Colorado Medicaid
Community Mental Health Services Program

FY 2010–2011 Site Review Report

for

Colorado Health Partnerships, LLC

May 2011

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

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Overview of FY 2010–2011 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 the State's quality strategy. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for the Colorado behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the seventh year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2010–2011 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the three performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard III—Coordination and Continuity of Care.

The BHO's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 20 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid denials that occurred between January 1, 2010, and September 15, 2010. For the record review, the BHO received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. For cases in which the reviewer was unable to determine compliance due to lack of documentation, a score of *Unknown* was used. Compliance with federal regulations was evaluated through review of the three standards and administrative denial records. The BHO received an overall percentage of compliance score for the standards and a separate overall percentage of compliance score for the record review.

This report documents results of the FY 2010–2011 site review activities for the review period—January 1, 2010, through the dates of the on-site review, February 14 and 15, 2011. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the BHO was successful in completing corrective actions required as a result of the 2009–2010 site review activities. Appendices A and B contain details of the findings. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action process the BHO will be required to complete and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing the three standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key BHO personnel to determine compliance. 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 findings from review of the three standards follow in Appendix A. Details of the findings from the on-site denials record review follow in Appendix B.

The three standards chosen for the FY 2010–2011 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, 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.

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 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 three areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal health care regulations and contract requirements 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 of the BHO's services related to the areas 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 requirement 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 requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for enhancement for some requirements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **Colorado Health Partnerships, LLC** for each of the standards. Details of the findings for each standard follow 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	Coverage and Authorization of Services	33	33	31	2	0	0	94%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	6	6	6	0	0	0	100%
	Totals	**51**	**51**	**49**	**2**	**0**	**0**	**96%**

Table 1-2—Summary of Scores for Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials Record Review	120	88	87	1	32	99%

2. Summary of Performance Strengths and Required Actions

for **Colorado Health Partnerships, LLC**

Overall Summary of Performance

For two of the three standards HSAG reviewed (Standard II—Access and Availability and Standard III—Coordination and Continuity of Care), the BHO earned overall percentage-of-compliance scores of 100 percent. For Standard I (Coverage and Authorization of Services), **CHP** earned a score of 94 percent. These scores demonstrated strong performance overall and an understanding of the Medicaid managed care regulations.

Standard I—Coverage and Authorization of Services

Summary of Findings and Opportunities for Improvement

CHP's policies and procedures were clear and concise and they included all the State and federal requirements. On-site interviews with **CHP** staff members confirmed that the policies and procedures for processing requests for initial and continuing services were being implemented as written. The HSAG reviewer found ample evidence to substantiate that authorization decisions were based on standardized criteria developed by participating providers and consistent with the State Medicaid covered services list and the State's definition of medically necessary services. **CHP** had comprehensive mechanisms for ensuring interrater reliability for authorization determinations.

Summary of Strengths

HSAG found evidence throughout its review of very extensive, open, and consistent communication between **CHP** administration and its providers. This open dialogue was a strength for this organization and a benefit to its members. Although one case did not meet the timeliness standards, 19 of 20 records demonstrated that **CHP** exceeded the requirements for timely notification. The average time in which requests for services were processed and notification provided was two days.

Summary of Required Actions

During the on-site review of 20 denial records, HSAG found one record that did not meet the requirement for timely notification of denial to the member. **CHP** must ensure that it meets requirements for timely notification for all denials.

HSAG found a conflict between **CHP**'s policies and its member handbook. While this issue appeared to be the result of an attempt to meet the readability requirement, the handbook led the reader to believe that prior authorization was required for poststabilization services. **CHP** must clarify the member handbook to provide information that is consistent with ValueOption's (VO's)/ **CHP**'s policies.

Standard II—Access and Availability

Summary of Findings and Opportunities for Improvement

CHP demonstrated that it had a robust provider network that was sufficient to meet the needs of its members. **CHP** performed an annual network adequacy analysis and assessment. **CHP** offered an array of services and ensured that it was adequately meeting the needs of its members. **CHP**'s policies and procedures related to access and availability were clear and concise and met all State and federal regulations.

Summary of Strengths

CHP had a variety of methods for monitoring the capacity of the provider network and the performance of community mental health center (CMHC) providers and the independent provider network (IPN). **CHP**'s Cultural Competency Plan was comprehensive. The Cultural Competency Plan was a two-year plan, with **CHP** having completed a significant number of the activities described in the work plan after two years of implementation.

Summary of Required Actions

There were no required actions for this standard.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

CHP's policies and procedures were clear, concise, and thorough. HSAG found ample evidence that suggested **CHP** staff members were implementing the policies and procedures as they were written. **CHP** had a process in place to monitor providers for the presence and the content of the assessment and individualized treatment plan. Furthermore, **CHP** monitored providers' medical records to ensure that they were in order and included all required documentation.

Summary of Strengths

CHP's extensive and open communication with its providers was an asset for the BHO. **CHP** clearly communicated the expectations for its providers and closely monitored providers' compliance with these expectations. **CHP** responded to instances of noncompliance with education and training, and implemented corrective action plans when necessary.

Summary of Required Actions

There were no required actions for this standard.

3. Follow-up on FY 2009–2010 Corrective Action Plan

for **Colorado Health Partnerships, LLC**

Methodology

As a follow-up to the FY 2009–2010 site review, each BHO that received scores of *Partially Met* or *Not Met* was required to submit a corrective action plan (CAP) to the Department. **CHP** scored 100 percent on the FY 2009–2010 compliance review and did not have any required actions.

Summary of 2009-2010 Required Actions

CHP scored 100 percent on the FY 2009–2010 compliance review and did not have any required actions.

Summary of Corrective Action/Document Review

CHP scored 100 percent on the FY 2009–2010 compliance review and did not have any required actions.

Summary of Continued Required Actions

There were no required actions continued from FY 2009–2010.

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *42CFR438.210(a)(3)(i)* *Contract: II.I.1.d*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 202L Medical Necessity – Entire policy 3. VO Colorado 223L Treatment Planning – Entire policy 4. VO Colorado 236L Clinical Level Care Guidelines – Entire policy 5. VO Colorado 259L Enhanced Clinical Management of Outpatient Services – Entire policy 6. Level of Care Guidelines – Entire folder of guideline documents 7. Clinical Rounds Minutes 2010OCT27 – Entire document 8. CHP Member Handbook (Misc folder) – Pages 7-9 9. Provider Handbook (Misc folder) – Page 3, Section II, *Continuum of Services* and Section IV, *Utilization Management Procedures* 10. Section13.4 Covered Diagnoses (Misc folder) –covered diagnoses 11. www.coloradohealthpartnerships.com **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). Multiple policies and avenues exist for ValueOptions® (VO) to ensure that services provided to CHP's members are reasonably expected to achieve their outcome. In addition to following policy and procedures, VO staff reference the Level of Care Guidelines for all levels of care to determine clear admission, continued stay and discharge criteria for use in case reviews. The guidelines are used to insure that services are appropriate for each member's situation and the services are reasonably expected to achieve the outcome for which the service	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	is furnished. ValueOptions®' clinical staff reviews guidelines, formally, at least annually. Members are made aware of the services that are available to them through the member handbook. The information includes explanations of covered benefits, available services, medical necessity and how determinations are made. Each new enrollee receives a copy of the handbook upon enrollment and handbooks are always available on the CHP website.	

Findings:
The CHP Delegation Agreement between CHP and VO delegated administrative services in the CHP service area to VO, including utilization management (UM) and authorization of services, as well as provider oversight and monitoring and quality management activities. CHP oversight of delegated activities was accomplished through review of policies, activities, and reports by the CHP executive director and CHP board during meetings (as evidenced by on-site review of CY 2010 CHP board minutes). The VO Medical Necessity policy described the use of standardized methods such as review of pertinent clinical information against level-of-care criteria and utilization review (UR) guidelines to make utilization determinations. The VO Distribution of Clinical Level Care Guidelines and Diagnostic Criteria policy described the process for developing and updating clinical guidelines. The VO Enhanced Clinical Management of Outpatient Services policy described the process for reviewing specific cases for the appropriateness of services (i.e., multiple providers, multiple family members, members approaching benefit limits). The member handbook described covered services. The provider manual described authorization processes and covered services. Methods of monitoring to ensure that services were sufficient in amount, duration, and scope included chart audits for both the IPN and the CMHCs, as well as weekly clinical rounds. Topics for clinical rounds included both general clinical issues and specific case processing for complex cases.

Required Actions:
None

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
2. The Contractor does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42CFR438.210(a)(3)(ii)* *Contract: II.I.1.e*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 202 L Medical Necessity – Pages 3-5, Section V.A-F 3. VO Colorado 303L Peer Advisor Adverse Determinations – Entire policy 4. CHP Member Handbook (Misc folder) – Pages 7-9 5. Section13.4 Covered Diagnoses (Misc folder) –covered diagnoses 6. Clinical Rounds Minutes 2010NOV17 – Highlighted section **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' staff refers to Medical Necessity and Clinical Criteria definitions to authorize care, based on individual case review to ensure that care is not arbitrarily reduced or denied based on diagnostic categories or conditions. Variables such as the member's situation and other care available are also taken into account in each individual situation as demonstrated by the Clinical Rounds process. ValueOptions®' staff refers cases for possible adverse clinical decisions to the Peer Advisor for review. Members are made aware of the services available to them through the member handbook. The information includes a description of services, a definition of medical necessity and an explanation of how to access the clinical care guidelines.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The CHP Delegation Agreement required VO to use level-of-care guidelines to make UR determinations. The VO Medical Necessity policy described the use of standardized criteria for making UR determinations. The VO Peer Advisor Adverse Determinations policy described the use of the peer		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
advisor review process to make adverse determinations. On-site review of 20 denial records demonstrated that UM staff made determinations based on whether a service was a covered service under the contract and the established medical necessity and UR criteria.		
Required Actions: None		
3. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. ◆ Consistent with the Contractor's published practice guidelines. ◆ On the basis of the Department's established utilization requirements or utilization review standards. *42CFR438.210(a)(3)(iii)* *Contract: II.I.1.f*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 202L Medical Necessity – Page 3, Section IV. A-B 3. VO Colorado 272L Tracking Medicaid Benefit Limits – Entire policy 4. Level of Care Guidelines – Entire folder of guideline documents 5. CHP Member Handbook (Misc folder) – Page 7 6. FY Inpatient Benefit Limit 2010 – Example of weekly monitoring report 7. www.coloradohealthpartnerships.com/index.htm **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® has several policies that explain medical necessity, Medicaid benefit limits and clinical criteria which are based on the level of care guidelines. Members are informed of the various levels of care and the services available in the member handbook and have access to the Level of Care guidelines through the CHP website.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The delegation agreement required VO to develop and maintain UR guidelines. The UR guidelines were available from the provider tab on CHP's Web site. The VO Medical Necessity policy described the development of UR criteria and guidelines for making UR determinations. The VO Tracking Medicaid Benefit Limits policy described the process for tracking whether a member was close to reaching benefit limits and for communicating with the provider, when necessary. The FY 2010 Inpatient Benefit Limit report provided an example of a tracking report and demonstrated CHP's monitoring		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
of members who were close to reaching benefit limits. The member handbook explained each covered service. During the on-site interview, CHP staff members explained that intensive levels of care (e.g., inpatient, acute, or residential treatment) require prior authorization with clinical care manager (CCM) review. Staff also clarified that while lower levels of care (e.g., routine outpatient services) also require prior authorization, these service requests do not require CCM review and could be accomplished online or via a telephonic automated system. The purpose of authorizing lower levels of care in this manner is to register use of services and for utilization control and reporting. Staff members explained that if providers attempted to use the online or automated system to authorize a higher level service, the system would prompt a CCM to contact the provider the next day and process the request.		
Required Actions: None		
4. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State Medicaid program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: ▪ The prevention, diagnosis, and treatment of health impairments, ▪ The ability to achieve age-appropriate growth and development, ▪ The ability to attain, maintain, or regain functional capacity. *42CFR438.210(a)(4)* *Contract: I.A.23*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 202L Medical Necessity – Entire policy, especially Section IV.A (State's definition) 3. VO Colorado 223L Treatment Planning – Entire policy 4. CHP Member Handbook (Misc folder) – Page 9 5. Provider Handbook (Misc folder) – Page 13, Section IV, *Utilization Management Procedures* 6. Section13.4 Covered Diagnoses (Misc folder) – covered diagnoses **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). Medically necessary services are needed for the diagnosis or treatment of a health impairment and also to prevent deterioration in functioning as a result of a covered mental health disorder. ValueOptions®' policies are based on the State Medicaid Program's definition for medical necessity and the covered diagnoses to best serve CHP members. The member handbook includes this information for members to reference.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The VO Medical Necessity policy contained the State definition of medical necessity. The member handbook contained a definition of medical necessity that was consistent with the State definition and at the required readability level.		
Required Actions: None		
5. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR438.210(b)* *Contract: II.I.1.g*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 203L Medical Necessity Determination – Pages 6-15 and Section IV 3. VO Colorado 204L Intake Data Collection for Initial Authorization to Higher Levels of Care – Entire policy 4. VO Colorado 206L Data Collection for Continued Authorization to Higher Levels of Care – Entire policy **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies clearly define and outline the procedures and information needed for each type of authorization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Medical Necessity Determination policy described procedures for processing requests for authorization of initial and continuing services. The policy also described processes for documenting the determination process and time frames for making a UR determination. The VO Intake Data Collection for Initial Authorization to Higher Levels of Care policy described the information needed and used to make preservice UR determinations for intensive levels of care such as inpatient, acute treatment unit (ATU), or subacute services. The VO Data Collection for Continued Authorization to Higher Levels of Care policy described the information needed and used to make UR determinations for continuing authorization for intensive levels of care.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
6. The Contractor's written policies and procedures include mechanisms to ensure consistent application of review criteria for authorization decisions. *42CFR438.210(b)(2)(i)* *Contract: II.I.1.j and II.I.1.q*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. ValueOptions® C409 Interrater Reliability – Entire policy 3. VO Colorado 236L Clinical Level Care Guidelines – Page 2, Section V.A.2.c 4. VO Colorado 408L Care Management Documentation Audit – Page 1, Sections I.A and III.A 5. Initial Assessment Audit Report 2010JUL01 – Example of documentation audit report **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies ensure consistent application of criteria for authorization decisions. Documentation audit reports demonstrate staff documents the same information for use in consideration of the authorization decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Interrater Reliability (IRR) policy was a VO national policy and included the processes for ongoing local IRR activities and an annual companywide IRR review for staff members engaging in UR activities. During the on-site interview, CHP staff confirmed that the VO requirement to pass was 80 percent. The Initial Assessment Audit Report (performed quarterly) measured CCM compliance with obtaining each of the required information elements from the member at the initial contact. Other methods of ensuring consistency of authorization decisions included review of UR and other clinical issues, as well as case processing for complex cases at clinical rounds meetings.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
7. The Contractor's written policies and procedures include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* *Contract: II.I.1.j*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 202L Medical Necessity – Page 4, Section V.D 3. VO Colorado 203L Medical Necessity Determination – Page 20, Section M.2 4. VO Colorado 303L Peer Advisor Adverse Determinations – Page 1, Section III.C **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies direct staff to contact the provider, when necessary, for a review determination. In addition, VO policies outline a formal process which includes consultation with a requesting provider, upon request, for reconsideration when initial authorization is denied. Finally, appropriate attempts are made to contact the requesting provider for reconsideration/peer to peer review before finalizing any adverse clinical decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Medical Necessity policy included the process for requesting additional medical records from the requesting provider when there was difficulty in making a review determination. The VO Medical Necessity Determination policy and the VO Peer Advisor Adverse Determinations policy described the process of peer clinical reconsideration review (peer-to-peer review). The on-site review of denial records demonstrated that the CCM documented in the electronic system that the requesting provider was offered a peer-to-peer review prior to finalizing the determination and sending the notice of action.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. *42CFR438.210(b)(3)* *Contract: II.I.1.h and Exhibit V.A.4*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado Policy 303L Peer Advisor Determinations – Pages 1-2, Sections III.B and IV.C **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy states the required expertise of the VO Peer Advisors who make decisions to deny or authorize less service than requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: During the on-site interview, CHP management and UM staff described both the peer advisor determination process and the peer-to-peer reconsideration review process. Staff clarified that any cases that did not initially meet the criteria for authorization by the CCM were escalated to the peer advisor (psychiatrist level for inpatient, ATU, or residential treatment center [RTC] and PhD level for nonovernight levels of care). Staff also reported that peer-to-peer reconsideration reviews were also performed by the same peer level based on the level of service requested. On-site review of records demonstrated that the notice of action letters specifically named the staff member who made the determination and that CHP policies regarding the qualifications of the individual making the determination were followed.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42CFR438.210I* *Contract: II.I.1.j*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 203L Medical Necessity Determination – Page 8-14, Section V.D-G **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy outlines the processes for notifying the requesting provider and involved member of any decision to deny or authorize less care than requested, for all types of requests and levels of care. Specifically, • **Section V.D.4** outlines that for denials/limited authorization or urgent prospective requests, the requesting provider is notified telephonically at the time of determination, and that the member, facility and provider all receive written notice of the determination; • **Section V.E.4** outlines the same notification guidelines indicated above for urgent concurrent reviews; • **Section V.F.4** outlines the same notification guidelines indicated above for routine initial reviews; and • **Section V.G.5** outlines the same notification guidelines indicated above for routine concurrent reviews.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Medical Necessity Determination policy included the process for verbal (telephonic) and written notification to the provider and written notification to the member. On-site review of denial records demonstrated that the CCM documented verbal notification to the requesting provider. Copies of the notice of action letters in the denial records indicated that the requesting provider also received a copy of the letter.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
10. The Contractor's written policies and procedures include the following timeframes for making standard and expedited authorization decisions: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 days. *42CFR438.210(d)* *Contract: Attachment K: 8.209.4.A.3.c and 8.209.4.A.6*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 203L Medical Necessity Determination – Pages 6 – 15, Section V.C-H **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy specifies the timeframes for each type of authorization and level of care. Specifically, • **Section V.C** outlines all authorization timeframes for decisions. Standard (non-urgent) decisions are made within 10 calendar days and expedited decisions (urgent) are made within 72 hours; • **Section V.D.1** notes 72 hours as timeframe for expedited initial authorizations; • **Section V.E.1** notes 72 hours as the maximum timeframe for concurrent urgent authorizations (expedited); • **Section V.F.1** notes the timeframe for routine initial authorizations is 10 calendar days; • **Section V.G.1** notes the timeframe for routine concurrent authorization is 10 calendar days; and, • **Section V.H.1** notes the timeframe for retroactive authorization request decisions is 10 calendar days.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Medical Necessity Determination policy included the required determination time frame for standard authorization decisions. For expedited authorization decisions, the policy stated the time frame as three calendar days or 72 hours. Three calendar days (equivalent to 72 hours) exceeds the federal requirement of three working days. The on-site review of denial records demonstrated that 19 of 20 records reviewed were in compliance with the required decision and notification time frames. One standard request for authorization of services was completed with notification provided in 15 calendar days.		
Required Actions: CHP must ensure that authorization determinations are made with notice provided to the member and the requesting provider within the required federal timelines.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
11. The Contractor's written policies and procedures include the following timeframes for possible extension of timeframes for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* Contract: None	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 203L Medical Necessity Determination – Pages 6-7 and 10-11, Sections V.D and V.F **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy details the conditions and timeframes for possible extensions for expedited and standard authorization decisions. For expedited authorizations, due to the urgent nature of the care and to meet URAC requirements, extensions are only given due to lack of information. **Section V.D.2** outlines the timeframe for an urgent (expedited) case is 4-5 calendar days' extension. For standard (routine) authorizations: • **Section V.F.2** notes a 14 calendar day extension is available if there is a lack of information to make an authorization decision; • **Section V.F.3** notes a 14 day extension is available if there are circumstances beyond the control of ValueOptions®.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Medical Necessity Determination policy included the provision that standard authorization determination time frames may be extended by up to 14 calendar days if the member requests the extension or if the BHO determines that the extension is in the member's best interest. For expedited decisions, the policy stated that if the determination cannot be made within three calendar days, CHP must notify the member and provider of the request to extend the authorization decision time frame within 24 hours of the decision to extend the time frame. The policy also stated that the provider is given two days to provide additional clinical information needed and that if the information is not received within the required time frame, the decision would be made with the available information. Although federal regulations allow for extensions of expedited decisions of up to 14 calendar days, CHP staff members explained that VO is URAC-accredited and that URAC does not allow an extension of 14 calendar days. CHP staff members stated that CHP/VO policies are designed to comply with both URAC and BBA requirements.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
12. The Contractor maintains a comprehensive utilization management (UM) program to monitor the access to, use, consumption, levels and intensity of care, outcomes of, and appropriate utilization of covered services. *Contract: II.I.1.a*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. ValueOptions® C101 Utilization Management Program Description – Entire document 3. ValueOptions® C101A UM Program Description Outline – Entire policy 4. ValueOptions® C102 Quality Management_Utilization Management Work Plans – Entire policy 5. ValueOptions® PR303 Monitoring Network Access and Availability – Entire policy 6. VO Colorado 103L Revisions to the Utilization Management Program Description Work Plan – Entire policy 7. FY11 CHP QMUM Work Plan – Goals 3 & 5 8. FY11 CHP QMUM Program Description – Section V.A.1 and V.B 9. 3 BHO FY2009 CCAR Outcomes – Entire report monitors outcomes on CCAR measures 10. CHP ATC Report Q1FY11 – Entire report demonstrates that VO monitors access to care timeframes **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® does develop and maintain a utilization management program to monitor the access to, usage, levels of care, outcomes of, and appropriate utilization of covered services as supported by the submitted documents.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO UM Program Description Outline was a VO national outline that specified the content requirements for local service center (such as VO Colorado/CHP) UM Descriptions. The VO Quality Management/Utilization Management (QM/UM) Work Plans policy was a VO national policy that described the required content for local service center QM/UM work plans. The CHP FY 2011 QM/UM Program Description was comprehensive and		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
included processes such as review and revision by the CHP Class B Board and the CHP Quality Improvement Steering Committee (QISC)/Clinical Advisory Utilization Management Committee. The CHP QM/UM Program Description outlined the committee structure of the program, task and reporting responsibilities, scope of the QM and UM programs, and the processes for medical necessity and UR determinations. The three BHO Colorado Client Assessment Record (CCAR) Outcomes report and the CHP Access to Care (ATC) report demonstrated reporting and evaluation of UM-related performance measure data. During the on-site interview, CHP staff reported that typical utilization reports reviewed and discussed weekly included services used six months prior to hospitalization, the top 10 and top 20 users of services by service mix and by diagnosis, the top five diagnoses, average daily census, and inpatient average length of stay. Staff also stated that other utilization reports were reviewed as needed.		
Required Actions: None		
13. The Contractor evaluates the medical necessity, appropriateness, efficacy, and efficiency of health care services, referrals, procedures, and settings. *Contract: II.I.1.a*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 202L Medical Necessity – Entire policy 3. VO Colorado IV403 Provider Treatment Record Review, Analysis and Reporting – Page 1, Section III.A 4. FY10 CHP QMUM Annual Evaluation – Entire document, especially Pages 4, 7 and 12 5. 3 BHO Chart Audit Summary Results 2010OCT – Entire document 6. 3 BHO FY2009 CCAR Outcomes – Entire document 7. 3 BHO Perf Meas IP ALOS – Entire document 8. 3 BHO Perf Meas Discharges per 1000 – Entire document 9. CHP and NBHP MHSIP_YSSF Results FY2010 – Entire document 10. Facility Site Visit Tool **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). Annually, ValueOptions® conducts a comprehensive review of the quality and utilization management programs which evaluate efficiency, efficacy and appropriateness	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	of services, referrals, and procedures. Throughout the year, appropriateness and efficacy of health care services are evaluated through Treatment Record Reviews, Chart Audits and the CCAR instrument. These monitoring activities ensure appropriate treatment planning and various aspects of care. Performance measures and satisfaction survey reports provide evidence of the monitoring and evaluation of health care services, procedures and settings, as in the example reports included. These and similar reports are reviewed and evaluated through Quality and Utilization Management Committees. Efficiency of Call Center operations is monitored through various telephone statistics and the timeliness of authorization decisions. Additionally, each facility is required, per NCQA, to have an accreditation or undergo a facility site visit upon credentialing and recredentialing. The on-site reviewer uses the facility site visit tool in order to measure contract compliance.	
Findings: The VO Medical Necessity policy described processes for making medical necessity and UR determinations. The Provider Treatment Record Review, Analysis and Reporting policy described the process for evaluating treatment records against medical record requirements. The three BHO Chart Audit Summary Results included results of chart audits for all eight of CHP's CMHCs as well as the IPN. Elements evaluated during chart audits (as evidenced by review of the chart audit form) included presence of required documentation and appropriate content of the assessment and treatment plan. Processes for evaluating outcomes and the efficiency and effectiveness of service provision included performance measure reports and daily or weekly review of UM reports and data (based on the type of report).		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
14. The Contractor's UM program is under the direction of an appropriately qualified clinician and includes policies and procedures that have been reviewed by the Department. *Contract: II.I.1.a*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. FY11 CHP QMUM Program Description – Page 6, Section IV.A 3. LSH Resume – Outlines the qualifications of the current CHP Medical Director who provides oversight to the UM program **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). The CHP QM/UM Program Description explains the CHP Medical Director provides oversight for the utilization management program. Also included in the materials is the résumé of the CHP Medical Director which highlights his expertise.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The CHP QM/UM Program Description stated that the medical director (a board-certified psychiatrist) was responsible for oversight of the UM program. The medical director's participation in the UM program was evidenced by participation in committee meetings and documentation within the denial records of the medical director having completed peer review determinations. Day-to-day management and oversight of UM operations was also accomplished by the clinical director (a licensed marriage and family therapist) and clinical peer advisor (a PhD-level clinical psychologist).		
Required Actions: None		
15. The Construction of the UM program does not impede Member's timely access of services. *Contract: II.I.1.b*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 – 21 2. VO Colorado 210L Member Request_Routine – Entire policy, especially Page 1, Section III.A 3. VO Colorado 211L Member Request_Urgent – Entire policy, especially Page 1, Section III.A 4. VO Colorado 203L Medical Necessity Determination – Entire policy, especially Sections III.A-B, V.A.2and V.B	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	5. VO Colorado 238L Service for Deaf and Hard of Hearing Clients – Entire policy 6. ValueOptions® PR303 Monitoring Network Access and Availability – Entire policy 7. CHP ATC Report Q1FY11 – Entire report demonstrates access timeframe monitoring **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies are designed to assist members with timely access to services, with all member requests receiving evaluation as to the urgency of the members' needs. Medical necessity determinations are made promptly so as not to interfere with the member's access to services and timeliness of authorization decisions is closely monitored. All standards for timeliness of authorization decisions are dependent on type and time of request. However, no authorizations are required for Emergency and Post Stabilization services. Specific policies are in place to address any special needs to assist members with timely access to treatment.	
Findings: The VO Member Request policies (Routine and Urgent) described assigning risk levels, the procedures, and responsibilities for timely processing and responding to requests for services. The CHP ATC Report demonstrated monitoring compliance with timely access-to-care standards. Review of denial records on-site demonstrated that the average time that requests were processed and notification provided was two days. The FY 2011 CHP ATC Report included access data for four quarters in FY 2010 and the first quarter of FY 2011. The report indicated 100 percent compliance with access standards for initial, routine, and urgent care, and 99 percent compliance with access standards for emergency services. The data for this report included information for both the IPN and the CMHCs.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
16. The Contractor ensures that the UM program incorporates mechanisms to continuously update guidelines, policies and procedures used in making determinations based on evaluation of new medical technologies and new application of established technologies, including medical procedures, drugs, and devices. *Contract: II.I.1.k*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 – 21 2. VO Colorado 104L Developing and Updating Clinical Criteria – Entire policy 3. VO Colorado 105L Developing and Updating Treatment Guidelines – Entire policy 4. VO Colorado 218L New Clinical_Medical Technologies – Entire policy **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies listed above describe the mechanisms to continuously update guidelines, policies and procedures used in making determinations based on evaluation of new medical technologies and new application of established technologies, including medical procedures, drugs, and devices.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Developing and Updating Clinical Criteria policy stated that an update and review of clinical criteria took place annually. The New Medical Technology policy described the process for evaluating new clinical/medical technology. The process included presentation to the QISC by any member of the QISC and final determination by the Board of Directors. QM/UM committee meeting minutes demonstrated committee review and approval of policies and UR review criteria. There were no examples of review for use of new technologies during the review period.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
17. The Contractor maintains mechanisms to evaluate the effects of the UM program. *Contract: II.I.1.l*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. ValueOptions® C113 Utilization Management Program Evaluation – Entire policy 3. ValueOptions® C113A UM Program Evaluation Outline – Entire policy 4. FY10 CHP QMUM Annual Evaluation – Entire document 5. 3 BHO Perf Meas IP ALOS – Entire report (part of dashboard- type presentation of UM indicators). 6. 3 BHO Perf Measure Discharges per 1000 –Entire report (part of dashboard-type presentation of UM indicators) 7. 3 BHO Perf Meas Amb FU 7 day –Entire report (part of dashboard-type presentation of UM indicators). 8. 3 BHO Perf Indicators Q4 FY10.swf (Flash file presentation of UM performance indicators) 9. CHP Notice of Action Log JUNE2010 – Entire report **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® completes an annual evaluation of the Quality Management and Utilization Management programs. Throughout the year a variety of performance measures and reports (examples listed above) are monitored and reviewed within quality and clinical committees.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The CHP annual evaluation of the QM/UM program was a combined evaluation and included evaluation of UM staff performance, departmental procedures, and performance measures against goals.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
18. The Contractor has UM review standards that are the same for network providers as they are for out-of-network or unaffiliated providers. *Contract: II.I.1.n*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. 3 BHO Colorado Medicaid Addendum Contract – Page 1, Section B (5) 3. VO Colorado 274L Provision of Services through an Out of Network Provider – Entire policy 4. SCA Letter Practitioner with Cover – Entire document, especially Page 2, paragraph 3 5. SCA Letter Facilities with Cover – Entire document 6. Provider Handbook (Misc folder) – Page 13, Section IV, *Utilization Management Procedures* **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® has mechanisms to ensure network and out-of-network providers follow the same utilization management review standards. In addition to a policy that explains the provision of services for network providers, out of network providers must sign a contract addendum in order to treat ValueOptions® Colorado members. All providers must comply with utilization management procedures as outlined in the provider handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The 3 BHO Medicaid Contract Addendum incorporated the provider handbook into the contract between CHP/VO and the CMHCs. The single-case agreement (SCA) template also incorporated, by reference, the provider handbook into the agreement. Both agreements provided the address where the provider handbook could be found on CHP's Web site. The provider handbook described processes and procedures for obtaining authorizations. The Provision of Services Through an Out-of-Network Provider policy described the criteria and process for entering into an SCA and stated that once the SCA was in place, services were authorized using medical necessity and UR review criteria. During the on-site interview, CHP staff confirmed that the CMHCs, IPN providers, and SCA providers were given access to the same provider handbook, as well as the same processes for obtaining service authorization.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
19. The Contractor's written policies and procedures provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42CFR438.210(e)* *Contract: II.D.6.a.1 and II.I.1.c*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. Code of Conduct Annual Training – Entire document 3. Annual Acknowledgment Signature Page – Sections 2 and 4 4. Code of Conduct Training Certification 0810 - Entire document **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® has policies in place that define conflict of interest and specifically state that employees are not provided incentives, nor permitted to accept gifts in relation to any UM activities. ValueOptions®' staff annually receives training regarding conflict of interest and employee code of conduct.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The CHP code of conduct training included specific conduct requirements for UM and QM staff members, including the requirement to attest to the agreement that no incentives for utilization decisions are permitted. During the on-site interview, CHP staff explained that all staff members were required to undergo this training at hire and annually, signing the acknowledgment attesting to receipt of the training, understanding of requirements related to the training, and understanding that utilization decisions are made based on appropriateness of care. The acknowledgment also specifically stated that VO does not reward practitioners or other individuals for denials of services. A signed example was provided for review.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
20. The Contractor defines Emergency Medical Condition as a 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. *42CFR438.114(a)* *Contract: I.A.10*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 270L Emergency and Post-Stabilization Services – Pages 2-3, Section IV.A defines Emergency Medical Condition. 3. CHP Member Handbook (Misc folder) – Page 13 provides definition of emergency medical condition and instructs members on how to access emergency services. 4. ValueOptions® C214 Member Request – 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 9 of the .pdf file defines Emergency Medical Condition for providers. **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L Emergency and Poststabilization Services policy defines emergency medical conditions. Members receive information in the member handbook about what defines an emergency or crisis and how to obtain emergency services. ValueOptions®' staff assists members and directs them to the nearest facility/ER when there is any question of an emergency medical condition. The provider handbook defines emergency medical condition for providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the BBA definition of emergency medical condition. The member handbook included a definition of emergency medical condition that met federal requirements and was at the State-required readability level. The VO Member Request policy included processes for determining the member's risk level during the initial call to request services. Risk Levels 3 and 4 were defined as conditions consistent with the BBA definition of emergency medical condition. The provider handbook included the BBA definition of emergency medical definition.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Required Actions: None		
21. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition. *42CFR438.114(a)* *Contract: I.A.11*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) - Entire policy 2. VO Colorado 270L Emergency and Post-Stabilization Services – Page 3, Section IV.C. **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L Emergency and Poststabilization Services policy clearly outlines the definition of emergency services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the BBA-compliant definition of emergency services. The member handbook included a discussion of emergency services and emergency care that was consistent with the BBA definition of emergency services and was at the required readability level.		
Required Actions: None		
22. The Contractor defines Post-stabilization Care Services 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. *42CFR438.114(a)* *Contract: I.A.29*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) - Entire policy 2. VO Colorado 270L Emergency and Post-Stabilization Services – Page 3, Section IV.D. **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L Emergency and Poststabilization Services policy clearly defines post stabilization care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the BBA-compliant definition of post-stabilization services. The definition of post-stabilization services in the member handbook was consistent with the federal definition and was at the required readability level.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Required Actions: None		
23. The Contractor makes emergency services available to members without preauthorization. *42CFR438.10(f)(6)(viii)(B)* *Contract: II.I.1.p.1*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) - Entire policy 2. VO Colorado 203L Medical Necessity Determination – Page 5, Section B 3. VO Colorado 270L Emergency and Post-Stabilization Services – Page 2, Section III.F. 4. VO Colorado ER claims procedures – Entire policy 5. Provider Handbook (Misc Folder) – Page 10 6. CHP Member Handbook (Misc folder) – Page 13 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L Emergency and Poststabilization Services policy outlines that no authorization is required for emergency services. In addition, the provider and member handbooks detail this specific information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Medical Necessity Determinations policy, the VO Emergency and Post-Stabilization Services policy, and the CHP ER Claims policies and procedures stated that no authorization is needed for emergency services provided in or out of network. The provider manual delineated the expectations of providers in emergency situations. The member handbook informed members that no prior authorization is needed for emergency services.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
24. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42CFR438.114(c)(1)(i)* *Contract: II.D.6.a.1*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) - Entire policy 2. VO Colorado 270L Emergency and Post-Stabilization Services – Page 1, Section III.A. 3. VO Colorado ER claims procedures – Entire policy **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' Colorado ER claims procedures indicates members can access these services without prior authorization. This procedure document states that claims for emergency services are accepted and paid for any provider, regardless of network status. Claims processors are instructed to consider claims from In or Out of network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that CHP covers and pays for emergency services regardless of whether the provider has a contract with CHP/VO. The CHP ER Claims policies and procedures stated that no authorization is needed for emergency services provided in or out of network. The member handbook directed members to go to the nearest emergency room and stated that members do not need prior authorization to receive emergency services and may receive emergency services from any qualified hospital or provider.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
25. 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 *not* 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. *42CFR438.114(c)(1)(ii)* *Contract: II.D.6.a.2*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) – Entire policy 2. VO Colorado 270L Emergency and Post-Stabilization Services – Page 1, Section III.B.1-2 3. VO Colorado ER claims procedures – Entire policy, especially Page 1, Policy and Section I 4. Provider Handbook (Misc folder) – Page 15 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L Emergency and Poststabilization Services policy clearly outlines that payment may not be denied under either of these circumstances. There is no authorization requirement at all for emergency services. These services are not denied when billed as emergency services, regardless of the actual outcome. Providers are also informed of this requirement through the provider handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that CHP would not deny payment in cases determined not to have been an emergency medical condition. During the on-site interview, staff reported that the claims system set aside all emergency claims for staff review to ensure appropriate payment of emergency claims.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
26. 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. *42CFR438.114(d)(1)* *Contract: II.D.6.c*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) - Entire policy 2. VO Colorado 270L Emergency and Post-Stabilization Services – Page 2, Section III.C.1-2 3. VO Colorado ER Claims Procedures – Page 1, Policy section and Section I **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L Emergency and Poststabilization Services policy does not limit what constitutes an emergency medical condition based on diagnoses, symptoms or refuse to cover emergency services based on the provider, hospital or fiscal agent not notifying the primary care providers within 10 days of presentation for services. During claims processing, ValueOptions®' staff pays these claims and does not review or analyze the criteria based on symptoms or diagnoses for emergency services claims.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Services policy included the required provisions. The ER claims procedures indicated that the list of covered diagnoses was used to determine if the services were covered.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
27. 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. *42CFR438.114(d)(2)* *Contract: II.D.6.c*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) - Entire policy 2. VO Colorado 270L Emergency and Post-Stabilization Services – Page 2, Section III.D. 3. CHP Member Handbook (Misc folder) – Page 15 informs members that they are not responsible for payment of services (any services) covered by Medicaid. **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L Emergency and Poststabilization Services policy releases the member from liability for payment for any subsequent screening and treatment needed to stabilize an emergency medical condition. Members are informed via the member handbook that the member is not responsible to pay for services covered by the Medicaid plan. Members are instructed to call the Behavioral Health Organization if the member receives a bill for services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Services policy included the provision that CHP 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. The member handbook informed members that they are not responsible for payment of any mental health services and instructed members to call CHP if they receive any bills for mental health services. The provider handbook informed providers that they may not assess any charges to Medicaid recipients for covered services, including co-payments, and that balance billing is not allowed.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
28. 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. *42CFR438.114(d)(3)* *Contract: II.D.6.d*	**Documents Submitted/Location Within Documents:** 1. CHP Delegation Agreement (Misc folder) - Entire policy 2. VO Colorado 270L Emergency and Post-Stabilization Services – Page 2, Section III.E. **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L Emergency and Poststabilization Services policy states the attending physician/facility makes decisions independent of any contact with the Behavioral Health Organization regarding stabilization, as there is no preauthorization required for emergency services, and no authorization needs to be on file for the claim to be paid. The provider makes treatment decisions and submits the bill after services have been rendered.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergency and Post-Stabilization Services policy included the provision that the provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge. Staff confirmed that the process for on-site CHP assessment in emergencies includes ensuring that the member is medically stable prior to assessing for the medical necessity of further mental health treatment.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
29. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are pre-approved by a plan provider or other organization representative. *42CFR438.114(e)* *42CFR422.113(c)(2(i)* *Contract: II.D.6.e*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 270L Emergency and Post Stabilization Services – Page 2, Section III.G.1 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy states that ValueOptions® is financially responsible for poststabilization services obtained in-network or out-of-network and are pre-approved by plan providers or ValueOptions®' representatives.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that CHP is financially responsible for post-stabilization care services obtained within or outside the network. The VO Emergency and Post-Stabilization Services policy and the VO Medical Necessity Determination policy stated that no precertification or preauthorization is required to obtain emergency services.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
30. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within 1 hour of a request to the organization for pre-approval of further post-stabilization care services. *42CFR438.114(e)* *42CFR422.113(c)(2)(ii)* *Contract: II.D.6.a*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 270L Emergency and Post Stabilization Services – Page 2, Section III.G.2 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy states if poststabilization services provided in- or out-of-network are not pre-approved by a plan provider or a ValueOptions® representative and are administered to maintain the member's stabilized condition within 1 hour of request for pre-approval of further services, ValueOptions® is financially responsible for the post-stabilization services provided.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that CHP is financially responsible for post-stabilization care services obtained within or outside the network. The VO Emergency and Post-Stabilization Services policy and the VO Medical Necessity Determination policy stated that no precertification or preauthorization is required to obtain emergency services. The member handbook stated, "You may need services *after the emergency is over* to help you stay stable or improve your mental health condition. *This is called Post-Stabilization Care*. Post-stabilization services are inpatient and outpatient services provided just after an emergency. *Your emergency provider must get approval from your BHO for these services after the emergency is over."* This statement leads the reader to believe that preauthorization is required for post-stabilization care and is in conflict with CHP's policies.		
Required Actions: CHP must clarify the member handbook to provide information that is consistent with VO's/CHP's policies.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
31. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: ◆ The organization does not respond to a request for pre-approval within 1 hour, ◆ The organization cannot be contacted, ◆ The organization representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in requirement number 33 is met. *42CFR438.114(e)* *42CFR422.113(c)(2)(iii)* *Contract: II.D.6.f*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 270L Emergency and Post Stabilization Services – Pages 2-3, Section III.G.3.a-c(1-4) **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy details the additional circumstances by which ValueOptions® maintains financial responsibility for provided services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that CHP is financially responsible for post-stabilization care services obtained within or outside the network. The VO Emergency and Post-Stabilization Services policy and the VO Medical Necessity Determination policy stated that no precertification or preauthorization is required to obtain emergency services.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
32. The Contractor must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor. *42CFR438.114(e)* *42CFR422.113(c)(2)(iv)* *Contract: II.D.6.g*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 270L Emergency and Post Stabilization Services – Page 2, Section III.D 3. CHP Member Handbook (Misc. folder) – Page 15 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy states members are not charged for post stabilization services. Members are informed they cannot be charged for any service covered under Medicaid mental health and are directed to contact the Behavioral Health Organization for assistance if they should receive a bill for services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that CHP/VO does not hold a member who has an emergency medical condition liable for payment of post-stabilization services, regardless of whether these services were obtained through CHP, and that members are not charged for these services. The member handbook informed members that they are not responsible for payment of any mental health service. The provider handbook informed providers that they may not assess any charges to Medicaid recipients for covered services, including co-payments, and that balance billing is not allowed.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
33. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when: ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care, ◆ A plan physician assumes responsibility for the member's care through transfer, ◆ A plan representative and the treating physician reach an agreement concerning the member's care, ◆ The member is discharged. *42CFR438.114(e)* *42CFR422.113(c)(3)* *Contract: II.D.6.h*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 270L Emergency and Post Stabilization Services – Page 3, Section III.G.3.c.1-4 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy describes all the circumstances which denote the end of ValueOptions®' financial responsibility for post stabilization services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy and the VO Medical Necessity Determination policy stated that no precertification or preauthorization is required to obtain emergency services. During the on-site interview, CHP staff described preauthorization processes, clarifying that post-stabilization services provided immediately following the emergency and prior to inpatient hospitalization do not require prior authorization. Staff confirmed the CHP/VO policy that inpatient hospitalization and other intensive services (e.g., ATC or RTC services) do require prior authorization.		
Required Actions: None		

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	33	**Total Score**		=	31

Total Score ÷ Total Applicable	=	94%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
1. The Contractor ensures that all covered services are available and accessible to members. *42CFR438.206(a)* *Contract: II.E*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 211L Member Request_Urgent – Entire policy 3. VO Colorado 210L Member Request_Routine – Entire policy 4. VO Colorado 224L Psychological Testing – Pg 1, Section III.C 5. VO Colorado 238L Service for Deaf and Hard of Hearing Clients – Entire policy, especially Page 1, Section III.A 6. VO Colorado 420L Continuous 24hr Care Management Phone Coverage – Entire policy 7. VO Colorado 246L Telephone Outage – Entire policy 8. VO Colorado 252L Timeliness of Answering Incoming Calls – Entire policy 9. VO Colorado 267LTwenty-four Hour Availability of Clinical Support – Entire policy 10. VO Colorado Schedule_Clinical On Call – Entire document 11. VO Colorado III306 Measurement of Access and Availability – Entire policy 12. 3 BHO Template Call Log Qtr3FY2010 – Entire document 13. VO Colorado Letter First Time 15 min – Example of monitoring 14. Provider Handbook (Misc folder) – Page 3, Section II, *Continuum of Service*, Pages 6, Section III, *Provider Assistance & Referrals*, Pages 8-9, *Provider Availability for Member Access to Care* 15. CHP ER Access IPN q4fy10 – Entire document 16. CHP ATC Report Q1FY11 – Entire document 17. CHP and NBHP FY2010 Contract Compliance - Items 44-48, 72 18. CHP Fact Finders Survey Access to Care Comparison CY2009 – Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	19. CHP 110510 DRAFT QISCCAUMC Meeting Minutes – Page 5, Section VI. Access Monitoring 20. Single Case Agreement Report 21. 2010 Colorado Medicaid Provider Forum 22. CHP Member Handbook (Misc folder) – Pages 5, 7-8 and 14-17 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies describe the access and availability of services for members and explain that a member's situation and needs are taken into consideration when determining the appropriate timeframes in which services must be provided. Specific policies listed above (Policy 211L and 238L) address non-routine services and members with special needs. These policies ensure that services are available and accessible to all populations eligible for the State Medicaid program. Additionally, the ValueOptions® Colorado Call Center is accessible 24 hours per day, 7 days per week to assist members telephonically with access to services and to assist in providing services in a timely manner. Staff is available despite inclement weather or other phone problems and senior clinical staff/management are accessible to assist staff with any member access concerns. Quarterly telephone statistic reports are monitored to ensure phones are answered quickly and efficiently so members can receive assistance in accessing care and finding services. In addition, timely access to services is monitored for urgent, emergent and routine care. Providers are given information about the continuum of services available to members and how members access those services via the provider handbook and through provider forums. Clinical and	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Provider Relations staff provides individualized training to providers on available services as needed. When services are not available within the network, services are made available by contracting with out of network providers through a single case agreement. Members are made aware of their right to access all covered services and the timeframe standards for these services through the member handbook and on the BHO's website. In addition to the fact that all covered services are made available to them, members are informed of all their rights and, specifically, their right to file a grievance if the BHO does not make all covered services available and accessible.	
Findings: The CHP Delegation Agreement with VO described delegation of quality and monitoring activities, including maintenance of policies and procedures for access and availability. CHP adequately monitored VO via CHP Class B Board meetings and review of access and availability reports. CHP had numerous policies and procedures that described the authorization and provision of covered services. The VO Measurement of Access and Availability policy included appointment standards and described methods of monitoring the call center, the CMHCs, and the IPN to ensure timeliness of response to requests for services. CHP provided an example of a letter sent to providers if the monitoring processes revealed noncompliance. The provider manual described covered services and expectations for providers' appointment availability. The CHP ER Access IPN report, the CHP ATC report, the CHP and NBHP contract compliance report, and Fact Finders Access to Care Comparison report provided results and demonstrated CHP's/VO's monitoring of access to care in both the CMHCs and the IPN. The November 5, 2010, QISC meeting minutes included discussion of monitoring activities and proposed interventions. The member handbook described appointment standards.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
2. The Contractor maintains and monitors a comprehensive provider network capable of serving the behavioral health needs of all members in the program. *42CFR438.206(b)(1)* *Contract: II.E.1.c.1*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado III306 Measurement of Access and Availability – Entire policy 3. VO Colorado III309 Quality of Care – Entire policy 4. VO Colorado IV403 Provider Treatment Record Review, Analysis and Reporting – Page 1, Section III.A 5. ValueOptions® PR302 Network Design and Access Standards 6. CHP ER Access IPN q4fy10 – Entire document 7. CHP ATC Report Q1FY11 – Entire document 8. CHP Residential After Care Timeliness Q1FY2011 – Entire document 9. CHP and NBHP MHSIP_YSSF Results FY2009 – Entire document 10. 3 BHO Audit Tool – Entire document 11. Facility Site Review Tool – Entire document 12. First Fail Audit Letter 13. 3 BHO Network Adequacy Report Q1FY11 14. Provider Network Language Specialties 15. Provider Directory **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® has several policies that describe the activities involved to assess and maintain a comprehensive provider network to serve the needs of eligible Medicaid members. In addition to policies, ValueOptions® conducts a variety of provider monitoring activities to assure providers are meeting the needs of BHO Medicaid members. These activities include monitoring of accessibility and availability, coordination of care, evaluation of member survey	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	responses regarding treatment and accessibility, review of quality of care concerns, treatment record documentation audits, and facility site reviews.	
Findings: CHP's provider directory listed all providers contracted with VO/CHP to provide services by county served. The directory included both independent providers and CMHCs and listed the type of provider, languages spoken, and specialty areas of practice. CHP provided numerous reports demonstrating that it monitored the timeliness of access to services and appropriateness of clinical record-keeping. Reports included the 3 BHO Audit Tool (assessing clinical documentation) and utilization and performance measure reports designed to measure access. The 3 BHO Network Adequacy Report contained an analysis of the number of members, number and types of providers in each county served, and number of miles members must travel to reach providers.		
Required Actions: None		
3. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated Medicaid enrollment, ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, ◆ The numbers of network providers who are not accepting new Medicaid patients, ◆ The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities, ◆ The potential physical barriers to accessing provider's locations,	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. ValueOptions® PR302 Network Design and Access Standards 3. FY2010 Annual Needs Assessment 4. Provider Network Language Specialties 5. Provider Directory 6. 3 BHO Network Adequacy Report Q1FY11 7. Facility Site Review Tool 8. Provider Handbook (Misc folder) – Page 20, Section V, *Member Choice of Providers,* Page 85, Section XVI, *Transportation* **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® reviews the network adequacy for CHP regularly to ensure Medicaid members have a range of providers that are able to serve their needs. The review includes the number of providers, specialties, languages, locations, and accessibility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
◆ The cultural and language expertise of providers, ◆ Provider to member ratios for behavioral health care services. *42CFR438.206(b)(1)(i) through (v)* *Contract: II.E.1.c.1*		
Findings: The FY 2010 annual needs assessment and the 3 BHO Network Adequacy Report addressed the upward trends in member eligibility and penetration rates as well as analysis of encounter claims trends. The report also evaluated the numbers and types of providers, languages spoken, specialty areas, and geographic locations of network providers and members in the service areas.		
Required Actions: None		
4. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. *42CFR438.206(b)(3)* *Contract: II.E.1.a.12*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 257L Request for Second Opinion – Pages 1-2, Sections III.A and V.A.1-2 3. VO Colorado Second Opinion Workflow – Entire document 4. Provider Handbook (Misc folder) – Pages 21-22, Section VI, *Second Opinion* 5. CHP Member Handbook (Misc folder) – Page 15, Paragraphs 3 and 4 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® has mechanisms for members to request and obtain a second opinion at no cost to members. Workflow documents demonstrate that ValueOptions® staff can assist members in getting a second opinion through either the Clinical Department or the Office of Member and Family Affairs. ValueOptions® clinical staff receives training on the process for members to obtain a second opinion. Members learn about their	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	rights to a second opinion through the member handbook and the receipt of member rights statements. Providers are informed of the second opinion process and that there is no cost to the member through the provider handbook.	
Findings: The VO Request for Second Opinion policy described the process used when the clinical team recommends a second opinion for complex cases. The policy stated that members may also request a second opinion and that members may receive a second opinion from an in-network or out-of-network provider, and addressed the process for obtaining an SCA if the member choses an out-of-network provider. The VO Second Opinion Workflow instructed CCM staff members how to assist and direct members asking for a second opinion. The provider manual informed providers that members have the right to a second opinion from an in-network or out-of-network provider at no cost to the member. The member handbook informed members of the right to request a second opinion and how to do so, and listed the right to a second opinion on the list of member rights. During the on-site interview, CHP staff members reported that they receive about four or five requests for a second opinion per year.		
Required Actions: None		
5. If the Contractor is unable to provide necessary services to a member in-network, the Contractor must adequately and timely cover the services out of network for the member, for as long as the Contractor is unable to provide them. *42CFR438.206(b)(4)* *Contract: II.E.1.c.3 and II.E.1.d.1*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 274L Provision of Services through an Out of Network Provider – Entire policy, especially Page 3, Section IV.A.7 3. SCA Letter Practitioner with cover 4. SCA Letter Facilities with cover 5. Provider Handbook (Misc folder) – Page 20, Section V, *Member Choice of Providers* 6. CHP Member Handbook (Misc folder) – Page 6 and 16 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies describe services not available through an in-network provider may be accessible to members through an out-of-network provider at no cost to the member and that all timeframes for authorization decisions must	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	be upheld. Policies outline the approval process and situations in which Single Case Agreements are approved for member services outside of the provider network. In the member handbook, members are informed that they can ask to see a provider who may not be listed in the provider directory. The provider handbook outlines the member's rights regarding choice of providers.	
Findings: The VO Provision of Services Through an Out of Network Provider policy included the provision that if services were not available within the network, CHP makes the services available from an out-of-network provider via an SCA. CHP provided templates for an SCA with an individual provider and for a facility. The provider manual listed the conditions under which members may receive services from an out-of-network provider. The member handbook informed members that they may receive services from an out-of-network provider and may ask that a provider be added to the network, but that the member may have to pay for the services if he or she does not obtain approval.		
Required Actions: None		
6. The Contractor requires out-of-network providers to coordinate with the Contractor with respect to payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42CFR438.206(b)(5)* *Contract: II.E.1.d.2*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. SCA Letter Facilities with cover 3. SCA Letter Practitioner with cover **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). Single Case Agreements require that out-of-network providers coordinate with ValueOptions® with respect to payment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The SCA template for individual providers and for facilities required the provider to coordinate with CHP/VO with respect to payment, explained how the provider submits claims, and informed the provider that he or she may not hold the member liable for any part of the bill.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
7. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Emergency services are available: ▪ By phone, including TTY accessibility, within 15 minutes of the initial contact, ▪ In-person within one hour of contact in urban and suburban areas, ▪ In-person within two hours of contact in rural and frontier areas. ◆ Urgent care is available within twenty four hours from the initial identification of need ◆ Routine services are available upon initial request within 7 business days. ◆ Outpatient follow-up appointments within seven days of an inpatient psychiatric hospitalization or residential facility. ◆ Providers are located throughout the Contractor's service area, within thirty miles or thirty minutes travel time, to the extent such services are available. *42CFR438.206(c)(1)(i)* *Contract: II.E.1.a.6 through II.E.1.a.8*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado III306 Measurement of Access and Availability – Entire policy 3. CHP ER Access IPN q4fy10 – Entire document 4. CHP ATC Report Q1FY11- Entire document 5. CHP and NBHP FY2010 Contract Compliance – Items 44-48 6. 3 BHO Perf Meas Amb FU 7 day – Entire document 7. CHP Residential After Care Timeliness Q1FY2011 –Entire document 8. 3 BHO Network Adequacy Report Q1FY11 9. 2010 Colorado Medicaid Provider Forum – Slides 101-102 10. Provider Handbook (Misc folder) – Pages 8-9, *Provider Availability for Member Access to Care* 11. CHP Member Handbook (Misc folder) – Pages 4-5 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies describe provider availability and members' access to care requirements. The provider handbook specifies access requirements and is incorporated into each provider's contract as a participating ValueOptions®/BHO provider. Further information regarding access standards is included in provider forums and provider newsletters. Access and availability standards are tracked and monitored throughout the year for emergent call response and access to emergent, urgent and routine care as well as follow-up visits completed post hospitalization and follow-up post residential treatment and acute treatment unit discharge. Members are made aware of their right to access services in the member handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The VO Measurement of Access and Availability policy included the requirements for timely access to appointments. Providers were informed of the timely access standards and provider responsibilities via the provider manual. Members were informed of the timely access standards via the member handbook. CHP monitored providers for compliance with standards for timely access. The CHP ER Access IPN report, the CHP ATC report, the CHP and NBHP contract compliance report, the 3 BHO Performance Measure report, and the CHP Residential Aftercare report demonstrated CHP's oversight and monitoring of its IPN and CMHCs for compliance with timely access standards. The VO Colorado provider forum conducted in fall 2010 included discussion of timely access standards. During the on-site interview, CHP staff members reported that they are considering repeating the provider forum via Webinar.		
Required Actions: None		
8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members. *42CFR438.206(c)(1)(ii)* *Contract: II.E.1.a.4*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado III306 Measurement of Access and Availability – Page 2, Section IV.A 3. VO Colorado 267LTwenty-four Hour Availability of Clinical Support – Entire policy 4. VO Colorado 420L Continuous 24hr Care Management Phone Coverage – Entire policy 5. CHP and NBHP FY2010 Contract Compliance – Items 47-48 6. CHP Member Handbook (Misc folder) – Page 3, 6-7 7. Provider Handbook (Misc folder) – Page 9, *Provider Availability for Member Access to Care* **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies describe provider availability and members' access to care requirements. The provider handbook is incorporated into each provider's contract as a participating ValueOptions®/BHO provider. Providers are required to offer hours of operation that are not less than that offered to any other client/member that has other coverage	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	including self pay. Contract compliance audits are conducted to evaluate several elements including access standards. Grievances or survey results may also be used for monitoring as applicable.	
Findings: The VO Measurement of Access and Availability policy included the provision that providers are required to offer hours of operation that are no less than the hours of operation offered to commercial members or are comparable to Medicaid fee for service. Providers were informed of this requirement via the provider manual. Members were informed of the CHP business office hours and the business and service hours for each CMHC via the member handbook.		
Required Actions: None		
9. The Contractor makes Services available 24 hours a day, 7 days a week, when medically necessary. *42CFR438.206(c)(1)(iii)* *Contract: II.E.1.a.5*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 420L Continuous 24hr Care Management Phone Coverage – Entire document 3. VO Colorado 210L Member Request_Routine – Page 1, Section III.A 4. VO Colorado 211L Member Request_Urgent – Page 1, Section III.A-C 5. CHP and NBHP FY2010 Contract Compliance – Item 44 6. CHP ATC Report Q1FY11- ATC Data tab, Rows 27-41 7. 3 BHO Template Call Log Qtr3FY2010 8. Provider Handbook (Misc folder) – Page 9, Section III, *Provider Assistance & Referrals* **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® ensures that crisis services are available throughout the CHP service areas 24 hours a day, 7 days a week. These services can be provided by contracted providers or, in the case of emergent services that are medically necessary, through non-contracted, out of network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Crisis evaluations are conducted in person primarily onsite at inpatient facilities, which offer services 24 hours a day, 7 days a week. The availability of crisis services are monitored through access to care data, and reported to HCPF quarterly, as well as through mental health center contract compliance audits. In addition, services are available through other facilities such as ATUs and residential treatment centers, which also offer service 24 hours a day, 7 days a week. The ValueOptions® Colorado Call Center has a policy and procedure to ensure clinical staff is available 24/7 to facilitate care for members, and to ensure services are coordinated in emergent situations. Telephone statistics are monitored to ensure timely responses to telephone-based emergency service requests.	
Findings: The VO Member Request policies included the process for responding to requests for services 24 hours a day. Providers were informed of their responsibilities for after-hours coverage via the provider manual. Members were informed of the availability of services 24 hours a day, seven days a week, and were given the telephone number for the 24-hour CHP access-to-care line. The CHP ATC report and the CHP ER IPN Access report demonstrated CHP's oversight and monitoring the provider network for compliance with availability 24 hours a day, seven days a week, when medically necessary.		
Required Actions: None		
10. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, and has mechanisms to monitor providers regularly to determine compliance and to take corrective action if there is failure to comply. *42CFR438.206(c)(1)(iv) through (vi)* *Contract: II.E.1.a. 9 through II.E.1.a. 11*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado III306 Measurement of Access and Availability – Entire policy 3. CHP and NBHP FY2010 Contract Compliance – Items 44-48 4. CHP 110510 DRAFT QISCCAUMC Meeting Minutes –Page 5, VI. Access Monitoring 5. CHP ER Access IPN q4fy10 – Entire document 6. CHP ATC Report Q1FY11- Entire document 7. 3 BHO Perf Meas Amb FU 7 day – Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	8. CHP Fact Finders Survey Access to Care Comparison CY2009 – Entire document 9. CHP Residential After Care Timeliness Q1FY2011 – Entire document 10. VO Colorado Letter First Time 15 min – Entire document 11. VO Colorado Access 15 min CAP Letter – Entire document 12. VO Colorado Provider CAP Emergent Response – Entire document **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy establishes the access to care standards and outlines monitoring of access and availability of services. A variety of mechanisms exist to monitor provider access and availability to determine compliance. Providers whose standards are not in compliance are notified and must submit corrective action plans. Along with various mechanisms for all levels of access monitoring, grievances regarding access are investigated through the Quality of Care process, and member survey results are evaluated. Annually, ValueOptions® conducts contract compliance audits and monitors access trends based on satisfaction survey data through quality committees and minutes.	
Findings: CHP provided numerous reports demonstrating oversight and monitoring of providers for compliance with access-to-care requirements. CHP also provided examples of a first-time warning letter and request for a corrective action plan for a provider when monitoring activities determined that the provider was noncompliant with requirements.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
11. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Addressing the language and cultural expertise of providers in the network plan, ◆ Ensuring members' right to receive culturally appropriate and competent services from participating providers, ◆ Assessing member demographics, cultural, and racial affiliations, language and reading proficiency, ◆ Evaluating members' cultural and linguistic needs, ◆ Utilizing information gathered [regarding cultural and linguistic needs] in the service plan. *42CFR438.206(c)(2)* *Contract: II.E.1.c.1.v; II.F.4.j.3.iv; F.7.d.1; F.7.e.2; and F.9.a*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. ValueOptions® CC106 Handling Calls with Limited English Speakers – Entire policy 3. VO Colorado Language Line Workflow 4. CHP Population Analysis FY11 QMUM Program Description 5. VO Colorado Population Analysis Worksheet 2009 – Entire document 6. CHP Fact Finders 2009 Survey Results Cultural Competency Breakout 7. CHP and NBHP MHSIP_YSSF Survey Results Cultural Competency 8. 3 BHO Audit Tool – row 25 9. VO Colorado Contract Compliance Audit Tool – Highlighted sections 10. CHP Cultural Competence Plan 2010 – Pages 8-9 and 14-15. 11. ReferralConnect_ScreenShot 12. Provider Handbook (Misc folder) – Page 80, paragraph two and bullets 4 and 5, Page 81-Cultural Competence, Section 15, *Office of Member and Family Affairs;* Page 86, bullet 4, Section 19, *Medical Record Documentation Standards* 13. Provider Network Language Specialties 14. CHP Manual de Miembro – CHP Member Handbook in Spanish 15. CHP Member Handbook (Misc folder) – Pages 1, 5 and 10 16. Provider Directory **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® conducts a demographic analysis for CHP using census data to determine the ethnic,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	linguistic, educational and economic characteristics of its membership. Member satisfaction survey results are also used to assist in the evaluation of the availability of culturally competent services. Providers are required to uphold member rights and provide culturally competent services; treatment record documentation audits evaluate cultural factors relevant to member treatment. This information is considered in the development of a provider network that includes providers who speak languages other than English and/or have expertise in the cultural needs of Medicaid members. A population analysis for CHP is included as part of the QM/UM Program Description. This analysis is used to develop the BHO's cultural competence plans and plan for member material distribution. Spanish is the most prevalent non-English language spoken by CHP's membership and member materials are available in both English and Spanish. Members are made aware of their right to get culturally competent care through the member rights statement within the member handbook. Members who contact the ValueOptions® Colorado Call Center and speak a language other than English are assisted using the language line. During the call, members are asked a series of questions to assess their cultural needs which are documented in our clinical systems. The provider directory and ReferralConnect, the ValueOptions®' online provider search tool for members, provide information about languages spoken by providers. ReferralConnect allows members to search for available providers with specific language and ethnic characteristics.	
Findings: CHP produced a provider language tracking document that indicated the number of providers in the network who speak languages other than English. Languages spoken by providers were included in the provider directory. The VO Handling Calls With Limited English Speakers policy described the process for using the 24-hour language translation line. The VO Language Line Workflow diagram assisted call center staff members in using the		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
language translation line. The Colorado Population Analysis (Attachment A to UM/QM Program Description) demonstrated CHP's efforts to evaluate the cultural and linguistic needs in each county. The 3 BHO Audit Tool demonstrated the BHO's monitoring of cultural and linguistic factors in the assessment and the treatment plan. The CHP Cultural Competence Plan was a comprehensive work plan that included policies, procedures, and work plan activities designed to confirm CHP's commitment to demonstrating the cultural competence of the organization and network. On the list of member rights in the member handbook was the right to receive culturally competent services. The provider handbook included provider responsibilities for documenting the member's cultural issues in the initial assessment and individual service plan and contained a Web site where the Cultural Competency Plan could be found. The CHP Web site could be translated into Spanish by clicking the "En Espanol" button. CHP also provided a copy of the member handbook in Spanish. During the on-site interview, staff reported that cultural competence activities completed so far included the demographic analysis of members and provider/staff training, analysis of access data by cultural group, and identification of community resources.		
Required Actions: None		
12. The Contactor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor: ◆ Offers an appropriate range of preventative, primary care, and specialty services that is adequate for the anticipated number of members for the services area, ◆ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area, ◆ Certifies that the network meets the requirements set forth in 438.206 and 438.207. *42CFR438.207(b)* *Contract: II.E1.b.1*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 – 21 2. 3 BHO Network Adequacy Report Q1FY11 3. 3 BHO Certification of Network Adequacy 4. 3 BHO Email Network Adequacy 2010OCT 5. FY2010 Annual Needs Assessment 6. Provider Handbook (Misc folder) – Page 3, Section II, *Continuum of Services* **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® reviews network adequacy on a quarterly basis and reports the outcomes to HCPF. Included in the submission is a certification that the provider network meets the needs of eligible Medicaid members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The 3 BHO Network Adequacy Needs Assessment and 3 BHO Network Adequacy Report included all requirements. CHP provided a copy of the e-mail confirming that CHP sent the report to the Department on October 29, 2010.		
Required Actions: None		

Results for Standard II—Access and Availability							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	12	**Total Score**		=	12

Total Score ÷ Total Applicable	=	100%

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination of the provision of covered services to its members and to ensure service accessibility attention to individual needs and continuity of care to promote maintenance of health and maximize independent living. *Contract: II.E.1.g.1*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 274L Provision of Services through an Out of Network Provider – Page 2, Section IV.A.3 3. VO Colorado 259L Enhanced Clinical Management of Outpatient Services – Pages 4-5, Section V.B.1-3 4. VO Colorado 254L Continuity of Care Among Providers and LOC – Entire policy, especially Page 2 5. VO Colorado 262L Coordination of Care – Entire document 6. VO Colorado 278L Coordination of Care – Entire policy 7. VO Colorado Systems Integration Department Policy and Procedure Guidelines – Entire document 8. CHP Member Handbook (Misc folder) – Pages 7-8 9. Provider Handbook (Misc folder) – Pages 11-12 and 18 **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies require coordination and continuity of care and ensure members' care is not interrupted due to a change in benefits. Coordination of care is enhanced through the authorization process and enhanced clinical management activities. The member handbook informs members of the treatment process and their role in the care coordination process. The provider handbook describes the care coordination responsibilities of providers and outlines the requirements of the general medical record relative to care coordination.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The CHP Delegation Agreement described tasks delegated to VO related to the coordination of services provided and care management activities. VO was responsible for administrative tasks, maintenance of policies and procedures related to care coordination, and oversight and monitoring of care coordination activities. The VO Coordination of Care policy and the VO Continuity of Care Among Providers policy described processes for enhanced care management of members with complex needs. The VO Coordination of Care With Physical Health Providers policy described processes for CHP's

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
providers to coordinate and communicate with physical health care providers. The provider manual informed providers of their responsibilities in coordinating care. The member handbook described the care management process and the member's role in obtaining and using services.		
Required Actions: None		
2. Policies and procedures address: ◆ The coordination of services furnished to the member by the Contractor with the services the member receives from any other MCO or PIHP. ◆ The coordination and provision of services in conjunction with other behavioral health care providers, physical health care providers, long term care providers, waiver service providers, pharmacists, county and state agencies, and other organizations that may be providing wrap around services. *42CFR438.208(b)(2)* *Contract: II.E.1.g.1 and II.E.1.g.2*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 278L Coordination of Care With Physical Health Providers – Entire policy 3. VO Colorado 248L Diagnosis and Treatment Early and Periodic Screen EPSDT – Entire policy 4. VO Colorado 269L Advance Directives – Entire policy 5. VO Colorado 237L Use of Residential Treatment for Children Adolescents – Pages 4-5, Section V.H.1-1a 6. VO Colorado 264L Use of Dispute Process Under the Child Mental Health Treatment Act – Entire policy 7. VO Colorado 271L Assisting Dual Medicare Medicaid Eligible Members with Referrals and Access to Services – Entire policy 8. VO Colorado 275L Services for Residents of Nursing Facilities – Entire policy 9. VO Colorado 278L Coordination of Care – Page 1, Section III.A and V.B 10. VO Colorado Systems Integration Department Policy and Procedure Guidelines – Entire policy, especially Page 1, Section III and Pages 3-4, Section V 11. VO Colorado CYF Outpatient – Page 1, Section III.A and Pages 1-2 Section V.C-D 12. VO Colorado CYF Residential Day – Page 1, Section III.A and Pages 1-2, Section V.A-C 13. Wraparound Services Guidelines attachment 14. Provider Newsletter_JUL2010 – Page 2, *Initiative to Improve*	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Coordination of Care with Physical Health Providers 15. 2010 Colorado Medicaid Provider Forum – Slides 19, 26 and 96-100 16. VO Colorado Centennial Peaks Care Coordination – Entire document 17. Provider Handbook (Misc folder) – Page 12, *Coordination of Mental Health and Primary Care*, Page 18, *General Medical Record Requirements*, Pages 25-26, Section VIII, *Coordination of Care*, Page 88, *Medical Record Documentation Standards* (bullet 2) **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies describe and require care coordination with physical health providers, behavioral health providers, long term care providers, county and state agencies and other organizations providing services to members. The provider handbook details the responsibilities and expectations of providers in coordinating care and newsletters inform providers about the current performance improvement project; an example of a provider letter outlining care coordination expectations is also included (VO Colorado Centennial Peaks Care Coordination).	
Findings: CHP had multiple policies and procedures that addressed coordinating care with other entities, including MCOs or BHOs, community agencies, and multiple providers furnishing services to the member. The policies delineated the responsibilities of CHP/VO clinical case management staff, the systems integration staff (responsible for more intense coordination with community agencies), and providers based on the needs of the member and the service setting. Providers were informed via the provider forum of the importance of communicating and coordinating with physical health providers. CHP provided a copy of a letter sent to a provider after it determined that the provider was not compliant with coordination-of-care requirements. The provider manual described CHP's coordination-of-care processes and informed providers of their responsibility to ensure coordination of members' services.		
Required Actions: None		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
3. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: None	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 278L Coordination of Care – Entire document 3. VO Colorado Systems Integration Department Policy and Procedure Guidelines – Page 1, Section III and Pages 3-4, Section V 4. 2010 Colorado Medicaid Provider Forum – Slides 19, 26 and 96-100 5. Provider Newsletter_JUL2010 – Page 2, *Initiative to Improve Coordination of Care with Physical Health Providers* 6. CHP Coordination of Care PIP – Entire document 7. VO Colorado Intensive Care Management Workflow – Entire document 8. Inpatient ATU Concurrent Review Process – Entire document 9. Provider Handbook (Misc folder) – Page 12, *Coordination of Mental Health and Primary Care*, Pages 25-26, Section VIII, *Coordination of Care* **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' has written policies and procedures to ensure coordination of services between its providers and medical health professionals. Clinical staff acts as a liaison with other health care organizations serving members with special health care needs to share clinical information to prevent duplication of services and the assessment of prior providers involved in the member's care. CHP continues to work with the Colorado Department of Health Care Policy and Financing on a statewide performance improvement project that is designed to coordinate behavioral and physical health care on specific adult populations. The provider handbook details the responsibilities and expectations of providers in coordinating care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The VO Colorado Intensive Care Management Workflow diagram outlined the process for sharing the assessment and other pertinent information with multiple providers and agencies to facilitate the provision of care. The provider forum included the expectation that assessment and other clinical information be shared between providers and levels of care to facilitate member transition.		
Required Actions: None		
4. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E (HIPAA), to the extent that they are applicable. *42CFR438.208(b)(4)* *Contract: II.E.1.g.1*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 245L Clinical Audits of Provider Medical Records – Pgs 1-2, Section V.A.1-2 3. VO Colorado 262L Coordination of Care – Page 3, Section V.A 4. VO Colorado 278L Coordination of Care With Physical Health Providers – Page 2, Section IV.A.3 5. 3 BHO Colorado Medicaid Contract Addendum - Page 2, Item F: Compliance 6. CHP Member Handbook (Misc folder) – Pages 8, 17 and 19-20 7. Provider Handbook (Misc folder) – Page 13, Section IV, *Utilization Management Procedures*, Page 18, *General Medical Documentation Requirements*, Page 25, Section VIII, *Coordination of Care*, Page 78, *Confidentiality* **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies describe members' privacy rights and explain the requirements that are considered when coordinating care with physical and non-physical health providers. The provider handbook informs providers of members' privacy rights and the importance of confidentiality.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The VO Coordination of Care With Physical Health Providers policy included the process of obtaining releases of information when coordinating with other providers and agencies. The 3 BHO Colorado Medicaid Contract Addendum required providers contracting with VO (as the administrative services organization for CHP) to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The VO Clinical Audits of Provider Medical Records policy described the process for CHP/VO to sample IPN medical records, including records from any outlier providers (defined in the policy as contracted providers whose practice patterns warrant examination). The clinical audit template form included a section to determine if releases of information were present when required. The member handbook explained how protected health information (PHI) is used. The provider handbook described HIPAA requirements and the use of member information in quality management activities.		
Required Actions: None		
5. The Contractor ensures that each member accessing services receives an individual intake and assessment within contractual timeframes for the level of care needed. The individual intake and assessment shall not be performed as part of any group orientation or therapy session. *42CFR438.208(c)(2)* *Contract: II.F.7.a and II.F.7.c*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 223L Treatment Planning – Page 1, Section V.A 3. CareConnect Authorization_Screenshot – Entire document 4. VO Colorado IV403 Provider Treatment Record Review, Analysis and Reporting 5. 3 BHO Audit Tool – rows 17 - 33 6. Provider Handbook (Misc folder) – Page 86, Section XIX, *Medical Record Documentation Standards* **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies explain that providers are expected to do individualized treatment planning for all members. Authorization systems, manual and automated, are available for providers to submit the required verification information they are treating the member according to ValueOptions®' treatment guidelines. The provider handbook specifies that a member must receive an individualized assessment and outlines the general requirements for documentation. Provider compliance with treatment planning and assessment is monitored through the Chart Audit process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The VO Provider Treatment Record Review Analysis and Reporting policy described the process for auditing medical records. The medical record audit form included assessment for the presence and appropriateness of the content of the individualized intake assessment. The July 2010 Provider Newsletter described CCAR processes. The provider manual listed medical record documentation standards, which included the required content of an individualized assessment.		
Required Actions: None		
6. Each member actively seeking services shall have an individualized service plan (treatment plan), developed by the member and/or the designated member representative and the member's provider or treatment team and: ◆ Utilizes the information gathered in the member's intake and assessment to build a comprehensive plan of service, ◆ Includes measurable goals, strategies to achieve the stated goals and a mechanism for monitoring and revising the service plan as appropriate, ◆ Is signed by the member and reviewing professional. If the member chooses not to sign his/her service plan, documentation is provided in the member's medical record stating the member's reason for not signing the plan, ◆ Service planning occurs annually or if there is a change in the member's level of functioning. *42CFR438.208(c)(3)* *Contract: II.F.9*	**Documents Submitted/Location within Documents:** 1. CHP Delegation Agreement (Misc folder) – Exhibit A, pages 8 - 21 2. VO Colorado 223L Treatment Planning – Entire document 3. VO Colorado IV403 Provider Treatment Record Review, Analysis and Reporting – Page 1, Section III.A 4. 3 BHO Audit Tool – Sections B-E 5. VO Colorado How to Write a Treatment Plan for Mental Health – Entire document 6. Provider Newsletter_JUL2010 – Page 3, Compliance Update 7. Provider Handbook (Misc folder) – Page 13, Section IV, *Utilization Management Procedures*, Page 86, Section XIX, *Medical Record Documentation Standards* **Description of Process:** This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' works with providers to assure treatment plans are developed to most effectively address the needs of members. ValueOptions® conducts regular treatment record audits and staff reviews the members' treatment plans for necessary requirements as outlined in the Utilization Management and Medical Record Documentation sections of the provider handbook. Provider communications such as newsletters and educational materials contain information about documentation expectations. Also included in the provider handbook are	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	guidelines for documentation and requirements that treatment plans must contain measurable goals, be signed by the member, or documented if the member refused to sign, and notes that the plan must be updated annually at minimum.	

Findings:
The VO Treatment Planning policy included the provision that providers complete an individualized service plan on each member seeking services. The medical record audit form included assessment for the presence and appropriateness of the content of the individualized treatment plan. The provider manual listed medical record documentation standards, which included an individual service plan and the required content of the plan. During the on-site interview, CHP staff members reported that the How to Write a Treatment Plan document was used by the network and development support staff to educate and work with providers whose treatment plans were inadequate.

Required Actions:
None

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	6	**Total Score**		=	6

Total Score ÷ Total Applicable	=	100%

Appendix B. Denials Record Review Tool for Colorado Health Partnerships, LLC

The completed compliance monitoring tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Colorado Health Partnerships, LLC

Review Period:	January 1, 2010–September 15, 2010
Date of Review:	February 14, 2011
Reviewer:	Barbara McConnell, Project Director
Participating Plan Staff Member:	Amie Adams, Clinical Director

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
1	******	1/27/10	2/11/10	15	Y ☐ N ☒ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments: This was a standard request for routine services. No extension was requested. Fifteen days for determination and notification to the member exceeded the required notification time frame of 10 calendar days.											
2	******	1/4/10	1/5/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
3	******	1/7/10	1/8/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
4	******	1/29/10	1/29/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
5	******	2/2/10	2/2/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
6	******	2/8/10	2/9/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
7	******	2/12/10	2/15/10	3	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
8	******	2/23/10	2/25/10	2	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
9	******	3/15/10	3/16/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments: This case involved an expedited request. Notification to the member was verbal, as required.											
10	******	3/16/10	3/16/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Colorado Health Partnerships, LLC

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
11	******	4/4/10	4/5/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: Doctor-to-doctor consultation offered. This case involved an expedited request. Notification to the member was verbal, as required.											
12	******	4/12/10	4/13/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: This case involved an expedited request. Notification to the member was verbal, as required.											
13	******	4/13/10	4/20/10	7	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
14	******	4/15/10	4/19/10	4	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
15	******	4/21/10	4/22/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
16	******	4/28/10	4/29/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
17	******	4/29/10	4/30/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
18	******	4/29/10	4/29/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
19	******	5/19/10	5/20/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
20	******	5/26/10	5/28/10	2	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
21	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments: No oversample records were required to obtain and review 20 records.											
22	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
23	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
24	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
25	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
# Applicable Elements					20		0	20	20	8	20
# Compliant Elements					19		0	20	20	8	20
Percent Compliant					95%		NA	100%	100%	100%	100%

Total # Applicable Elements	**88**
Total # Compliant Elements	**87**
Total Percent Compliant	**99%**

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

Table C-1 lists the participants in the FY 2010–2011 site review of **CHP**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
CHP Participants	**Title**
Amie Adams	Clinical Director
Erica Arnold-Miller	Vice President, Quality Management
Steve Coen	Clinical Peer Advisor
Michelle Denman	Director of Provider Relations
Haline Grublak	Vice President, Member and Family Affairs
Steve Holsenbeck, MD	Medical Director
Arnold Salazar	Executive Director
Department Observers	**Title**
Lisa Keenan	Contracts Performance Specialist
Suzanne Sigona (telephonically)	Health Outcomes and Quality Management Unit Manager
Jerry Ware	Quality/Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2010–2011

for **Colorado Health Partnerships, LLC**

CHP is required to submit a CAP to the Department for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the health plan should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the BHO must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

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 provided. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the plan, the BHO should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

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 as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the BHO must submit additional documentation. The Department will inform each BHO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable contract requirements.

The template for the CAP follows.

Table D-2—FY 2010–2011 Corrective Action Plan *for* Colorado Health Partnerships, LLC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
I. Coverage and Authorization of Services 10. The Contractor's written policies and procedures include the following timeframes for making standard and expedited authorization decisions: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 days.	The on-site review of denial records demonstrated that 19 of 20 records reviewed were in compliance with the required decision and notification time frames. One standard request for authorization of services was completed with notification provided in 15 calendar days. CHP must ensure that authorization determinations are made with notice provided to the member and the requesting provider within the required federal timelines.				

Table D-2—FY 2010–2011 Corrective Action Plan *for* Colorado Health Partnerships, LLC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
30. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within 1 hour of a request to the organization for pre-approval of further post-stabilization care services	The member handbook stated, "You may need services *after the emergency is over* to help you stay stable or improve your mental health condition. *This is called Post-Stabilization Care.* Post-stabilization services are inpatient and outpatient services provided just after an emergency. *Your emergency provider must get approval from your BHO for these services after the emergency is over."* This statement leads the reader to believe that preauthorization is required for post-stabilization care and is in conflict with CHP's policies. CHP must clarify the member handbook to provide information that is consistent with VO's/CHP's policies.				

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 listed below 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 and a meeting at the Department to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff attended Behavioral Health Quality Improvement Committee (BQUIC) meetings and discussed the FY 2010–2011 compliance monitoring review process as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions from the BHO via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the BHO was prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the BBA Medicaid managed care regulations and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, desk audit request, on-site agenda, record review tool, 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 via delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk audit request included instructions for organizing and preparing the documents related to the review of the three standards. Thirty days prior to the review, the BHO provided documentation for the desk audit, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk audit form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ The 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 and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.) ◆ HSAG reviewed additional documents requested as a result of the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with BHO staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2010–2011 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 required of the BHO to achieve full compliance with Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2010–2011 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG incorporated the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG incorporated the BHO's comments and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.