA CR2— Element B	4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioner who do not meet established thresholds ◆ Medical director or equally qualified individual review and approval of clean files	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. National Credentialing Committee Minutes November 2009 3. Local Credentialing Committee Minutes November 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing Process policy and the Facility Provider Credentialing Process policy described VO’s process for making credentialing decisions and selecting providers to participate in the network. VO’s process for credentialing practitioners included the use of an application completed by the practitioner, attestation from the practitioner, and primary source verification. The policies described the process by which “clean” files with recommendations for approval were forwarded to the VO medical director, who acted on behalf of the VO NCC, to approve clean credentialing files. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of recredentialing files to the NCC prior to the NCC’s review of recredentialing files. The VO NCC and CLCC meeting minutes reviewed on-site provided evidence of the committees’ review of provider credentials that did not meet minimum thresholds. The meeting minutes also provided evidence of the medical director’s review and approval of “clean” practitioner credentialing files.		
	Required Actions: None		

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NCQA CR3— Element A Element B	5. The Contractor conducts timely verification (using primary sources) of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification includes: ◆ A current, valid license to practice ◆ A valid DEA or CDS certificate ◆ Education and training, including board certification, if applicably ◆ Work history ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N401 Primary Source Verification Policy – Page 1-2, Section III.A, Page 3, Section V.D.1, Page 4, Section V.D.10, 11 and 14 3. N401A Primary Source Verification Report 4. Provider Credentialing Criteria Checklist	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source a provider’s current, valid license to practice; valid U.S. Drug Enforcement Administration (DEA) or Controlled Dangerous Substances (CDS) certificate; education and training, including board certification, if applicable; work history; and history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. The policy listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities. The timelines for verification listed in the Primary Source Verification policy were consistent with the NCQA managed behavioral healthcare organization (MBHO) standards.		
	Required Actions: None		

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NCQA CR4— Element A NCQA CR7— Element C	6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation ◆ Lack of present illegal drug use ◆ History of loss of license and felony convictions ◆ History of loss or limitation of privileges or disciplinary activity ◆ Current malpractice insurance coverage (minimums= physician—.5mil/1.5mil; facility—.5mil/3mil) ◆ The correctness and completeness of the application	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N201 Practitioner Credentialing Process – Page 1, Section III.A, Page 3, Section V.D.1-6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing Process policy detailed VO’s credentialing process, which included the procedure for practitioners to complete and submit an application and attestation statement that addressed the following: reasons for inability to perform the essential functions of the position with or without accommodation, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitation of privileges or disciplinary activity, current malpractice insurance coverage, and the correctness and completeness of the application.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
NCQA CR5— Element A	7. The Contractor receives information on practitioner sanction before making a credentialing decision, including ◆ State sanctions, restrictions on licensure or limitations on scope of practice ◆ Medicare and Medicaid sanctions	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N401 Primary Source Verification Policy – Pages 1-2, Section III.A.1-11, Page 3, Section V.D.1 and Page 4, Section V.D.10, 11 and 14. 3. N401H Sanction Notification Letter	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source a provider’s current, valid license to practice; valid DEA or CDS certificate; education and training, including board certification, if applicable; work history, and history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. The policy listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities. The Primary Source Verification Report provided evidence that practitioner information regarding State sanctions, restrictions on licensure, and Medicaid or Medicare sanctions was obtained for practitioners. The VO Practitioner Credentialing Process policy described the process by which the network coordinator forwarded clean credentialing files to the medical director, who had the authority to approve clean files on behalf of the NCC and forward recommendations for denial to the NCC for review and determination. Only complete credentialing files with all primary source verification documents enclosed were forwarded to the medical director or NCC for review and determination.		
	Required Actions: None		

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NCQA CR6— Element A	8. The Contractor has a process to ensure that the offices of all practitioners meets its office-site standards. The organization sets standards for ◆ Office site criteria ▪ Physical accessibility ▪ Physical appearance ▪ Adequacy of waiting and examining room space ▪ Availability of appointments ◆ Medical/treatment record criteria ▪ Secure/confidential filing system ▪ Legible file markers ▪ Records are easily located	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N406A Practitioner Site Visit – Entire policy 3. N406AA Data Definitions for the Environmental Site Review Tool for Practitioners 4. N406AC Practitioner Environmental Site Review 5. N406B Facility Organization Site Visit – Entire policy 6. N406BA Data Definitions for the Organization Facility Environmental Site Review 7. N406BB Organization Facility Environmental Site Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Environmental Site Review form and the VO Organization Facility Environmental Site Review form provided evidence that VO maintained a process to ensure that the offices of all practitioners met office site standards. The completed Organization Facility Environmental Site Review tools for Mile High Council, Jacob Family Services Main Street, and Jacob Family Services Remington Street provided evidence that VO conducted the site visits and assessed the following criteria: physical accessibility and Americans with Disabilities Act (ADA) compliance, physical appearance, adequacy of waiting and examining room space, availability of appointments, medical/treatment record criteria, secure/confidential filing system, and legible file markers. VO also verified that records were easily located. The on-site credentialing and recredentialing file review for Youth Ventures of Colorado provided evidence of completed site visits for nonaccredited providers.		
	Required Actions: None		

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NCQA CR6— Element B	9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints ◆ Instituting actions to improve offices that do not meet thresholds ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds ◆ Monitoring member complaints for all practitioner sites at least every six months ◆ Documenting follow-up visits for offices that had subsequent deficiencies	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N406A Practitioner Site Visit - Pages 1, Section III, Page 3, Section V.E-H, and Page 4, Section V.K 3. N406B Facility Organization Site Visit – Entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Site Visit policy described VO’s provision for conducting a structured site visit review for all practitioner offices with two or more documented member complaints in a six-month time frame related to physical accessibility, physical appearance, adequacy of waiting/examining room space, the availability of appointments, and/or the adequacy of treatment record-keeping, and/or when a quality-of-care issue indicates that a site visit may assist in resolution of the identified quality-of-care issue and/or when contractually obligated. The policy detailed VO’s procedure for requiring a corrective action plan for office site visits that did not meet the minimum performance thresholds. The policy also stated that VO would conduct a follow-up visit every six months to evaluate the effectiveness of the interventions detailed in the facility’s corrective action plan and to determine if the facility met the minimum performance threshold. The policy detailed the provisions by which VO documented the site visits and forwarded the information to the NCC. VO staff stated that if VO receives two or more member complaints about a practitioner office site within a six-month period, VO staff members conduct a site visit of the provider.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
NCQA CR7— Element A Element B Element D NCQA CR8	10. The organization formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information includes: ◆ A current, valid license to practice ◆ A valid DEA or CDS certificate ◆ Board certification ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner ◆ State sanctions, restrictions on licensure, or limitations on scope of practice ◆ Medicare and Medicaid sanctions	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N501 Practitioner Recredentialing Process – Page 1, Section III and Page 2, Section IV.C 3. N502 Facility Program Clinic Recredentialing Process – Page 1, Section IV.A, Page 2, Section V.D-E and Page 3, Section V.G	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Recredentialing Process policy described VO’s process for recredentialing practitioners, which included primary source verification of identified credentialing elements at least every 36 months. The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source a provider’s current, valid license to practice; valid DEA or CDS certificate; education and training, including board certification, if applicable; work history; and history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. The policy also listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities. VO staff stated that the recredentialing process begins five months prior to the due date for recredentialing, which included provider recredentialing application mailings and reminder letters to practitioners. Staff stated that if a provider does not respond to communication from VO, VO staff members disenroll the provider until the provider contacts VO to participate in the recredentialing process and complete the required elements for recredentialing.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
NCQA CR11— Element A	11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include:	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N203 Facility Provider Credentialing Process – Pages 2-3, Section V.G 3. N203A Facility Provider Credentialing Workflow 4. N206 Credentialing Criteria for Facility Organizational Providers – Page 1, Section III, Page 2, Section IV.A.1 and IV.A.6	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	11.A. The Contractor confirms that the provider is in good standing with state and federal regulatory bodies.		
	Findings: The VO Facility/Provider Credentialing Process policy detailed VO’s provision for credentialing organizational providers. The policy stated that eligibility was determined by the extent to which applicants met VO credentialing criteria. The VO Credentialing Criteria for Facility/Organizational Providers policy listed the facility/organizational criteria that were applicable to all providers and the program-specific criteria for specialized providers, such as inpatient psychiatric facilities. The VO Facility/Provider Credentialing Process policy described the process by which VO staff verified that providers were in good standing with state and federal regulatory bodies. The Primary Source Verification Report provided evidence that practitioner information regarding State sanctions, restrictions on licensure, and Medicaid or Medicare sanctions was obtained for practitioners and that the providers reviewed were in good standing.		
	Required Actions: None		
	11.B. The Contractor confirms whether the provider has been reviewed and approved by an accrediting body.	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N206 Credentialing Criteria for Facility Organizational Providers – Page 2 Section IV.4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Facility/Provider Credentialing Process policy detailed VO’s provision for credentialing organizational providers. The policy stated that eligibility was determined by the extent to which applicants met VO credentialing criteria. The VO		

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	Facility/Provider Credentialing Process policy described the process by which a credentialing verification specialist verified the facility/organizational provider's accreditation status from the accrediting body to determine that accreditation was current at the time of the credentialing decision. Required Actions: None		
	11.C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N206 Credentialing Criteria for Facility Organizational Providers – Page 2, Section IV.4	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Facility/Provider Credentialing Process policy described the process by which a credentialing verification specialist requests that a structured site visit be scheduled and completed for applicants that meet established credentialing criteria but are not accredited. The completed Facility Site Review reports for Mile High Council, Jacob Family Services Main Street, and Jacob Family Services Remington Street provided evidence that VO conducted an on-site quality assessment. Required Actions: None		
	11.D. At least every three years, the Contractor confirms that the organizational provider continues to be in good standing with state and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider is not reviewed and approved by an accrediting body.	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N502 Facility Program Clinic Recredentialing Process – Pages 1-2, Section IV.A	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Facility Program Clinic Recredentialing Process policy described VO's recredentialing process, which included a review of organizational providers to determine if providers remained in good standing. The VO Facility/Provider Credentialing Process		

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	policy described the process by which the credentialing verification specialist requests that a structured site visit be scheduled and completed for applicants that meet established credentialing criteria, but are not accredited, prior to recredentialing decisions and within 36 months from the initial or previous recredentialing decision. The completed Facility Site Review reports for Mile High Council, Jacob Family Services Main Street, and Jacob Family Services Remington Street provided evidence that VO conducted an initial site visit of providers. The on-site review of the recredentialing files provided evidence that VO conducted site visits of nonaccredited providers every 36 months. VO staff stated that facilities undergo another site visit within 36 months if the facility is not reviewed or approved by an accrediting body.		
	Required Actions: None		
	11.E. The selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N206 Credentialing Criteria for Facility Organizational Providers – Entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Credentialing Criteria for Facility Organizational Providers policy detailed VO’s selection process and assessment criteria for each type of nonaccredited organizational provider with which it contracts.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
NCQA CR11— Element A	12. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N206 Credentialing Criteria for Facility Organizational Providers – Page 8, Section V.C.16.c 3. Facility Environmental Site Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Facility Environmental Site Review audit form provided evidence that VO maintained a process for ensuring that the facility credentialed its practitioners. The completed Facility Site Review reports for Mile High Council, Jacob Family Services Main Street, and Jacob Family Services Remington Street provided evidence that VO verified that the organization credentialed its practitioners. The on-site review of the Youth Ventures of Colorado facility provided evidence of the on-site review completed by VO.		
	Required Actions: None		
NCQA CR11— Element B	13. The Contractor’s organizational provider assessment policies and process includes at least: ◆ Inpatient facilities ◆ Residential facilities ◆ Ambulatory facilities	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy 2. N206 Credentialing Criteria for Facility Organizational Providers – Entire policy 3. Facility Environmental Site Review	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Credentialing Criteria for Facility Organizational Providers policy described the process for credentialing facilities and organizational providers. The policy detailed the program-specific criteria for the following provider types: inpatient psychiatric, inpatient detoxification, inpatient substance abuse rehabilitation, residential, partial hospitalization, 23-hour observation, ambulatory detoxification, intensive outpatient, day treatment, halfway house, methadone maintenance program, treatment group home, therapeutic foster care, home health, respite care, outpatient mental health and/or substance abuse clinic, eating disorders, dual diagnosis, pathological gambling, crisis intervention, crisis stabilization, psychiatric residency training programs, therapeutic nursery programs, employee assistance program services, and child placement agency.		
	Required Actions: None		

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Standard VIII—Credentialing and Recredentialing			
References	Requirement	Evidence Submitted by the BHO	Score
NCQA CR11— Element D	14. The Contractor has documentation that organizational providers have been assessed.	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. N206 Credentialing Criteria for Facility Organizational Providers – entire policy. 3. N406AC Practitioner Environmental Site Review 4. Facility Site Review Mile High Council 5. Facility Site Review Jacob Family Services Main Street 6. Facility Site Review Jacob Family Services Remington Street	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Facility Site Review reports provided evidence that VO conducted a site visit and assessed the following organizational providers: Mile High Council, Jacob Family Services Main Street, and Jacob Family Services Remington Street. The on-site review of credentialing and recredentialing files provided evidence of VO’s assessment of organizational providers.		
	Required Actions: None		
NCQA CR12— Element A—H	15. If the Contractor delegates any credentialing activities, the Contractor: ◆ Has a written delegation document with the delegate ◆ Retains the right to approve, suspend, and terminate individual practitioners, providers, and sites. This right is reflected in the delegation agreement ◆ Audits credentialing files annually against NCQA standards ◆ Performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations	Documents Submitted/Location Within Documents: 1. CHP Credentialing and Recredentialing Delegation Policy – entire policy 2. CHP Delegation Agreement – entire agreement 3. CHP Delegation Credentialing Audit – entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Standard VIII—Credentialing and Recredentialing			
References	Requirement	Evidence Submitted by the BHO	Score
	◆ Evaluates regular reports ◆ The organization identifies and follows up on opportunities for improvement, if applicable		
	Findings: The CHP Credentialing/Recredentialing Delegation policy detailed CHP’s provisions for delegating credentialing to VO. The CHP Delegation Agreement and Delegation Oversight policy detailed the requirements of the delegation, which specified the following: CHP’s right to approve, suspend, and terminate individual practitioners, providers, and sites; CHP’s policy to audit credentialing files annually against NCQA standards; CHP’s annual evaluation of delegated activities against NCQA standards and organization expectations; CHP review and evaluation of reports on an ongoing basis; and VO’s follow up on opportunities for improvement, if applicable. The CHP Credentialing Delegation Oversight Monitoring Report, which was presented to the Class A Board of Managers, provided evidence of CHP’s oversight monitoring of VO credentialing and recredentialing activities. The report detailed the results of the credentialing and recredentialing file review conducted by CHP, which occurred February 3 and 4, 2010, and provided a summary stating that VO’s credentialing and recredentialing processes and procedures were in compliance with CHP requirements. Required Actions: None		

Results for Standard VIII—Credentialing and Recredentialing									
Total	Met	=	39	X	1.00	=	39		
	Partially Met	=	0	X	.00	=	0		
	Not Met	=	0	X	.00	=	0		
	Not Applicable	=	0	X	NA	=	0		
Total Applicable		=	39		Total Score	=	39		

Total Score ÷ Total Applicable		=	100%
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Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.230(a)(1) Contract: II.H.1	1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor.	Documents Submitted/Location Within Documents: 1. Management Services Agreement , page 2, section 1.4; 2. CHP Delegation Agreement- entire agreement 3. Class A/B Board Grid – entire document 4. Provider Contract Colorado Medicaid Addendum, Page 1, C	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Delegation Agreement with VO delineated the functions delegated to VO and stated that CHP maintained oversight responsibilities for all functions. Further, the agreement detailed the obligations of CHP, including the monitoring and review activities conducted by CHP for each of the delegated activities during the oversight process. The CHP Management Services Agreement reflected this verbiage. The Class A/B Board Grid outlined the ongoing report responsibilities of VO, detailed the submission timelines to CHP, and delineated the CHP board that reviewed the reports.		
	Required Actions: None		
42CFR438.230(b)(1) Contract: II.H.1	2. Before any delegation, the Contractor evaluates a prospective subcontractor’s ability to perform the activities to be delegated.	Documents Submitted/Location Within Documents: None	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: CHP delegates several administrative activities to VO, including claims, credentialing, information technology/health information systems, grievances, member and family affairs, provider relations, quality management, utilization management, and compliance. CHP has delegated activities to VO since 2005; therefore, a preassessment was not necessary during 2009. The VO policy, Delegation of Utilization Management Activities, contained the provision that VO implements a process to review a potential delegate’s capacity to perform a delegated function prior to delegation.		
	Required Actions: None		

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Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR 12— Element D	3. There is a written agreement with each delegate.	Documents Submitted/Location Within Documents: 1. CHP Management Services Agreement –entire document 2. Provider Participation Agreements- all documents - Colorado West Regional Mental Health Center (CWRMHC) - Midwestern Colorado Mental Health Center (MWMHC) - Pikes Peak Mental Health Center (PPMHC) - Southeast Mental Health Services (SEMHS) - Spanish Peaks Mental Health Center (SPMHC) - San Luis Valley Mental Health Center (SLVMHC) - Southwest Colorado Mental Health Center (SWCMHC) - West Central Mental Health Center (WCMHC) 3. Delegation Agreement – entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: CHP maintained the CHP Management Services Agreement and the CHP Delegation Agreement with VO, which detailed the delegated functions, terms of the agreement, delegate reporting requirements, and CHP oversight activities. In addition, CHP submitted copies of the provider participation agreements with each of its CMHCs for HSAG’s review.		
	Required Actions: None		

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Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR12— Element A Element B Element C	4. The written delegation agreement: - Specifies the activities and reporting responsibilities delegated to the subcontractor - Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate For delegation of Credentialing only, the agreement: - Is mutually agreed upon - Describes the responsibilities of the Contractor and the delegated entity - Describes the delegated activities - Requires at least semiannual reporting to the Contractor - Describes the process by which the Contractor evaluates the delegated entity's performance - Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement - Includes a list of allowed uses of PHI - Includes a description of delegate safeguards to protect the information (PHI) from inappropriate uses - Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards	Documents Submitted/Location Within Documents: - CHP Management Services Agreement, Exhibit A - CHP Delegation Agreement – entire document - CHP Credentialing and Recredentialing Delegation Policy – entire policy - Class A/B Board Grid – entire document - BA Agreement , page 22 section 7.5 (Part of Management Services Agreement_	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
	◆ Includes a stipulation that the delegate will provide individuals with access to their PHI ◆ Includes a stipulation that the delegate will inform the Contractor if inappropriate use of the information (PHI) occur ◆ Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends ◆ Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making		
	Findings: CHP maintained the CHP Management Services Agreement and the CHP Delegation Agreement with VO, which specified the reporting responsibilities delegated to the subcontractor. The Class A/B Board Grid outlined the ongoing report responsibilities of VO and detailed the submission timelines to CHP. In addition, the agreements between CHP and VO contained a provision that allowed CHP to revoke delegation or impose other sanctions if the subcontractor’s performance was inadequate. The CHP Credentialing and Recredentialing Delegation policy, together with the agreements between CHP and VO, contained each of the requirements pertaining to delegation of credentialing and recredentialing.		
	Required Actions: None		

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Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.230(b)(3)	5. The Contractor monitors the delegate's performance on an ongoing basis. The Contractor subjects subcontractor/delegate to a formal review according to a periodic schedule established by the State, consistent with industry standards or state MCO laws and regulations.	Documents Submitted/Location Within Documents: 1. CHP Delegation Agreement - entire document 2. CHP Management Services Agreement, Page 2, section 1.3 and 2.1 3. Class A/B/ Board Grid – entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Delegation Agreement with VO delineated the functions delegated to VO and stated that CHP maintained oversight responsibilities for all functions. Further, the agreement detailed the obligations of CHP, including the monitoring and review activities conducted by CHP for each of the delegated activities during the oversight process. The CHP Management Services Agreement reflected this verbiage. The Class A/B Board Grid outlined the ongoing report responsibilities of VO and detailed the submission timelines to CHP. During the on-site interview, CHP staff members provided evidence of the CHP annual review conducted in February 2010 regarding the delegated activities for grievances, appeals, and credentialing and recredentialing. Evidence was provided in the form of summary results sent in letter format to the Class A Board.		
	Required Actions: None		
42CFR438.230(b)(4)	6. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance, the Contractor and the subcontractor take corrective action.	Documents Submitted/Location Within Documents: 1. CHP Delegation Agreement – entire document 2. CHP Management Services Agreement – entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Delegation Agreement and CHP Management Services Agreement contained sections addressing the topic of corrective action. The agreements contained the process by which a corrective action plan was implemented for reasons such as performance problems. In addition, the CHP Provider Participation Agreement with each of its CMHCs contained the required corrective action provision, as well.		
	Required Actions: None		

Results for Standard IX—Subcontracts and Delegation						
Total	Met	=	<u>6</u>	X	1.00	= <u>6</u>
	Partially Met	=	<u>0</u>	X	.00	= <u>0</u>
	Not Met	=	<u>0</u>	X	.00	= <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA	= <u>0</u>
Total Applicable		=	<u>6</u>	Total Score	=	<u>6</u>

Total Score ÷ Total Applicable		=	<u>100%</u>
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Appendix A. Colorado Department of Health Care Policy & Financing
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Standard X—Quality Assessment and Performance Improvement

References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.240(a)	1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program. 41	Documents Submitted/Location Within Documents: 1. CHP QM Delegation Policy – entire document 2. FY10 CHP QMUM Program Description – entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: CHP delegated quality management functions to VO as detailed in the CHP Delegation Agreement and CHP Management Services Agreement. The CHP QM Delegation policy specified that the BHO delegates operational responsibility for its quality management (QM) program to a qualified delegate. The delegate is expected to maintain a comprehensive QM program that includes standards for quality, accessibility, and availability of services; monitoring and evaluation of important aspects of care and services; and systematic measurement, identification of improvement opportunities, corrective action, and follow-up. VO, along with the CHP Quality Improvement Steering Committee (QISC), developed the CHP Quality Management Utilization Management (QMUM) Program Description. The document described the ongoing quality activities for the year. The annual plan was reviewed and approved by CHP’s QISC and Class B Board. During the on-site interview, staff members described in detail the approval process for the QAPI through the QISC and the Class B Board.		
	Required Actions: None		
42CFR438.240(b)	2. The QAPI Program includes the following basic elements: ◆ Performance improvement projects ◆ The submission of performance measurement data	Documents Submitted/Location Within Documents: 1. CHP QM Delegation Policy - entire policy 2. FY10 CHP QMUM Program Description Pages 16 - 18 3. Final_BHO_PM_FY09 – Entire document, CHP measures 4. QISC_c_TrendReport_Q1FY10 – Entire report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP QMUM Program Description contained performance data reporting and the completion of PIPs. The document stated that the QM program monitored and evaluated quality across the entire range of services it provides and described that when opportunities for improvement were identified, interventions and/or PIPs were implemented. The document further described the indicators used and the departments that are key participants in the QM program. The CHP policy, Quality Indicators, described the means by which measurement, data collection, and reporting for key performance indicators was conducted. The CHP QM Delegation policy reflected that CHP conducted an annual evaluation of VO to verify that the scope of the QM program included		

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References	Requirement	Evidence Submitted by the BHO	Score
	PIPs and performance measurement and analysis. In addition, CHP provided example performance data reports for HSAG’s review. During the on-site interview staff provided detailed information pertaining to current performance improvement processes, including statewide collaborative and BHO-specific processes. The PIPs addressed the topics of coordination of care between Medicaid physical and behavioral health providers and increasing penetration rates for older adult Medicaid members. Required Actions: None		
42CFR438.240(b)(3)	3. The Contractor’s QAPI program includes mechanisms to detect both underutilization and overutilization of services. Findings: The CHP Quality Indicators policy contained the provision that VO collected, reported, and evaluated utilization management processes and provider and member utilization. The policy further specified the means by which under- and overutilization was identified, including the review of multiple data reports. The CHP QM Delegation policy stated that through its annual evaluation of VO and report review processes, CHP monitored VO’s under- and overutilization identification and evaluation processes. CHP provided the following reports for HSAG’s review: 2008–2009 Penetration Rates by Healthcare Effectiveness Data and Information Set (HEDIS®) age groups and CHP Indicator Trending as of Quarter 1, FY 2010, which reflected the processes in place to detect over- and underutilization. During the on-site interview, staff members described ongoing development of new reports addressing under- and overutilization and provided evidence of draft reports. Required Actions: None	Documents Submitted/Location Within Documents: 1. CHP QM Delegation Policy - entire policy 2. FY10 CHP QMUM Program Description – Pages 13, 38 3. Iii30112 Quality Indicators – Page 3.A.1-3 4. QISC_c_TrendReport_Q1FY10 – Pages 4-7 5. PP_Oct_09 – Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.240(b)(4)	4. The Contractor's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	Documents Submitted/Location Within Documents: 1. CHP QM Delegation Policy - entire policy 2. FY10 CHP QMUM Program Description – Pages 8, 17, 18, 20 and 27. 3. Clinical Chart Audit ToolTxDischg_revised0110 – Entire document 4. Iii30818CriticalAdverse Incidents – Entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP QMUM Program Description demonstrated that the BHO included mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. During the on-site interview, staff members stated that individuals with mental illness are considered as having special health care needs. During the on-site interview, staff members described a PIP to assess coordination of care between behavioral health service providers and PCPs for adult members with severe and persistent mental illness.		
	Required Actions: None		
42CFR438.240(e)(2)	5. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program.	Documents Submitted/Location Within Documents: 1. CHP QM Delegation Policy - entire policy 2. FY10 CHP QMUM Program Description – Page 43-44. 3. CHP QMUMAnnualEvalFY09_FINAL 082809 – Entire document 4. CHP CAUMC QISC Minutes 090409	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP QM Delegation policy described that CHP verified the scope of activities of the VO QM program through its annual evaluation and report review process. The CHP QMUM Program Description outlined the CHP annual evaluation process. The Fiscal Year 2009 Quality Management and Utilization Management Program Annual Evaluation demonstrated that CHP had mechanisms in place for evaluating the impact and effectiveness of the QAPI program. In addition, CHP provided the Clinical Advisory/Utilization Management/Quality Improvement Steering Committee meeting minutes from September 4, 2009, which provided evidence of annual and ongoing review of the QM/UM Program Description and annual evaluation.		
	Required Actions: None		

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Standard X—Quality Assessment and Performance Improvement

References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.236(b)	6. The Contractor’s QAPI program addresses practice guidelines. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field ◆ Considers the needs of the Contractor’s members ◆ Are adopted in consultation with contracting health care professionals ◆ Are reviewed and updated periodically as appropriate	Documents Submitted/Location Within Documents: 1. CHPQM Delegation Policy - Entire policy 2. FY10 CHP QMUM Program Description – Pages 6, 8, 11, 13, 38, 39 3. 107LDeveloping and Updating Treatment Guidelines_may09 – Page 1, III.A,D., Page 3, V.A.1., 2.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP QMUM Program Description and the Fiscal Year 2009 Quality Management and Utilization Management Program Annual Evaluation contained provisions related to practice guidelines. The CHP policy, Developing and Updating Treatment Guidelines, detailed the process for developing and adopting practice guidelines and included each of the required elements. During the on-site interview, staff members described efforts to gain consistency in practice guidelines across all the BHOs that VO contracts with through the VO Policy and Guideline Committee.		
	Required Actions None		

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Standard X—Quality Assessment and Performance Improvement

References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.236(c)	7. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members.	Documents Submitted/Location Within Documents: 1. CHP QM Delegation Policy - Entire policy 2. Provider Handbook – page 29 3. http://www.coloradohealthpartnerships.com/provider/prv_clin_gd.htm 4. C107Dev and updating Tx guidelines – Page 1, III.B, Page 3, V.B.2.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP policy, Developing and Updating Treatment Guidelines, contained that provision that the treatment guidelines be disseminated to providers and to members and potential members. The policy stated that VO or the service centers in the community disseminated consumer versions of guidelines through mailings, consumer outreach sites, client member newsletters, and the VO Web site. The CHP Web site contained the treatment guidelines and the member handbook notified members that they may view the practice guidelines on the CHP Web site or call CHP to obtain a copy. During the on-site interview, staff members described efforts to gain consistency in practice guidelines across all the BHOs that VO contracts with through the VO Policy and Guideline Committee.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.236(d)	8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	Documents Submitted/Location Within Documents: 1. CHP QM Delegation Policy - Entire policy 2. C107Dev and updating Tx guidelines – Page 3.V.3	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP QM Delegation policy stated that CHP verifies that the scope of the QM program includes practice guidelines through the annual evaluation and report review process. The CHP policy, Developing and Updating Treatment Guidelines, specified how CHP monitored adherence to guidelines through the Executive Medical Management Committee (EMMC) work group by developing and recommending to the full committee appropriate diagnosis-specific adherence measures (indicators) for specific guidelines, as required. The policy further stated that the service centers may collect and track adherence data and conduct the initial aggregation and analysis of data, as appropriate. The information is then reviewed by Service Center Clinical Quality Committee and Subcommittees. In addition, during the on-site interview, staff members described efforts to gain consistency in practice guidelines across all the BHOs that VO contracts with through the VO Policy and Guideline Committee.		
	Required Actions: None		
42CFR438.242(a)	9. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data that is used to support administration of the Contractor's Program.	Documents Submitted/Location Within Documents: 1. CHP Information Technology-Health Information Systems Delegation Policy 2. Health Info System Flow 3. CHP Data Report Card November 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Information Technology—Health Information Systems Delegation policy stated that CHP delegated operational responsibilities for its health information system to a qualified delegate and detailed the terms of the delegation. The policy defined the requirement of the health information system, delineated the activities through which CHP evaluated and monitored VO compliance, and described how noncompliance was managed. The Health Information Data Flow document illustrated the flow of eligibility, claims, and encounter data between providers, the Department, CHP, and VO. The CHP Data Report Card demonstrated monthly data error reporting.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.242(a)	10. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	Documents Submitted/Location Within Documents: 1. CHP Information Technology-Health Information Systems Delegation Policy 2. Health Info System Flow 3. CHP Data Report Card November 2009	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: VO had systems in place to collect, analyze, and report data in the areas of utilization and grievances and appeals. VO provided copies of several example utilization reports for October 2009, including the average day treatment census by month and inpatient days per 1,000 members. Information provided at the time of the desk review showed that some reports regarding member disenrollment were produced by the Department. VO staff members indicated that they also had the ability to report data regarding members who lose their eligibility due to incarceration. During the interview, VO staff members reported that they maintained a Web-based grievances and appeals application that could produce reports that include summary data regarding the subject of the grievance or appeal and information regarding the resolution status.		
	Required Actions: None		
42CFR438.242(b)	11. The Contractor collects data on member and provider characteristics and on services furnished to members.	Documents Submitted/Location Within Documents: 1. CHP Information Technology-Health Information Systems Delegation Policy 2. Health Info System Flow	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Health Information Data Flow document illustrated the flow of eligibility, claims, and encounter data between providers, the Department, CHP, and VO. Reports provided by CHP for HSAG's review demonstrated data collection, analysis, and reporting capabilities related to utilization and member demographics. During the on-site interview, staff members described data elements contained in the system pertaining to providers. Provider characteristics included specialty, language, gender, and ethnicity.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.242(b)	12. The Contractor ensures that data received from providers is accurate and complete by: ♦ Verifying the accuracy and timeliness of reported data ♦ Screening the data for completeness, logic, and consistency ♦ Collecting service information in standardized formats to the extent feasible and appropriate.	Documents Submitted/Location Within Documents: 1. CHP Information Technology-Health Information Systems Delegation Policy 2. Health Info System Flow 3. CHP Data Report Card November 2009 4. Encounter file for errors log sample	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The CHP Information Technology—Health Information Systems Delegation policy contained the provisions that VO verifies provider data completeness and accuracy, including verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate. The policy specified how CHP monitored VO’s compliance through the annual evaluation and report review process. The CHP Data Report Card for November 2009 and the Encounter File for Errors Log Sample demonstrated that the health information system has the ability to screen data for accuracy and completeness.		
	Required Actions: None		

Results for Standard X—Quality Assessment and Performance Improvement

Total	Met	=	<u>12</u>	X	1.00	=	<u>12</u>
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>
Total Applicable		=	<u>12</u>	Total Score	=	<u>12</u>	

Total Score ÷ Total Applicable	=	<u>100%</u>
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Appendix B. **Grievance Record Review Tool**
for Colorado Health Partnerships, LLC

The completed grievance record review tool follows this cover page.



Appendix B. Colorado Department of Health Care Policy & Financing
2009–2010 Grievances Record Review Tool
for Colorado Health Partnerships, LLC

Plan Name:	Colorado Health Partnerships, LLC
Review Period:	July 1, 2009–December 15, 2009
Date of Review:	March 16, 2010
Reviewer:	Gretchen Thompson
Participating Plan Staff Member:	Haline Grublak and Sarah Lang

1	2	3	4	5	6	7	8	9	10	11
File #	Case ID #	Date Grievance Received	Date of Acknowledg- ment Letter	Acknowledg- ment Sent in 2 W-days?*	Date of Written Notice of Disposition	# of Days to Notice	Resolved and Notice Sent in 15 W-days?*	Not Involved in Previous Level of Review	Appropriate Level of Expertise?	Resolution Letter Included Required Content
1	***	7/1/09	7/1/09	Y ☒ N ☐ N/A ☐	7/17/09	16	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
2	***	7/13/09	7/13/09	Y ☒ N ☐ N/A ☐	7/15/09	2	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
3	***	7/24/09	7/24/09	Y ☒ N ☐ N/A ☐	8/28/09	34	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: VO sent a 14-day extension notice to the member August 17, 2009. The grievance was resolved within the required time frame.										
4	***	8/10/09	8/11/09	Y ☒ N ☐ N/A ☐	8/20/09	9	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
5	***	8/11/09	8/12/09	Y ☒ N ☐ N/A ☐	8/13/09	2	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
6	***	8/12/09	8/12/09	Y ☒ N ☐ N/A ☐	8/24/09	12	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
7	***	8/27/09	8/27/09	Y ☒ N ☐ N/A ☐	9/4/09	8	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
8	***	9/14/09	9/15/09	Y ☒ N ☐ N/A ☐	9/23/09	8	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
9	***	10/6/09	10/6/09	Y ☒ N ☐ N/A ☐	10/15/09	9	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										
10	***	10/9/09	10/9/09	Y ☒ N ☐ N/A ☐	10/22/09	13	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: This grievance did not involve a clinical issue.										



Appendix B. Colorado Department of Health Care Policy & Financing
2009–2010 Grievances Record Review Tool
for Colorado Health Partnerships, LLC

1	2	3	4	5	6	7	8	9	10	11
File #	Case ID #	Date Grievance Received	Date of Acknowledg- ment Letter	Acknowledg- ment Sent in 2 W-days?*	Date of Written Notice of Disposition	# of Days to Notice	Resolved and Notice Sent in 15 W-days?*	Not Involved in Previous Level of Review	Appropriate Level of Expertise?	Resolution Letter Included Required Content
11				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
12				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
13				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
14				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
15				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
# Applicable Elements				10			10	10	3	10
# Compliant Elements				10			10	10	3	10
Percent Compliant				100%			100%	100%	100%	100%

*W-days = Working days

# Applicable Elements	43
# Compliant Elements	43
Percent Compliant	100%

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

Table C-1 lists the participants in the FY 2009–2010 site review of **CHP**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	Title
Gretchen Thompson	Executive Director, State & Corporate Services
Lora Wagner	Project Leader
CHP Participants	Title
Erica Arnold-Miller	Vice President, Quality Management
Steve Coen, PhD	Clinical Peer Advisor
Michelle Denman	Director of Provider Relations
Haline Grublak	Vice President, Office of Member and Family Affairs
Steve Halsenbeck, MD	Medical Director
Rhonda Hernandez	Director of Credentialing
Chris Jacobson	Quality Management Specialist
Sarah Lang	Grievance and Appeals Coordinator
Val Pinder	Facility Credentialing Manager
Arnold Salazar	Chief Executive Officer
Maggie Tilley	Contract Compliance Officer
Department Observers	Title
Jerry Ware	Quality/Compliance Specialist
Diane Riggs	Contracts Performance Specialist

Appendix D. Corrective Action Plan Process for FY 2009–2010 for Colorado Health Partnerships, LLC

CHP is required to submit to the Department a corrective action plan (CAP) for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each 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 CAP has been approved by the Department. Following Department approval, the BHO must submit documents per the timeline that was approved.

Table D-1—Corrective Action Plan Process	
Step 1	Corrective action plans are submitted
	Each BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting. The BHO will submit the CAP using the template that follows. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of <i>Partially Met</i> or <i>Not Met</i>, 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, it 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 interventions to HSAG via e-mail or through the FTP site, with an e-mail notification regarding the FTP 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 require that, based on the nature and seriousness of the noncompliance, the BHO submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	Documentation substantiating implementation of the plans is reviewed and approved
	Following a review of the CAP and all supporting documentation, the Department will inform the BHO 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 that substantiates the 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 D-2—FY 2009–2010 Corrective Action Plan *for* CHP

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring/Follow-up Planned	Documents to be Submitted as Evidence of Completion
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There are no corrective actions required by CHP for FY 2009–2010.

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

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	Planned for Monitoring Activities
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the 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 for other review activities. ◆ HSAG staff members provided an orientation on September 22, 2009, for the BHO and the Department to preview the FY 2009–2010 compliance monitoring review process and to allow the BHO 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 members to the review team. ◆ Prior to the review, HSAG representatives responded to questions from the BHO related to the process and federal managed care regulations to ensure that the BHO was prepared for the compliance monitoring review. HSAG maintained contact with the BHO as needed throughout the process and provided information to 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
	◆ Since the BHOs had just completed the RFP/contracting process, with new organization having been formed, HSAG used only the BBA Medicaid managed care regulations to develop HSAG's monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	Reviewed Documents
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The BHO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the standards. ◆ Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	HSAG completed the following activities:
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 it needed and had identified during its desk audit. - HSAG requested and reviewed additional documents it needed and had 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 members to provide an overview of preliminary findings of the review. - HSAG used the FY 2009–2010 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. - HSAG analyzed the findings and assigned scores. - HSAG determined opportunities for improvement based on the review findings. - HSAG determined actions to be required of the BHO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	Reported Results to the Department
	- HSAG completed the FY 2009–2010 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.