Colorado Medicaid
Community Mental Health Services Program

FY 2011–2012 Site Review Report

for

Colorado Health Partnerships, LLC

February 2012

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

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Overview of FY 2011–2012 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations and contractual requirements. The Department of Health Care Policy and 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 eighth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2011–2012 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The BHO's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to Medicaid member appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid appeals that were filed between January 1, 2011, and September 30, 2011. For the record review, the BHO received a score of *M* (met), *N* (not met), or *NA* (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 *U* (unknown) was used and did not impact the overall record review score. Compliance with federal regulations was evaluated through review of the four standards and appeal records. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2011–2012 site review activities for the review period—January 1, 2011, through the dates of the on-site review, November 21 and 22, 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 2010–2011 site review activities. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the appeals record review. 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 for FY 2011–2012 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four 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.

The four standards chosen for the FY 2011–2012 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, 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 as outlined in the CMS final protocol.

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements in the four 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, services 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.

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 requirements 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 elements, 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** (**CHP**) for each of the standards. Details of the findings for each standard follow in Appendix A—Compliance Monitoring Tool.

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)
V	Member Information	19	19	17	2	0	0	89%
VI	Grievance System	26	26	22	4	0	0	85%
VII	Provider Participation and Program Integrity	15	15	15	0	0	0	100%
IX	Subcontracts and Delegation	8	7	6	1	0	1	86%
	Totals	**68**	**67**	**60**	**7**	**0**	**1**	**90%**

Table 1-2 presents the scores for **CHP** for the Appeals Record Review. Details of the findings for the record review follow in Appendix B—Appeals Record Review Tool.

Table 1-2—Summary of Scores for Appeals Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals Record Review	60	60	60	0	0	100%

2. Summary of Performance Strengths and Required Actions

for **Colorado Health Partnerships, LLC**

Overall Summary of Performance

For the four standards reviewed by HSAG, **CHP** earned an overall compliance score of 90 percent. **CHP**'s strongest performance was in Standard VII—Provider Participation and Program Integrity, which earned a compliance score of 100 percent. Although scoring only 86 percent for Standard IX—Subcontracts and Delegation, due to the small number of elements scored, **CHP** performed very well for this standard as it presented only one minor item requiring action. **CHP**'s scores for Standard V—Member Information, and Standard VI—Grievance System, were 89 percent and 85 percent, respectively. **CHP** demonstrated strong performance overall and a solid understanding of the federal regulation.

Standard V—Member Information

Summary of Findings and Opportunities for Improvement

CHP's member handbook was thorough, easy to read, and available in alternative formats and languages. The handbook clearly outlined the requirements and benefits and repeatedly provided telephone numbers members could call with questions or for additional information. The member handbook defined emergency and poststabilization services, explained how and where to obtain the services and that the services are available without prior approval. The handbook included information about advance directives, as required. **CHP** provided evidence that its welcome packet—which included a copy of the member handbook—was mailed to new members within six weeks of enrollment.

CHP printed a comprehensive list of member rights in its member handbook and required that posters containing these rights be displayed in all provider locations. **CHP** confirmed the posting of member rights at provider locations during its annual compliance reviews. **CHP**'s policies and procedures provided that members would be given notice of significant changes at least 30 days before the intended date of change. **CHP** also had processes in place to notify members within 15 days of learning of provider terminations. HSAG reviewed documentation that showed **CHP** had informed members of a provider termination. HSAG suggested that **CHP** include the effective date of provider termination in the member notification letter to increase clarity.

Summary of Strengths

CHP demonstrated very strong commitment to making its materials available to all members in an easy-to-understand language and format. **CHP**'s policies required that all member materials be subjected to multiple levels of review to ensure clarity and relevance. All printed materials were translated into Spanish and English versions and included statements written in Spanish informing members that documents were available in Spanish. Materials also included statements reminding members that documents were available in large type or audiotape and that interpreter services were available for any language, free of charge.

Summary of Required Actions

The BBA requires plans to notify their members at least once a year that the member has the right to ask for information at any time and receive it upon request. Although **CHP**'s member handbook accurately reflected this requirement, the annual member letter notified its members that they may ask for and receive materials only once a year. **CHP** must review and/or revise member materials and policies to clarify the requirement for **CHP** to provide annual notice to members of the right to request the required information at any time and receive it upon request.

CHP erroneously interchanged the terms "calendar days" and "working days" when describing the appeal resolution time frames in its member handbook. It must revise its member handbook to accurately describe appeal resolution time frames. **CHP** must also clarify in the member handbook

the circumstances under which members may request that previously authorized services continue during the appeal or State fair hearing and accurately describe the duration of continued benefits.

Standard VI—Grievance System

Summary of Findings and Opportunities for Improvement

CHP had a well-organized system for processing grievances and appeals. **CHP** used database programs to document grievances and appeals and generate detailed reports for submission to the quality improvement committee and to the Department, as required. The on-site review of 10 appeals records demonstrated that acknowledgement letters and notices of resolution were sent within the required time frames for all 10 records. The record review also demonstrated that individuals who made decisions on the grievances and appeals were not involved previously and had the requisite clinical expertise to do so. Resolution notices reviewed in the records included all of the required information. **CHP** worked with members when lacking the required information to decide the appeal and used the extension process in two cases. While there were no expedited records in the records reviewed on-site, it was clear through that review that **CHP** staff members were proactive in determining whether appeals should be processed as expedited appeals.

None of the general member materials reviewed (i.e., member handbook, brochure, appeals guide) included information that members have the right to request and review records related to their appeal. The notice of action template letters, however, did inform members of this right. **CHP** might want to consider adding this information to the other member materials as well. The **CHP** Complaint/Grievance Information for Members brochure described certain aspects of the grievance and appeal processes for members. During the on-site interview, **CHP** staff members reported that the brochure was not intended to include every aspect of the grievance system. **CHP** may want to consider, however, reviewing the brochure to determine priorities for inclusion, given that the distribution of the brochures is through the Community Mental Health Centers (CMHCs), the point of service for a large percentage of **CHP**'s members.

Several **CHP** documents that addressed the provisions for continuation of previously authorized services during the appeal or the State fair hearing, while accurate, were awkward or confusing. **CHP** may want to review and revise policies to clarify the continuation of benefits provision, and consider revising the **CHP** Help Guide for Appeals to combine the two sections regarding continuation of services for clarity. The policy and the PowerPoint training presentation included an example which illustrated the situation accurately; however, **CHP** may want to consider clarifying the example to ensure understanding that services would not be terminated without the required 10-day advance notice per 42CFR438.404(c)(1)/42CFR431.211. The ValueOptions (VO) Appeal Process policy included effectuation language embedded within the context of required content of the appeal resolution letter. **CHP** may want to clarify the policy to describe **CHP**'s internal processes regarding effectuation of appeal decisions related to the termination, suspension or reduction of previously authorized services.

Summary of Strengths

CHP used multiple methods to communicate to members regarding the right to file grievances, appeals, and to request a State fair hearing. It was clear, as evidenced by the record review, that appeals had been filed by members, designated client representatives (DCRs), and providers acting on behalf of the member. **CHP** used excellent training materials to familiarize new network providers with members' grievance system rights. The on-site record review demonstrated that (1) timelines were met, and (2) notices included the required content, were written in a way that was easily understood and were clearly customized to the member's situation.

Summary of Required Actions

While certain aspects of the **CHP** Appeals Help Guide were accurate, other areas were inaccurate. **CHP** must revise the help guide to state that members may request the continuation of previously authorized services during the appeal or State fair hearing if:

- The appeal is filed timely—defined (only for continuing benefits) as within 10 calendar days of the date of the notice of action, or before the intended effective date of the action, whichever is later.
- The appeal involves the termination, suspension, or reduction of previously authorized services.
- The services were ordered by an authorized provider.
- The original period covered by the original authorization has not expired.
- The enrollee requests the extension of services.

CHP must also revise the help guide to state that, if requested, services must be continued until one of the following occurs:

- The enrollee withdraws the appeal.
- Ten days pass after the BHO mails the notice providing *resolution* of the appeal against the member, *unless* the enrollee, within the 10-day time frame, has requested a State fair hearing.
- A State fair hearing officer issues a hearing decision adverse to the member.
- The time period or service limits of the previously authorized service have been met.

While **CHP**'s member handbook addressed each of the required elements, **CHP** must specifically notify providers that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.

The VO Appeal Process policy included the required content of appeal resolution letters; however, the content for letters regarding the request for continuation of previously authorized services and liability for cost if the adverse decision is upheld was listed as required content only if providers requested the appeal on behalf of the member. **CHP** must revise its policy to clearly state that language regarding continuation of previously authorized services is required (if applicable) regardless of whether the member or the provider, acting as the DCR, requested the appeal.

Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

CHP delegated the responsibility of credentialing potential providers and recredentialing existing providers to VO. VO's processes and procedures were comprehensive and compliant with NCQA requirements. The policies were designed in a way that ensured consistent application of standards and prohibited decisions based on race, national identity, gender, age, sexual orientation, or the type of procedure or patient in which the practitioner specializes.

VO employed numerous methods to conduct ongoing monitoring of covered services. Providers were made aware of the stringent requirements in the provider manual. The procedures included implementing corrective action plans if providers did not meet the standards and follow-up, as needed, until the provider achieved full compliance.

CHP provided several documents that clearly stated it would not knowingly employ a director, officer, partner, employee, consultant, or owner who is debarred or excluded from participation in federal programs. **CHP** demonstrated that it regularly monitored numerous State and federal databases to identify individuals or entities fitting this description with whom CHP had already established or was considering establishing a relationship.

CHP and VO demonstrated an extensive program developed to guard against fraud and abuse. This program included a detailed corporate compliance plan, code of conduct, and policies and procedures. While the program was thorough and included all of the required components, HSAG noted a possible discrepancy between the procedure for reporting suspected fraud to the Department as it was written in **CHP**'s various documents and how it was described by employees. **CHP** may want to review its documentation to ensure information related to the timelines for reporting suspected incidents to the Department is consistent across documents.

Summary of Strengths

CHP's use of automated systems through Network Connect proved to be an asset to its ability to monitor providers. The program allowed for cross-referencing of processes with provider files and for tracking and documentation of provider-related information. **CHP** was able to limit system access to appropriate staff. The program efficiently linked provider functions and information from numerous sources into a single electronic record of all provider information and activity.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

CHP had policies and procedures in place that addressed the delegation of specific BHO tasks and included all of the required information. There was evidence that **CHP** had a signed, executed agreement with each delegate that included most of the required provisions.

CHP had not considered or entered into additional delegation agreements during the review period, nor had additional delegation relationships been anticipated at the time of the on-site review; however, **CHP** may want to consider developing a process for predelegation review should it consider additional delegation in the future.

Summary of Strengths

After reviewing multiple examples of **CHP**'s ongoing monitoring and formal review of its delegates, HSAG concluded that **CHP** demonstrated clear oversight and ultimate responsibility of delegated tasks. Ongoing monitoring included regular review of reports submitted by **CHP**'s delegates, regular meetings between **CHP** and its delegates, and review of the delegates' managers and directors. Formal review included review or audit of records including policies, procedures and financial records and annual on-site contract compliance audits.

Summary of Required Actions

The two agreements between **CHP** and VO, as well as **CHP**'s member participation agreements with the CMHCs, presented each of the required provisions except the clause to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. **CHP** must revise its agreements with VO and with the CMHCs to address these requirements.

3. Follow-Up on FY 2010–2011 Corrective Action Plan

for **Colorado Health Partnerships, LLC**

Methodology

As a follow-up to the FY 2010–2011 site review, each BHO that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the BHO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with **CHP** until the BHO completed each of the required actions from the FY 2010–2011 compliance monitoring site review.

Summary of 2010–2011 Required Actions

During the 2010–2011 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** was required to ensure that it met requirements for timely notification for all denials.

HSAG also found a conflict between **CHP**'s policies and its member handbook. **CHP** was required to clarify the member handbook to provide information that was consistent with its policies.

Summary of Corrective Action/Document Review

CHP submitted its CAP to HSAG and the Department in June 2011. HSAG and the Department reviewed and approved the plan. **CHP** submitted documents demonstrating it had implemented its plan, as written, in July 2011. In August 2011, HSAG and the Department notified **CHP** that it had successfully completed all required actions.

Summary of Continued Required Actions

There were no required actions continued from 2010–2011.

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor provides all enrollment notices, informational materials and instructional materials relating to members in a manner and format that may be easily understood. ◆ The Contractor makes written information available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency and informs members of how to access those formats. *42CFR438.10(b)(1),(d)* *Contract: II.F.4.a, d, g*	**Colorado Health Partnerships (CHP) delegates all requirements in Standard V to ValueOptions® as indicated by the "CHP_OMFAInformationDelegation_Policy.pdf".** **Documents Submitted/Location Within Documents:** 1. 306L_MemberMaterials_Policy - page 1, III, A through E 2. 304L_MemberRightsandRespons_Policy - page 9, V, D, 1- 4 3. 307L_MemberInfoReqmnt_Policy2 - page 1, III, A, B and D Page 5, V, D, 1 Page 6, V, F 4. 304L_MemberRightsandRespons_Policy - III.A.18 5. Member Handbook - Page 2 CHP_MemberHandbook_2011EQRO - (Misc. Folder) - bottom1st page 6. BHO_Handbooks_HCPFreview_April2011_email - Communications with Marceil Case, Health Care Policy and Financing: 4 items that indicate her involvement in reviewing/editing and email approval of all three handbooks. 7. BHO_Handbooks_HCPFreview_July2011_email - Communications with Marceil Case 8. BHO_Handbooks_HCPFreview_June2011_email - Communications with Marceil Case 9. Handbooks_HCPFapproval_2011JUL_emails - Communications with Marceil Case 10. HealthLiteracy_NOA – entire document 11. Simple_Word_Thesaurus – entire document 12. CHP_MemberHandbook_LargePrint – entire document. **Description of Process:** All materials developed for members go through a rigorous process to ensure that material is easy to read and relevant. They are reviewed by multiple individuals before we get approval from the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Department. CHP has policies and procedures in place that guide the development of member materials. Member materials are available in alternate formats such as large type. Members are informed of the availability of these alternative formats through the member handbook and on the Web site. All program materials distributed to members are reviewed for ease of reading and relevance. CHP OMFA staff provides training in developing member materials to staff who, for example, write member letter segments. Included in this training, OMFA has distributed a simple language thesaurus. Other materials, such as letters pertaining to a quality program, are approved by OMFA staff for readability.	

Findings:

The CHP Office of Member and Family Affairs (OMFA) Information Delegation policy stated the delegated entity, Value Options (VO), was expected to develop and distribute written materials —paper and electronic—in an easy-to-understand language and in alternative formats for special needs. The VO Member Materials Development policy defined member materials as the member handbook, provider directory, welcome letters, and member rights and responsibilities. The policy stated that materials would be written at the appropriate reading level, available in other languages, orally translated free of charge, and available in alternate formats such as large print and audio tape. The policy also stated that completed materials were submitted to the Department of Health Care Policy and Financing (the Department) for final approval before distribution. The VO Member Information Requirements policy stated CHP would provide all member enrollment notices, informational materials, and instructional materials in an easy-to-understand language and format, in formats that consider the special needs of those who are visually limited or have limited reading proficiency. The policy stated that written materials would include a statement regarding availability in alternative formats and how to access those formats.

The introductory page of the CHP Member Handbook included a statement that the handbook was available in large print or audio format or could be interpreted into another language and included a telephone number for such requests. In addition, a statement written in Spanish informed members that the handbook was available in Spanish. CHP provided the CHP Member Handbook in large print as an example of an alternative format. VO e-mails exchanged with the Department documented submission and approval of the member handbook in July 2011. The CHP Member Enrollment Letter also informed members that written materials were available in large print or audio format or could be interpreted into another language free of charge.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. ◆ The Contractor educates members on: • The availability and use of the mental health system. • Appropriate preventative health care procedures. • Self care. • Appropriate health care utilization. • How to navigate the mental health system. • How to locate information and updates to the Colorado Prescription List (PDL) program. *42CFR438.10(b)(3)* *Contract: II.F.4.b, h*	**Documents Submitted/Location Within Documents:** 1. 307L_MemberInfoReqmnt_Policy2 - page 1, III, C Member Handbook: 1. CHP_MemberHandbook_2011EQRO - (Misc. Folder) - page 5 2. CHP_MemberHandbook_2011EQRO - (Misc. Folder) - pages 13 and 14, How do I get my medications? (covers bullet 6 at left) 3. CHP_MemberHandbook_2011EQRO - (Misc. Folder) - page 25, bullet 3 (covers bullets 1 and 5 at left) 4. CHP_WorkPlan20082012_2011JUL19_OMFA 5. CHP_Advocates_MeetingPacket_2011MAY05 – page 2 & 3 (CMHC discusses wellness programs. 6. CHP_AdvocatesMinutes_2010NOV04_OMFA - page 3 – discusses wellness 7. http://www.coloradohealthpartnerships.com/members/mbr_omfa.htm - describes the role of the OMFA in more detail. 8. http://www.coloradohealthpartnerships.com/provider/handbook/Section15_OMFA.pdf - information on how IPN providers can access services and trainings from the OMFA. 9. https://www.achievesolutions.net/achievesolutions/en/chp/Home.do - landing page for CHP specific AchieveSolutions ® Web site. 10. SAMHSA_10X10Brochure – entire document regarding self-care and preventative health care 11. CHP_AchieveSolutions_ScreenShot 12. CHP_AchieveSolutions_ScreenShot_Spanish	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: The Office of Member and Family Affairs is the entity responsible for assisting members in understanding their plan, how to use services; preventative health services; self-care; how to navigate the system; and how to locate information and updates to the PDL. Members are informed of the role of the Office of Member and Family Affairs (OMFA) through the Web site and the member handbook. The CHP OMFA is structured so that members can access the OMFA through a toll free telephone number and reach the service center, directly through a local number, or through their local community mental health center (CMHC) advocate. Each CMHC has a client advocate employed to carry out the functions of the OMFA at the local level. The serve as both mental health center and BHO advocates. The BHO advocates meet bi-monthly to discuss issues specific to member and community education, grievances, contract compliance issues and other things relative to ensuring members have access to services that will help them in their recovery. The CHP OMFA developed a work plan at the beginning of the contract and revises it annually. Goals of the work plan specific to this contract include promoting wellness, self-care and prevention. The OMFA (CHP service center OMFA, CMHC advocates and peer specialists employed at the mental health centers) help members navigate the system. Peer Specialists and Advocates are responsible for a significant portion of the wellness, self-care and health promotion activities. Self-Care and self-empowerment are the most important tenets of the Recovery Model. Advocates and peer specialists teach a variety	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	of classes in recovery, maintaining healthy lifestyles, preventing relapses and other trainings to help keep members well. This is a component of our proposal, and the OMFA reviews progress on this goal annually in their meetings. Information is distributed by OMFA such as brochures for the SAMHSA 10x10 campaign to help advocates and peers inform members of self-care and preventative health care matters. The Independent Provider Network can access OMFA services, trainings, etc., and is informed about how to do this in the provider handbook (link above). AchieveSolutions ® is one of ValueOptions® prime tools for providing wellness information to members and providers. Members and providers have access through the CHP Web sites. The Web site contains over 6000 articles on hundreds of health, wellness and prevention topics. CHP & ValueOptions® promote the use of Achieve Solutions by distributing fliers through the mental health centers, peer programs and advocates.	

Findings:
The CHP Member Enrollment Letter provided a toll-free number for assistance with obtaining mental health services, including making an appointment, and explained that members may receive services from a mental health center or other network provider without a referral. The letter also described the categories of mental health services available including inpatient, outpatient, emergency, case management, medication management, and psychosocial rehabilitation services. The letter described how to access emergency care and directed members to the member handbook, CHP Web site, or a CHP community mental health center (CMHC) to obtain more information on their mental health benefits.

The CHP Member Handbook stated that members may receive services from a network CMHC or an independent network provider, provided telephone numbers for all CHP partner CMHCs, and directed members to the Web site for the independent provider listing. The handbook also described in detail the core covered services and provided a listing of additional covered community-based services in the "What Mental Health Services Can I Get?" section, provided instructions on how to obtain access to both mental health and physical health emergency services, and explained benefit limitations on services including individual therapy sessions and inpatient hospitalization. The handbook also described examples of unlimited services. The OMFA section of the handbook and the CHP member Web site explained that one of the roles of OMFA was to assist members in understanding their mental

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
health benefits and other community support programs and provided contact information for OMFA staff. The handbook also described the Colorado Prescription Drug program, including how to obtain information on drugs requiring approval, and provided the Department's Web site address and contact information for the Department's pharmacy liaison, and for CHP's member services department. CHP used the following materials to educate members on preventive and self care services: ♦ The Achieve Solutions program, available through the CHP member Web site provided numerous articles regarding depression and schizophrenia, family relationships, stressors and fears, health and wellness, substance abuse, financial and legal issues, self-advocacy, and other mental health subjects. ♦ The Substance Abuse and Mental Health Services Administration (SAMHSA) brochure described the components of the federal 10 by 10 wellness initiative and provided contact information for members to obtain more information. The OMFA Advocates Committee meeting minutes indicated that health and wellness programs were being provided by the partner CMHCs and were regularly reviewed at OMFA advocate meetings held with the VO/CHP Director of OMFA. During the on-site interview, staff members reported that the OMFA Advocates Committee provided input into rules and regulations of the BHO, made recommendations to the CHP Board regarding the recovery program, reviewed grievance data, and reviewed member materials for readability. Staff cited the development of a "Tips for Talking to Your Doctor" document as a result of committee recommendations related to member grievances.		
Required Actions: None.		
3. The Contractor makes its written information available in the prevalent non-English languages in its particular service area and notifies its members that written information is available in prevalent non-English languages and how to access those materials. *42CFR438.10(c)(3) and (5)* *Contract: II.F.4.c*	**Documents Submitted/Location Within Documents:** 1. 306L_MemberMaterials_Policy – page 1II,C 2. 307L_MemberInfoReqmnt_Policy2 – page 6 of 17, III, F 3. CHP_MemberHandbook_2011EQRO- inside front cover Member Handbooks: 1. CHP_MemberHandbook_2011EQRO - (Misc. Folder) top of 1st page as well as page 10 2. CHP_MemberRightsPoster_Spanish 3. http://www.coloradohealthpartnerships.com/espanol.htm - link to Spanish version of member handbook on CHP Web site	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: CHP has policies and procedures to ensure that written information is available in the prevalent non-English language. Spanish is the prevalent non-English language as identified by the state. Members learn how to access materials in Spanish by the notation at the beginning of written materials stating," *Si usted necesita una copia de esta información en español, por favor llame al 1-800-804-5008."* Meaning "If you need a copy of this information in Spanish, please call 1-800-804-5008." Additionally, we work to provide member materials to Spanish speaking members without them having to ask for them. We have a process for organizing the data for member mailings that enables us to identify the primary language spoken in the home. Members self-identify preferred language in the enrollment (for Medicaid) process. When we process our member mailing, and a member has selected Spanish, we will mail all materials to the member in Spanish. Otherwise, a member can call to request Spanish materials. A link to Spanish materials is prominently posted on the member home page. Members can access member handbooks and information about their services. The 2011 version of the handbook was recently approved, and the revised member handbooks are currently being translated.	

Findings:
The VO Member Materials Development policy stated that written member materials would be available in other languages and orally translated free of charge. The introductory page of the CHP Member Handbook included a statement that interpreter services were available for member materials, and a statement written in Spanish informed members that the handbook was available in Spanish, with a contact number for requests. CHP provided examples of member materials written in Spanish, including the Member Enrollment Letter, the CHP Member Handbook, the Member Rights Poster, the Notice of Privacy, and the "Achieve Solutions" and "Member Handbook" sections of the CHP Web site.

CHP staff members stated that the member's preferred language, as stated in the Medicaid enrollment information, was maintained within CHP's mailing database system to flag those members who automatically receive member materials in Spanish. During the on-site interview, staff members confirmed that Spanish was the only prevalent non-English language in the CHP member population.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
Required Actions: None.		
4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. *42CFR438.10(c)(4)&(5)* *Contract: II.F.4.c, f*	**Documents Submitted/Location Within Documents:** Policies: 1. 306L_MemberMaterials_Policy - page 1, III, D 2. 307L_MemberInfoReqmnt_Policy - page 6, III, F 3. CC106_HandlingCallsWithLimitedEnglishSpeakingMembers_Policy – entire policy Member Handbook: 1. CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 10 2. CHP_MemberRightsPoster_Spanish **Description of Process:** Members who have language or speech disabilities, member's whose language is a language other than English or Spanish, or members who have hearing disabilities are provided interpreter services free of charge. The ValueOptions® service center contracts with the LanguageLine to provide interpreter services to our members in over 150 languages. This service is used for members calling into the service center or members who request an oral translation of written materials into a language other than English or Spanish. If members need interpreter services to facilitate communication between persons, CHP also uses the language line initially to determine the extent of the need for further interpreter services. If interpreter services will be needed beyond the initial call, the request is forwarded to the OMFA or customer service staff. They will work to find either a provider in our network who speaks the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	member's language, or find an interpreter service that can provide additional interpretation. If interpreter services are needed for clinical services, they will work with the clinical department to connect with an interpreter. If interpreter services are needed for an administrative reason (grievances, etc.) they will work with the OMFA department to connect with the interpreter. For members who are Deaf or hard of hearing, CHP uses RelayColorado initially, to determine the extent of the member's needs. If interpreter services will be needed beyond the initial phone call, the request is transferred to the OMFA/ service center customer service department. The OMFA/ service center customer service staff will find a provider in the network who is proficient in sign language, or contract with a sign language interpreter if no providers are available in the region. Lastly, through our provider network, we seek providers who are fluent in other languages. These languages are listed in the member handbook and on Referral Connect, so a member may be able to get a provider who speaks their native language. screen_shot_referral_connect.docx shows main Referral Connect Page and the Provider Directory can be found at http://www.coloradohealthpartnerships.com/members/pdf/ValueOptions_Colorado_Partnerships_Provider_Directory.pdf	

Findings:
The VO Member Materials Development policy stated that member materials would be orally translated free of charge. The VO Handling Calls With Limited English Speaking Members policy outlined the detailed process for customer service representatives to access the translation line, which provided oral translation in 150 languages on a 24-hour, seven-day-per-week basis.

The CHP Member Handbook and CHP Member Rights poster, available in both English and Spanish, informed members of the right to "have an interpreter if you [the member] have problems communicating or do not speak English." The introductory page of the CHP Member Handbook provided a contact number for members who need interpreter services. In addition, the handbook described the following services as available free of charge for

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
non-English speaking members or members with special needs: ♦ The AT&T Language Line for telephone interpretation of communications. ♦ Provision of a provider who speaks the member's native language or provision of an interpreter for provider interactions. ♦ Relay Colorado or a TTY line, as well as sign language interpreters for the deaf or hard-of-hearing. ♦ An interpreter to read member materials for non-English or non-Spanish members.		
Required Actions: None.		
5. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information, upon request [information required at 438.10(f)(6) and 438.10(g)(and (h)]. *42CFR438.10(f)(2)* *Contract: II.F.4.m*	**Documents Submitted/Location Within Documents:** 1. 307L_MemberInfoReqmnt_Policy2 - page 6, III, G, 2 Member Handbook: 1. CHP_MemberHandbook_2011EQRO - (Misc. Folder) lower page 8, bullet 2 2. CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 43 3. CHP_AnnualMemberLetter 4. CHP_AnnualMemberMlg_Letter_2011 5. BHO_AnnualLetter_HCPFapproval2011 **Description of Process:** The Contractor mails a letter to all enrollee households on an annual basis. The letter explains how to ask for member handbooks and outlines the information that is covered in the member handbook material. This letter also provides information about how to request a copy of the Member Handbook in alternative languages or formats. In order to use the most up to date list of members and member addresses, OMFA requests a "snapshot" list of all Medicaid members on a date as close as possible to the mailing date. The same process is used to develop the mailing list as is used for the monthly mailing. Once the list is refined (remove bad data), the list	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	is sent to the bulk mail processor through a password protected, secure FTP site. The bulk mail processing company (Webb Mason) prints and mails the letters. The last mailing was done in December 2010, and the next mailing for the current year is planned for late 2011. The 2011 annual letter has been approved by HCPF Medicaid Contract Manager.	
Findings: The VO Member Information Requirements policy stated that members "would be informed of their right to receive the required member information on an annual basis." The CHP Member Handbook provided information on all elements of information specified in 42 CFR 438.10(f)(6) and 438.10(g)and (h). In addition, the handbook stated that CHP would notify members, in writing, at least once a year of the right to ask for information that is in the handbook. The handbook also informed members that they may obtain a copy of information at any time by contacting the OMFA and included the telephone number. The CHP 2010 annual member letter and the proposed 2011 annual member letter summarized the type of information available in the CHP Member Handbook, and provided telephone and Web site contact information for members to obtain a copy of the handbook. The letter notified members that the handbook was available in alternative formats including audio, large print, and Spanish, and that CHP would provide interpreter services, at no charge, for non-English speaking or hard-of-hearing members. The letters, however, erroneously stated that members had a right to receive information once a year.		
Required Actions: CHP must review and/or revise member materials and policies to clarify the requirement for CHP to provide annual notice to members of the right to request information at any time and receive it upon request.		
6. The Contractor gives written notice of any significant change (as defined by the State) in the information [required at 438.10(f)(6) and 438.10(g)] provided to members at least 30 days before the intended effective date of the change. *42CFR438.10(f)(4)* *Contract: II.F.4.k*	**Documents Submitted/Location Within Documents:** Policies: 1. 307L_MemberInfoReqmnt_Policy2 - page 2, V, B Member Handbook: 1. CHP_MemberHandbook_2011EQRO - (Misc. Folder) lower page 8, bullet 1 2. CHP_ScreenShot_NewsEvents_2011OCT01	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: CHP has policies and processes that assure all significant changes to the program are communicated to members within 30 days of the intended effective change. Members are made aware of our requirement to do this in the member handbook. There are several internal processes we use, depending on the universality of the change. If it is a change that affects all members, but it's not a change that will affect the quality or quantity of services they receive or expect to receive, we will post the information on the CHP web site as soon as we learn of the change. Information is posted on the home page, under "News and Events." Member materials are revised at least annually, and if the change occurs between a print cycle, we will include a slip sheet with the changes along with each member handbook that's mailed to new members. We also provide information, such as fliers to our providers, so they can post the information about the change in waiting rooms, bulletin boards, etc. If it is a change that might seriously impact a member's ability to get the level of services they expect (such as benefit limits, changes in covered diagnoses, etc.), we will do a mailing to all members. For example, when the Department implemented benefit limits, CHP sent a notice to all members who had been in care. If it's a change that is significant relative to services, but that has regional impact, we mail information to all members in the region that is affected. For example, when CHP took over the contract in the Pikes Peak region, we mailed a notice to all members in the	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Pikes Peak region. In summary, we work closely with the department to assure that members are kept up to date with changes in program so that they can adapt and make informed decisions about their care.	
Findings: The VO Member Information Requirements policy stated that member handbooks were revised when significant changes were made to existing contracts that affect member benefits and that, for any change that occurred prior to the printing cycle, members would be notified at least 30 days before the intended effective date of the change. The CHP Member Handbook stated that members would receive written notification of any major change in coverage or benefits at least 30 days prior to the date of the change and that any changes would be posted on the CHP and partner CMHCs' Web sites. During the on-site interview, staff members stated that when any change has financial implications for the member, a general member mailing would be completed to inform members of the change. Staff stated that when a change did not have significant implications, such as when the Colorado Rule changed from the 20-calendar-day filing time frame to the 30-calendar-day filing time frame for grievances, appeals and for requesting a State fair hearing, the written materials were changed for future distributions and the member Web site information was changed immediately. CHP Staff members confirmed that there were no significant changes to be communicated within the review period.		
Required Actions: None.		
7. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary mental health care from, or was seen by, the terminated provider. *42CFR438.10(f)(5)* *Contract: II.F.4.l*	**Documents Submitted/Location Within Documents:** Member Handbook: 1. CHP_MemberHandbook_2011EQRO - (Misc. Folder) lower page 8, bullet 3 2. CHP_MHCContractComplianceTool_FY2011 - Line 23 & 43 3. Provider_Disenrollment_Letter - template 4. Preliminary_Disenrollment_List - (redacted) 5. ProviderDisenrollments_SampleEmail_2011SEP27 – entire document 6. VOCO_Provider_Termination_Letter_Process **Description of Process:** The CHP member handbook explains to members that they will be notified if their provider is disenrolled or stops seeing clients 15	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	days before the termination. The ValueOptions® Colorado service center has an internal process to identify when a provider is being disenrolled or voluntarily resigns from the network. Unless a provider has engaged in egregious behavior, providers can appeal a disenrollment recommendation by ValueOptions®. Therefore, disenrolling a provider can take weeks or months. Data Management and Analysis has developed an automatic report that sends an e-mail to OMFA when a provider has exhausted all their appeals. OMFA gets the data 30 days before the actual disenrollment date. The automatic report includes the provider's name, date of disenrollment, and lists members who are currently seeing or have seen the provider in the last 6 months. We use the report to generate mailing labels and send all members who have seen the provider a letter explaining how to find a new provider. We also receive a preliminary disenrollment list from provider relations, if Colorado providers are included in the list. This preliminary information allows us to do research to see if any members are seeing these providers. We may do outreach to the provider to ensure they have a transition plan with the member, or we may wait to send the letter template, depending on the client list and their needs. Please reference VOCO_Provider_Termination_Letter_Process.vsd Sometimes, a provider is not disenrolled by VO, but instead, moves, resigns from the network, or leaves the network in some other way. Provider Relations staff inform OMFA staff as soon as they're aware of a provider termination, other than a disenrollment. We follow the same plan as noted above; we send the letter	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	template to all members who are or have been in care with the provider during the previous 6 months. A letter is sent. CHP also monitors providers for this requirement through contract compliance audits. Switching providers can be difficult for a member and we monitor our mental health centers to ensure they have acceptable processes in place to inform members of a provider termination or voluntary resignation. Since we do not get this data about individual mental health center providers, we monitor the mental health center's internal processes to ensure members can make a smooth transition between providers. Letters and mailing lists are stored on SharePoint in the OMFA drive.	

Findings:
The CHP Member Handbook stated that the member would be notified by mail of any change with the provider or provider location within 15 days prior to the change.

The VO Provider Termination Letter process outlined the routine monitoring of data files for identifying providers who are being terminated from the health plan within 30 days, research of the members who have received services through that provider within the past six months, and generation of provider termination letters to those members by the OMFA. The VO Provider Disenrollment letter template informed members that their provider would no longer see Medicaid members and invited members to call the toll-free CHP number for assistance in finding another provider. During the on-site interview, staff members described that when OMFA received information about the termination of a provider, whether voluntary or involuntary, OMFA conducted a search of active members seeing the provider, obtained addresses from the database for those members, and generated individual provider termination letters to those members. A sample case was confirmed through internal e-mail communications, which verified an effective provider termination date of June 30, with mailings to members dated May 24. HSAG staff suggested that the member notification letter might include the effective date of provider termination for increased clarity.

The CHP CMHC Contract Compliance Tool, which was used to monitor service provided as well as functions delegated to the CMHCs, included a section to evaluate whether the CMHC had policies and procedures in place for notifying members of a provider termination within 15 days after receipt of the provider termination notice for each member who has received services in the last six months from that provider.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
8. The required information (438.10(f)(6) and 438.10(g) is furnished to members within a reasonable time after notification from the State of the recipient's enrollment and includes: ◆ Notice that the member has been enrolled in the Community Mental Health Services Program operated by the Contractor and that enrollment is mandatory. ◆ The Contractor's hours of operation. *42CFR438.10(f)(3)* *Contract: II.F.4.i, j*	**Documents Submitted/Location Within Documents:** 1. MemberMailing_Work_Flow – entire document 2. 307L_MemberInfoReqmnt_Policy2 - V.G. 3. Member Handbook a. CHP_MemberHandbook_2011EQRO –(Misc. Folder) page 2 b. CHP_MemberHandbook_2011EQRO –(Misc. Folder) page 8 4. CHP_EnrollmentLetter_English_August2011 – page 1 5. CHP_EnrollmentLetter_Spanish 6. CHP_Notice_of_Privacy_Practices_English – entire document 7. CHP_Notice_of_Privacy_Practices_Spanish – entire document 8. MemberMailing_Report_2011JUL01 **Description of Process:** The member handbook states that members have been automatically enrolled in the program. We use this terminology because in developing materials for people with low health literacy, it is preferable not to use terms that imply something negative and that we use words that are common in conversational language. We will provide copies of postage statements and receipts for the monthly mailing during the site visit. CHP has an efficient process in place to ensure members receive enrollment materials in a timely way; and information contained in enrollment materials are relevant and contain correct information to help members make choices about their care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Several times per month, the ValueOptions® Data Management and Analysis staff receives enrollment files from the Department. This enrollment data is "scrubbed" to remove all Medicaid members who: 1. Are newly enrolled in Medicaid in the CHP service area. 2. Have not been actively enrolled in Medicaid during the previous 12 months. This list will be used to create our mailing labels. The next step is to: Separate members by Spanish Speaking vs. Non-Spanish Speaking. This allows us to mail Spanish materials to Spanish-speaking members and English language handbooks to everyone else. Separate members by age groups – < or =18 vs. or > or = 18 years, one day. For members < 18, we will address mail to *"To the Guardian of <<Medicaid Member.>>* OMFA mail room staff print, stuff, and address and mail the materials within 21 days of when we received the enrollment data. Included in the packet are 1. Welcome letter 2. Notice of Privacy Practices 3. Member Handbook, which includes a statement that they have been enrolled in the Community Mental Health Services Program and hours of operation. 4. Provider Directory The monthly mailing report, MemberMailing_Report_2011JUL01, is compiled by the bulk mail coordinator, lists all pieces that were sent through July 2011. We maintain the member mailing list for 18 months on our secure server.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	When we get returned mail, we log the information into the returned mail data base. This data base is used for the annual mailing (cross reference bad addresses so mail is not sent to bad addresses).	

Findings:
The VO Member Information Requirements policy stated that member materials, including the member handbook, enrollment notices, and provider listing, would be distributed within a reasonable time after member enrollment. CHP staff members stated that enrollment packets included the Member Welcome Letter, CHP's Notice of Privacy Practices, the member handbook, and the provider directory. These materials were available in both Spanish and English. The CHP Member Handbook and the CHP Member Welcome Letter stated that CHP was the BHO for specified Colorado counties, and Medicaid recipients were automatically enrolled. The member handbook defined the hours of operation for CHP business offices and associated CMHCs and provided telephone numbers for the 24-hour Access to Care Line, the CHP offices, and each CMHC.

During the on-site interview, staff members explained that, at the end of each month, CHP takes the list of new enrollees for the month and "cleans" the list by screening for multiple members in a household and for members who were on and off Medicaid enrollment recently. Staff stated that the mailing list was finalized by the 15th of the following month. HSAG reviewed member mailing reports and mailing receipts while on-site and verified that monthly mailings were tracked and completed two to three weeks after the list was finalized.

CHP staff members stated that once the mailing list was finalized, the enrollment packets were mailed within two weeks. The member mailing report and mailing receipts, reviewed on-site, verified that monthly mailings were being tracked and were completed four to six weeks after the member's actual enrollment.

Required Actions:
None.

9. The member information materials sent following enrollment include: ◆ Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers, including identification of providers who are not accepting new patients. ◆ Any restrictions on freedom of choice among network providers. *42CFR438.10(f)(6)(i) and (ii)* *Contract: II.F.4.i.1, 2*	**Documents Submitted/Location Within Documents:** Policies: 1. 304L_MemberRightsandRespons_Policy - bottom page 7, V, C, 1, d (covers bullet 1 at left) 2. 304L_MemberRightsandRespons_Policy - bottom page 7, V, C, 1, c (covers bullet 2 at left) Member Handbooks: 1. CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 4 2. VO_ReferralConnect_ScreenShot 3. 3BHO_ProviderDirectory	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: The contractor mails provider directories to each new enrollee or upon request. Members can also access the provider directory for their region through the CHP web site, www.yourchp.org. Members can also utilize the ReferralConnect option for a searchable list of providers in their area. The Link to Referral Connect is prominently placed on the BHO Web sites and links point to https://www.valueoptions.com/referralconnect/doLogin.do?j_username=colmem&j_password=colmem Currently, CHP places no restrictions on choice of network providers. This is noted in the CHP_MemberHandbook_2011EQRO, page 4. It is also stated in the member rights policy 304L_MemberRightsandRespons_Policy, number 12.	

Findings:
The VO Member Information Requirements policy stated that members would receive names, locations, telephone numbers of current contracted providers, including non-English languages spoken and identification of providers not accepting new patients. The policy stated that the information could be in a separate provider listing or included in the member handbook. The VO Member Rights and Responsibilities policy stated that members would receive information through the member handbook or other means, such as member newsletters, periodic informational forums, member mailings, or Web site postings.

The VO Provider Directory listed names, addresses, telephone numbers, languages spoken, and any specialty areas of all contracted providers. During the on-site interview, staff members confirmed that the provider listing does not reflect whether the provider is accepting new patients. Staff stated that it is CHP's process that the listing is printed from CHP's database and is reflective of the most recent list. CHP staff stated that providers not accepting new patients are removed from the active list, rather than using a notation that they are not accepting new patients. The CHP Member Handbook stated that members may choose from any of the network MHCs or contracted independent providers and provided a listing of partner CMHCs with locations and contact information. The handbook referred members to the CHP Web site link to the ReferralConnect online directory to access a searchable database of network providers. The handbook also instructed members to call the member services telephone number to request a provider directory.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
10. The member information materials sent following enrollment include the following member rights and protections as specified in 42CFR438.100(b)(2)–(3) and in the Medicaid managed care contract. Members have the right to: ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. ◆ Request and receive a copy of his or her medical records, and request that they be amended or corrected. ◆ Be furnished health care services in accordance with federal healthcare regulations for access and availability, care coordination and quality. ◆ Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its providers, or the State Medicaid agency treats the member. *42CFR438.10(f)(6)(iii)* *Contract: II.F.4.i.3*	**Documents Submitted/Location Within Documents:** Policies: 1. 307L_MemberInfoReqmnt_Policy2 - page 2, V, C, 2 2. 304L_MemberRightsandRespons_Policy - pages 1-4, III, A, 1-27 3. 304L_MemberRightsandRespons_Policy - page 6, V, B, 1 and 2 4. CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 16 a. CHP, bullet 1 b. CHP, bullet 17; c. CHP, bullet 4; d. CHP, bullet 5; e. CHP, bullet 6; f. CHP, bullet14; g. CHP, bullet 15, 5. CHP_ MemberRightsPoster_English 6. CHP_ MemberRightsPoster_Spanish 7. CHP_MHCContractComplianceTool_FY2011.xlsx **Description of Process:** Member rights are prominently communicated in a variety of methods when a member becomes enrolled. Member rights are prominently placed in the CHP member handbook. The Web site has an entire page dedicated to member rights and can be found at: http://www.coloradohealthpartnerships.com/members/mbr_your_rights.htm Member Rights posters are displayed in waiting rooms, bulletin boards and other areas where members wait.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	The VO service center conducts annual contract compliance audits. As noted in the audit tools, we review the CMHC and provider practices for communicating member rights. We look to see that member rights are posted in a prominent place, that member handbooks are available in waiting areas, and review copies of member rights statements distributes at intake.	

Findings:
The VO Member Rights and Responsibilities policy stated that the VO member rights included all of the rights specified in 42CFR438.100(b)(2)-(3), including the right to be treated with respect and dignity, receive information on treatment options, participate in treatment decisions, freedom from restraint, receive copies of medical records, access and quality of services, and free exercise of rights. The "Member Rights" section of the CHP Member Handbook, as well as the CHP Member Rights poster (displayed at provider locations) listed each of these rights in easy-to-understand language. The CHP Web site also included a link to the list of member rights.

The CHP CMHC Contract Compliance audit tool included a section to evaluate whether the CMHC informed its staff of member rights and responsibilities through written policies and periodic training and whether rights and responsibilities were provided to members through intake materials and were posted at the facilities.

Required Actions:
None.

11. The member information materials sent following enrollment include the following additional member rights. Members have the right to: ◆ Have an independent advocate. ◆ Request that a specific provider be considered for inclusion in the provider network. ◆ Receive a second opinion. ◆ Receive culturally appropriate and competent services from participating providers. ◆ Receive interpreter services for members with communication disabilities or for non-English speaking members. ◆ Prompt notification of termination or changes in services or providers.	**Documents Submitted/Location Within Documents:** Policies: 1. 307L_MemberInfoReqmnt_Policy2 - page 2, V, C, 2 2. 304L_MemberRightsandRespons_Policy - pages 1-4, III, A, 1-27 3. 304L_MemberRightsandRespons_Policy - page 6, V, B, 1 and 2 4. CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 16 5. CHP_ MemberRightsPoster_English 6. CHP_ MemberRightsPoster_Spanish 7. CHP_MHCContractComplianceTool_FY2011.xlsx	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Express an opinion about the Contractor's services to regulatory agencies or the media without the Contractor causing any adverse effects upon the provision of covered services. *Contract: II.F.4.j.3*	**Description of Process:** Member rights are prominently communicated in a variety of methods when a member becomes enrolled. Member rights are prominently placed in the CHP member handbook. The Web site has an entire page dedicated to member rights and can be found at: http://www.coloradohealthpartnerships.com/members/mbr_your_rights.htm Member Rights posters are displayed in waiting rooms, bulletin boards and other areas where members wait. The VO service center conducts annual contract compliance audits. As noted in the audit tools, we review the CMHC and provider practices for communicating member rights. We look to see that member rights are posted in a prominent place, that member handbooks are available in waiting areas, and review copies of member rights statements distributes at intake.	
Findings: The VO Member Rights and Responsibilities policy specified that member rights included the right to have an independent advocate, request the inclusion of a provider in the network, obtain a second opinion, receive culturally appropriate care, receive interpreter services, receive prompt notification of benefit or provider changes, and express an opinion without recourse. The "Member Rights" section of the CHP Member Handbook, as well as the CHP Member Rights poster (displayed at provider locations) listed each of these rights in easy-to-understand language.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
12. Members are informed in these materials about: ◆ Assistance available through the Medicaid Managed Care Ombudsman program. ◆ Appointment Standards for routine, urgent and emergency situations. ◆ Procedures for requesting a second opinion. ◆ Procedures for requesting accommodation for special needs. ◆ Procedures for arranging transportation. ◆ Information on how members will be notified of any changes in services or service delivery sites. ◆ Procedures for requesting information about the contractor's quality improvement program. ◆ Information on any member and/or family advisory board(s) the contractor may have in place. *Contract: II.F.4.j.4–11*	**Documents Submitted/Location Within Documents:** Policies and Procedures: 1. 309L_MemberAdvisory_Policy 2. CHP_MemberHandbook_2011EQRO (Misc. Folder): a. CHP_MemberHandbook_2011EQRO - page 19 (member rights), page 21 (grievances), page 24 (appeals), page 25 (overview of Ombuds program). b. CHP_MemberHandbook_2011EQRO - page 8 (appointment standards), page 8 (when will I be seen), c. CHP_MemberHandbook_2011EQRO - page 14 d. CHP_MemberHandbook_2011EQRO - page 17 (second opinion); page 18 (member rights e. CHP_MemberHandbook_2011EQRO - page 13 (asking for accommodations); page 13 (waiver programs for members with special needs) f. CHP_MemberHandbook_2011EQRO - page 17 (arranging for transportation) g. CHP_MemberHandbook_2011EQRO - page 11-12 (requesting information on QI programs. h. CHP_MemberHandbook_2011EQRO - pages 25 and 26 (advisory committees) **Description of Process:** The CHP member handbook contains all of the information required in Standard V, item 12. In addition to the handbooks, members are also directed to the CHP web site. It is important to note at this point, that the handbooks were written using the same templates, especially for required information. Since there are structural differences in the two BHO's, the handbooks aren't mirror images of each other. However, all the required information is nearly identical.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Members are made aware of the Ombudsprogram through the member handbooks CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 23 and through the Web site. http://www.coloradohealthpartnerships.com/members/rights/mbr_ombudsman.htm and through the enrollment letter CHP_EnrollmentLetter_English_August2011. Appointment standards are noted in CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 5&6; Procedures for requesting a second opinion are found for CHP at CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 14; Procedures for requesting accommodation for special needs CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 10; Procedures for arranging transportation are found at CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 15; Information on how members will be notified of any changes in services or service delivery sites at CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 8; Procedures for requesting information about the contractor's quality improvement program can be found at CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 25; Information on any member and/or family advisory board(s) the contractor may have in place can be found at CHP_MemberHandbook_2011EQRO (Misc. Folder) page 25; The handbook directs members to contact the OMFA for information about the quality program or to learn about member and family advisory committees. The handbook also has the URL for the web sites. These Web sites contain much more detailed information about committees, requirements, etc.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**

Findings:

The CHP Member Handbook defined the role of the Medicaid ombudsman as a free service to assist members with resolving health care issues, including filing grievances and appeals, and included a prominent display of contact information for the ombudsman. The CHP Member Enrollment Letter also provided contact information for the ombudsman.

The "When Will I Be Seen?" section of the CHP Member Handbook described appointment standards as follows: 7 days for a routine visit; 24 hours for an urgent situation; within 1 hour (2 hours if rural) for an emergency; and an appointment wait time of no more than 15 minutes. The handbook also included an extensive description of how to access emergency services.

The CHP Member Handbook described services available for members with special needs, such as disabilities, deaf or hard-of-hearing, or non-English-speaking members, and directed members to the member services telephone number to request assistance. In addition, the handbook provided the member services telephone number to obtain second opinions or transportation services to get to their appointments.

The CHP Member Handbook stated that members would receive written notification of any major change in coverage or benefits at least 30 days prior to the date of the change and would be notified by mail of any change with the provider or provider location within 15 days prior to the change. The handbook stated that any changes would be posted on the CHP and CMHC Web sites. In addition, the CHP Member Handbook described, in easy-to-understand language, the components of the CHP Quality Improvement Program and instructed members to contact CHP's member services to request more information about quality programs or receive a copy of the quality plan.

The VO Member Advisory policy described the intent of CHP to provide clients and families with a means for input into Medicaid BHO operations through the establishment of forums such as the Member/Family Advisory Committees. The policy stated that the forums/committees would meet at least quarterly; consist of members, family members, other member stakeholders, and CHP staff; and would perform functions such as reviewing member materials, reviewing results of member satisfaction surveys, providing input into wellness and other member education programs, and reviewing complaints and grievance issues. The CHP Member Handbook explained that the Member/Family Advisory Committees provide feedback to CHP on "how they are doing" and provided a contact number for members to obtain more information.

The CHP CMHC Contract Compliance audit tool included a section to evaluate whether the CMHCs posted information regarding the Medicaid ombudsman program in all places where services were being provided. The audit tool indicated that photographic evidence of posting in satellite locations was required.

Required Actions:

None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
13. The member information materials sent following enrollment also include the following information regarding the grievance, appeal, and fair hearing procedures: ◆ The right to file grievances and appeals. ◆ The requirements and time frames for filing a grievance or appeal (including oral filing). ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing, and the rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing, and the service authorization has not expired. • The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The right that providers may file an appeal on behalf of the member with the member's written consent. *42CFR438.10(f)(6)(iv) and438.10 (g)(1)(i–vii)* *Contract: II.F.4.i.4 and II.F.4.i.13*	**Documents Submitted/Location Within Documents:** Policies: 1. 307L_MemberInfoReqmnt_Policy2 - page 2, V, C, 3 and page 4, V, C, 9, a through f 2. CHP_MemberHandbook_2011EQRO (Misc. Folder) a. CHP_MemberHandbook_2011EQRO - page 16, bullet 21, pages 18 and 20 b. CHP_MemberHandbook_2011EQRO, -pages 19and 20 c. CHP_MemberHandbook_2011EQRO, -page 16, bullet 22 and page 22 d. CHP_MemberHandbook_2011EQRO - pages 19, 20 and 21; e. CHP_MemberHandbook_2011EQRO - pages 19 and 21; f. CHP_MemberHandbook_2011EQRO - page 22; g. CHP_MemberHandbook_2011EQRO - pages 18 and 19; 3. 305L_Appeal_Policy http://www.coloradohealthpartnerships.com/members/handbook/mbr_hbk_mbr_rights_and_responsibilities.htm describes the CHP process for filing grievances and appeals. **Description of Process:** Members are informed of appeal, grievance and fair hearing procedures in the member handbook, in detail, the welcome letter and on the Web sites. There are multiple references throughout the member handbook supporting the requirements. Members are informed about assistance available and the numbers to call to file a grievance or appeal throughout the materials and Web sites as well. Detailed information about the grievance process is found in	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	the CHP member handbook at CHP_MemberHandbook_2011EQRO - (Misc. Folder).pdf pages 18 through 23 (Misc. Folder); Member rights policies, (304L_MemberRightsandRespons_Policy.doc) grievance policies and procedures (303LGrievance_Policy_SC_OMFA.doc), appeal policies and procedure (305L_Appeal_Policy.doc) internally reinforce this information for staff. The provider handbook explains this information for providers, so that not only are members made aware of the right to file a grievance, but staff and providers are made aware of the rights and processes. The information also reference timeframes and methods for appeals. Staff follows these policies and procedures and is knowledgeable to assist members telephonically or face to face.	

Findings:
The VO Member Information Requirements policy stated that the member handbook would include information on filing grievances, appeals, and State fair hearing processes. The CHP Member Handbook stated that the member has a right to file a complaint or appeal a decision he or she does not agree with, that the OMFA could provide assistance with the process and included the toll-free telephone number. The handbook stated that a designated client representative (DCR), which could include the provider, could file on behalf of the member with the member's permission. The handbook provided simple definitions of the terms "action," "notice of action," "appeal," "DCR," "grievance," and "State fair hearing." The handbook outlined the procedures for filing and processing grievances, appeals, and requesting a State fair hearing.

The CHP Member Handbook included the 30-calendar-day filing time frame for grievances and appeals and for requesting a State fair hearing. The handbook informed members that grievances and appeals may be filed orally or in writing, that an oral request for an appeal would be considered the date of the appeal, and that oral appeals must be followed in writing. The handbook also described CHP's responsibilities in processing the grievances and appeals. The time frames for resolving appeals, however, were incorrectly listed as 10 *calendar* days for a standard appeal and three *working* days for expedited appeals. While particular time frames would be in compliance, if accurately representative of CHP's practices, CHP's other documentation and staff members confirmed that the correct time frames are 10 *working* days to resolve a standard appeal and three *calendar* days to resolve an expedited appeal.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
The member handbook addressed the provision to continue previously authorized services during the appeal or State fair hearing; however, some of the details provided regarding timelines were confusing and inaccurate. On page 20 of the handbook the "on time" filing was depicted as, "from within 10 calendar days from when CHP sent the notice or 10 calendar days before the treatment was scheduled to stop or change—whichever is later." The other conditions for requesting continued services were accurate in this section as well as on page 22, although it may be less confusing for members if CHP revised the two lists to mirror each other. The duration of continued services on page 20 was described accurately and in easy-to-understand language; however, on page 22, the same list was inaccurate and confusing. The second bullet stated that services would continue until 10 days pass after the notice of *action* (which should read notice of *appeal resolution*). The continuation of previously authorized services, while may be described separately in the appeal section or State fair hearing section, is the same set of regulations; and the language need not change.		
Required Actions: CHP must revise the member handbook to accurately describe resolution time frames. CHP must also clarify in the member handbook that members may request that previously authorized services continue during the appeal or State fair hearing if the appeal is filed within 10 calendar days of the notice of action, or before the intended effective date of the action, whichever is later. In addition, CHP must clarify page 22 of the handbook to describe the duration of continued benefits to be until one of the following occurs (as is stated on page 20 of the handbook): ♦ The member withdraws the appeal. ♦ Ten days pass after CHP mails the notice of appeal *resolution*, unless within these 10 days, the member requests a State fair hearing with continued services. ♦ The State fair hearing officer issues a decision adverse to the member. ♦ The original period authorized by CHP has been met.		
14. The member information materials sent following enrollment include: ◆ The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. ◆ Procedures for obtaining benefits including authorization requirements. ◆ The extent to which and how members may obtain benefits, from out-of-network providers.	**Documents Submitted/Location Within Documents:** Policies: 1. 307L_MemberInfoReqmnt_Policy2 - page 3, V, C, 4-6 2. 304L_MemberRightsandRespons_Policy - page 7, V, C, 1, a and b 3. 304L_MemberRightsandRespons_Policy - page 8, V, C, 2, f 4. 274L_ProvisionSvcsOutOfNetworkProvider_Policy - IV; 1-5 5. CHP_MemberHandbook_2011EQRO (Misc. Folder):	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
42CFR438.10(f)(6)(v) through (vii) *Contract: II.4.i.5–7*	a. CHP_MemberHandbook_2011EQRO - pages 7, 8, and 13 b. CHP_MemberHandbook_2011EQRO - page 4, 7, and 8 c. CHP_MemberHandbook_2011EQRO - page 12 6. CHP_EnrollmentLetter_English_August2011 **Description of Process:** Members are made aware of the amount duration and scope of benefits available through CHP through the member handbook, enrollment letter and Web site. Information is provided with enough detail to enable members to understand benefits they have, written in simple, easy to understand language. Covered benefits are described in an easy to read, chart format. MemberHandbook_2011EQRO.pdf - pages 7 (Misc. Folder). Benefit limits are clearly explained. Members are directed to contact the BHO Office of Member and Family Affairs with questions about their benefits and the toll free numbers are listed throughout the handbook. The methods for accessing services are easily explained in the member handbooks MemberHandbook_2011EQRO.pdf - pages 4 (Misc. Folder). Members have several choices for how to access services. No authorization is necessary if member's follow the guidelines for accessing services noted on page 4. If members want to see a specialist (provider outside the network) members are instructed to call us to get a referral. Members are also told they can request to have a provider added to the network. The handbook states that only emergency services can be provided	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	by a provider not in the network or without an authorization CHP_MemberHandbook_2011EQRO.pdf - pages 11 (Misc. Folder).	

Findings:
The CHP Member Handbook described the categories of mental health services available including inpatient hospital, outpatient treatment, residential treatment, emergency care, case management, medication management, and school-based services. In addition, the handbook provided a listing of community-based services and directed members to contact the CMHC for more information. The handbook outlined the limitations on number of outpatient therapy sessions and inpatient days, and also described the CHP approval of services based on medical necessity, clinical criteria, least restrictive setting, and provider determination. The handbook provided an extensive description of emergency and poststabilization services. The handbook stated that members have a right to choose a network provider or may request that a non-network provider be added to the network. Members were directed to the CHP member services telephone number throughout the handbook for more information or assistance.

The CHP Enrollment Letter provided a brief description of the mental health services available, including inpatient, outpatient, rehabilitation, case management, medication management, and emergency services, and directed members to the member handbook, the CMHCs, or the CHP Web site to obtain more information about their mental health benefits.

Required Actions:
None.

15. The member information materials sent following enrollment include the extent to which and how after hours and emergency coverage are provided, including: ◆ What constitutes an emergency medical condition, emergency services, and post-stabilization care services with reference to the definitions in 42CFR438.114(a). ◆ The fact that prior-authorization is not required for emergency services. ◆ The process and procedures for obtaining emergency and post-stabilization services, including the use of the 911-telephone system or its local equivalent.	**Documents Submitted/Location Within Documents:** Policies: 1. 304L_MemberRightsandRespons_Policy - page 8, V, C, 2, e and d (addresses bullets 1 and 3 at left) 2. 307L_MemberInfoReqmnt_Policy2 - page 3, V, C, 7, a through e Member Handbook: 1. CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 11 (addresses bullets 1-3 and 5 at left) 2. CHP_MemberHandbook_2011EQRO - (Misc. Folder) Appendix B, pages 36-38 (addresses bullet 4)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services. ◆ The fact that the member has the right to use any hospital or other setting for emergency care. *42CFR438.10(f)(6)(viii)* *Contract: II.F.4.i.8*	Information about after-hour and emergency coverage is provided to members through the member handbook and our Web site, http://www.coloradohealthpartnerships.com/services/emergencies.htm **Description of Process:** The definition of emergency services and a description of what constitutes an emergency medical condition are paraphrased from the federal regulations so that they read at a low grade reading level. They are listed on page 11 & 12 of the CHP handbook. The process for obtaining emergency services is listed in simple language on page 11 of the CHP handbook. Members are told that prior authorization is not required for emergency services on page 11 of the CHP handbook and members are instructed to go to the nearest hospital emergency room. The list of hospitals providing emergency services are located on in Appendix B, pages 36-38 of the CHP handbook. Post-stabilization care is described on page 12 of the CHP handbook. Members are instructed how to get emergency services, including using the 911 system, in the member handbook, page 11 in the CHP handbook. The enrollment letter, CHP_EnrollmentLetter_English_August2011.doc tells members they can use the 911 system. Local hospital contact information is found on the Web site at http://www.coloradohealthpartnerships.com/services/emergencies.htm and in the handbook on pages 36-38. Members are told they can use any hospital or qualified provider for emergency services on page 11 of the handbook.	
Findings: The "Emergencies" section of the CHP Member Handbook included the definition of an emergency situation in easy-to-understand terms and described what to do in both a mental health and physical health emergency. Members were directed to use 911 or go to the nearest emergency facility and were		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
informed that authorization is not required for emergency services. The handbook stated that members can get care from any emergency facility in the area, and provided a detailed listing of the location and telephone numbers for hospitals within the BHO service area. The CHP Web site also included the information on emergency services including what to do in a mental health emergency and the listing of emergency facilities/hospitals in the service area. The CHP Enrollment Letter included a paragraph describing "What to Do in an Emergency," which provided instructions for accessing care and stated that emergency services do not need to be authorized. The CHP Member Handbook also defined mental health poststabilization services and stated that only emergency services were covered when the member was out of the service area, that the member should go to the nearest emergency facility, and that CHP would assist the member with transfer back to a network provider after the emergency situation was stabilized. The CHP Web site also included the definition of poststabilization services. The VO Provider Manual outlined the expectations of provider availability and response in case of member emergency. The CHP CMHC Contract Compliance audit tool included a section to evaluate whether the CMHCs provided information to members via treatment discussions, in intake materials, or general postings regarding what constitutes a mental health emergency and how to access emergency services.		
Required Actions: None.		
16. The member information materials sent following enrollment include the poststabilization care services rules at 422.113(c) and include: ◆ The contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are pre-approved by a plan provider or other plan representative. ◆ The contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are not pre-approved by a plan provider or other plan representative. ◆ That charges to members for poststabilization services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the Contractor. ◆ That the organization's financial responsibility for	**Documents Submitted/Location Within Documents:** Member Handbook: 1. CHP_MemberHandbook_2011EQRO - (Misc. Folder) page 11 (What happens when the emergency is over?) Policies and Procedures: 1. 270L_PostStabilizationServices_Policy Website links, which link to the policy on post stabilization. http://www.coloradohealthpartnerships.com/services/emergencies.htm. **Description of Process:** ValueOptions®' 270L Emergency and Post stabilization Services Policy releases the member from liability for payment of emergency services. Members are informed via the Member	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
poststabilization services it has not approved ends when: • A plan physician with privileges at the treating hospital assumes financial 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; or • The member is discharged. *42CFR438.10(f)(6)(ix) and 42CFR422.113(c)* *Contract: II.F.4.i.9*	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 Member handbook provides basic information telling the member that no fees can be charged to the member for post stabilization services. Overall, the member handbook contains information and directions members need to use their benefits and get care. It is written in simple, low grade reading level language. Medicaid members reviewed the original drafts of the member handbook and recommended that we include only the information a person needs to use their benefits. As a result of their recommendations, we kept the information simple. Consequently, the member handbook does not include detailed information about internal UM processes, the BHO's responsibility for payment, or rules for the BHO. Rather, the more complicated and detailed information is posted on the web sites or can be obtained by contacting the OMFA office through the toll free number. When a member makes a request for additional information, the OMFA will either send paper copies, or provide direction to web site links. This strategy is used when members request clinical and level of care guidelines, policies and procedures that cover utilization management processes or payment policies to providers. For example, if a member called for more information about post stabilization services, we would direct them to the Web site at http://www.coloradohealthpartnerships.com/services/emergencies.htm or we would send the member a paper copy of 270L_PostStabilizationServices_Policy.doc. We would also answer any questions the member had, or explain how the policy or guideline was relevant to their situation. The memo included in	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	the mailing directs the member to call the OMFA at the toll free number to get any questions answered. The Web site posting links to the ValueOptions® policy, 270L_PostStabilizationServices_Policy.doc. The policy contains all of the evidence listed in Standard V, item 16.	
Findings: The CHP Member Handbook defined mental health poststabilization services as inpatient or outpatient services provided after an emergency to assist the member in remaining stable, and that there was no charge for poststabilization services. The VO Emergency and Post-Stabilization Services policy, available to members on the CHP Web site, stated that: ♦ CHP does not hold a member liable for payment of subsequent screening and treatment after an emergency that is needed to diagnose or stabilize the member, or for poststabilization services, regardless of whether these services were in or out of network. ♦ CHP allows the treating provider to determine when the member is sufficiently stabilized for transfer or discharge. ♦ CHP does not require preauthorization for any poststabilization services. ♦ CHP is financially responsible for poststabilization care services obtained within or outside the network that are either pre-approved or not pre-approved but meet the conditions as specifically outlined in 42 CFR 422.113(c).		
Required Actions: None.		
17. The member information materials sent following enrollment include: ◆ Policies on referral for specialty care and other services not provided by the member's care provider. ◆ That no fees will be charged for covered mental health services provided to members. ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract including how transportation is provided. *42CFR438.10(f)(6)(x) through (xii)* *Contract: II.F.4.i.10–12*	**Documents Submitted/Location Within Documents:** Policies: 1. 304L_MemberRightsandRespons_Policy - page 8, V, C, 2, b (address bullet 1 at left) 2. 307L_MemberInfoReqmnt_Policy2 - page 4, VI, C, 9, a through c 3. CHP_MemberHandbook_2011EQRO (Misc. Folder): a. CHP_MemberHandbook_2011EQRO - page 4; b. CHP_MemberHandbook_2011EQRO - pages 4 and 14 c. CHP_MemberHandbook_2011EQRO - pages 15, 25-27 (transportation & other benefits)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: Member Information Policy 307L_MemberInfoReqmnt_Policy2 - page 4, VI, C, 9, a through c directs the information that is required in member handbooks, including accessing specialty care, the fact no fees are charged for covered services, where to access benefits under State Plan but not covered and transportation. The member rights policy, 307L_MemberInfoReqmnt_Policy2 - page 4, VI, C, 9, a through c provides that members have the right to specialty care. For CHP, members are informed about the fact that no fees may be assessed for covered services through the CHP member handbook (page 14) and on the Web site http://www.coloradohealthpartnerships.com/members/pdf/CHP_Member_Handbook.pdf. Specialty care and Information about benefits available under the State plan, but not covered under the Medicaid managed care contract is also provided in the member handbook on pages 26-29. This includes information about other Medicaid programs, how to get help for a physical health problem, EPSDT, services for DD and TBI and waiver programs. The member handbook describes where to go to get transportation services on page 15.	
Findings: The CHP Member Handbook stated that CHP would refer members to a specialist, if needed. The handbook stated that mental health services were free of charge and that members should contact CHP if they received a bill for services. Members were instructed to call the care coordinator or the member services contact number (provided) to arrange for transportation to appointments. The handbook described other Medicaid health care benefits that the member may receive outside of the BHO, including physical health care benefits, EPSDT services, and a number of Medicaid waiver programs for special needs individuals. The handbook directed members to contact Medicaid Customer Service or HealthColorado for more information and provided contact numbers and the Web site addresses for both. The handbook also stated that CHP could assist members to find a medical doctor by calling the member services telephone number.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
18. Advance directives requirements: The Contractor maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the BHO. Advance directives policies and procedures include: ◆ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. ◆ The difference between institution-wide conscientious objections and those raised by individual physicians. ◆ Identification of the State legal authority permitting such objection. ◆ Description of the range of medical conditions or procedures affected by the conscientious objection. ◆ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. ◆ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. ◆ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ◆ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive.	**Documents Submitted/Location Within Documents:** 1. 269L_AdvanceDirective_Policy (reference by bullets at left) a. Page 3-4, IV, H, and page 4, V, C, 1 b. N/A (Since there is no limitations on implementing Advance Directives by the Contractor, bullets 2-4 do not apply) c. N/A d. N/A e. Page 5, V, D, 2 f. Page 5, V, D, 3 g. Page 4, V, A and B h. Page 2, III, C i. Page 1, III, A j. Pages 1-2, III, A, 1 k. Pages 5-6, V, H, 1-7 l. Pages 5-6, V, H, 1-7 2. CHP_MemberHandbook_2011EQRO - (Misc. Folder) Page 22-23 describing member right to having an Advance Directive 3. CHP_Advance_Directives_Training 4. CHP_MHCContractComplianceTool_FY2011.xlsx – items 7 & 8 5. Colorado_Law_Advance_Directives **Description of Process:** VO Colorado has an Advance Directives Policy that covers the required guidelines of 42CFR438.10(g)(2) and 42CFR422.128. The policy applies to all Adult members seeking services. Because very little behavioral health care is provided in facilities that also provide medical and surgical care, adult members would be covered be the facility's advanced directive's policies. Relative to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Provisions for ensuring compliance with State laws regarding advance directives. ◆ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ◆ Provisions for the education of staff concerning its policies and procedures on advance directives. ◆ Provisions for community education regarding advance directives that include: • What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. • Description of applicable state law concerning advance directives. The member information materials regarding advance directives include: ◆ The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. ◆ The Contractor's policies respecting implementation of advance directives. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the Colorado Department of Public Health and Environment. *42CFR438.10(g)(2) and 42CFR422.128* *Contract: II.F.4.i.14*	CHP, we do not place limits on a member's right to implement an advance directives. Also, because our providers typically do not provide behavioral health services at a medical or surgical environment or in an environment where patients are likely to suffer terminal illnesses, they would not have a reason to express a conscientious objection to following an advance directive. Therefore, we have not addressed this in our policy. If a member is incapacitated at the time of hospital admission due to an incapacitating condition or mental disorder and is unable to receive information, the member's family or surrogate can request information through their outpatient provider after discharge or from hospital staff. If a member is no longer incapacitated, the member can request information through their outpatient provider after discharge or from hospital staff. On hospital admission, adult members will be asked by hospital staff if he/she has an advance directive. This will be noted in the medical record. It shall be the responsibility of the member or someone acting for him/her to submit the declaration to the attending physician for entry in the member's medical record. On Outpatient admission, adult members will be asked by admitting staff if he/she has an advance directive. It will be noted in the medical record, typically on an intake sheet at the front of the chart that contains demographic and emergency contact information. A member's care and treatment is not conditioned on whether or not he/she has an advance directive, and members are not discriminated against based on whether they have executed an Advance Directive.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	A member's care and treatment is not conditioned on whether or not he/she has an advance directive, and members are not discriminated against based on whether they have executed an Advance Directive. When appropriate, ValueOptions® Colorado Partnerships will provide consumer, staff, providers, and community education about Advance Directives using the training materials CHP_Advance_Directives_Training. Depending on the audience (staff, provider or community), training will be conducted through the following mean as part of the staff orientation process: 1. OCFA events and Consumer Directed Programs 2. Provider Forums 3. Postings at the CMHC with Consumer Advocate contact information for additional information 4. Postings on provider and consumer web sites. 5. Provider news letters 6. E-mail and mail notices to providers with instructions on how to access Advanced Directive information on the web. The member Handbook describes advance directives on page 22. They are directed to file complaints with the Colorado Department of Health and Environment if they believe a provider is not following their advance directive. The CHP Web site posts more comprehensive information about advance directives. The Web site links to 1. Our policy on Advance Directives - 269L_AdvanceDirective_Policy	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	2. The state law, Title 15, Article 18, the Colorado Medical Decisions Treatment Act – Colorado_Law_Advance_Directives 3. Our PowerPoint training on Advance Directives – CHP_Advance_Directives_Training The CHP Contract compliance audit tool reviews Advance Directives requirements CHP_MHCContractComplianceTool_FY2011.xlsx – items 7 & 8.	

Findings:
The VO Advance Directives policy stated that:

- It was VO's policy to inform members of their advance directives rights and assist members with that right, in compliance with federal and State laws.
- As a behavioral health entity, CHP did not have any limitations regarding implementation of advance directives, since advance directives relate to medical/surgical procedures, which mental health providers were not trained to provide.
- On inpatient or outpatient admission, the member would be asked if they had advance directives, and their response would be noted in the medical record.
- If a member was incapacitated, the family/surrogate could request or provide advance directives information on admission or the member could request or provide information when no longer incapacitated.
- The member would not be discriminated against nor provision of care dependent on whether a member had executed advance directives.
- Advance directives information was distributed to members through the CHP Member Handbook and CHP Web site.
- Any changes in State law concerning advance directives would be communicated to members through the CHP Web site no more than 90 days following the date of change.
- Staff, provider, and community education would be provided, as appropriate, through staff orientation, consumer events and programs, postings at the CMHCs, provider forums or newsletters, and the CHP Web site, which is accessible to providers, members, and the public.

The "Advance Directives" section of the CHP Member Handbook included a statement that members have the right to formulate advance directives, a definition of advance directives in easy-to-understand language, and the types of advance directives recognized in Colorado law The handbook provided direction to members to talk to their PCP about advance directives and to provide copies to their mental health provider. The handbook included an offer of assistance or a copy of the CHP policy upon request by contacting member services. The handbook also included contact information for the Colorado Department of Public Health and Environment for filing a complaint about provider noncompliance with advance directives. The handbook also stated that mental health advance directives were not required by law, but that a mental health crisis plan could be developed that would allow members to have

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
more control over their care in a mental health crisis. The CHP Enrollment Letter also described the member's right to develop advance directives with a brief explanation of advance directives and directions to ask the doctor or contact CHP OMFA for more information. The "Member Rights and Responsibilities" section of the CHP Web site included a link for advance directives, which provided an expanded description of advance directives and offered additional links to the full CHP Advance Directives policy, the Colorado Laws concerning advance directives, and Advance Directives Training. The VO Provider Manual outlined provider expectations related to advance directives. The CHP CMHC Contract Compliance audit tool included a section to evaluate whether the CMHCs provided members with advance directives information including the State laws and member rights and if the medical record noted whether or not a member had advance directives.		
Required Actions: None.		
19. The member information materials sent following enrollment include: ◆ Notice that additional information that is available upon request, includes information on: • The structure and operation of the Contractor. • Physician incentive plans. *42CFR438.10(g)(3)* *Contract: II.F.4.i.15*	**Documents Submitted/Location Within Documents:** 1. CHP_MemberHandbook_2011EQRO (Misc. Folder): a. CHP_MemberHandbook_2011EQRO -, page 43 b. CHP_MemberHandbook_2011EQRO - page 4 2. CHP_AnnualMemberLetter 3. CHP_AnnualMbrMlg_Letter_2011 **Description of Process:** Members are sent an annual letter to remind them they can request a copy of their member handbook. Members are directed to contact the Office of Member and Family Affairs to request information on the structure and operations of the Contractor. The Contractor does not have physician incentive plans and such information is also described in the member handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The CHP Member Handbook instructed members to contact the OMFA to obtain information on the structure and operation of CHP. The member handbook informed members that CHP physicians do not have incentive plans in the section, "How to Choose a Provider." The CHP annual letter to members informed members of their right to receive a copy of the member handbook, and informed members of the availability of the handbook on the CHP Web site.		
Required Actions: None.		

Results for Standard V—Member Information							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	19	**Total Score**		=	17

Total Score ÷ Total Applicable	=	89%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has a system in place that includes a **grievance** process, an **appeal** process, and access to the **State fair hearing** process. *42CFR438.402(a)* *Contract: II.F.10* *Grievance and Appeal State Rule (version 11—January 2011): 8.209*	**Colorado Health Partnerships (CHP) delegates all requirements in Standard VI to ValueOptions® as indicated by the "CHP_GrievanceDelegation_Policy.pdf".** Policies: 1. 303L_Grievance_Policy - page 1, I; 2. 305L_Appeal_Policy a. Page 1, I b. Page 7, V, A, 3, b-d c. Page 14, V, F 3. Member Handbook: a. CHP_MemberHandbook_2011EQRO (Misc. Folder) - pages 18-22 4. CHP_GrievanceBrochure 5. CHP_Grievance_FlowChart 6. CHP_Appeal_FlowChart 7. CHP Grievance Help Guide 8. CHP_AdvocatesList_2011 9. ProviderManual2011OCT01 (Misc. Folder) - Section 9, page 30 and Section 15, pages 79-80 10. Final Delegation_Agreement_2011July01_COM.pdf **Description of Process:** CHP has a grievance process in place that is based on federal and state regulations, state statute and the contract with the state of Colorado. CHP has delegated the grievance process to the VO Office of Member and Family Affairs (OMFA). The OMFA staff is responsible for informing members and providers about the grievance process, and member rights. The OMFA staff at the service center includes; the VP of Member and Family Affairs, the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	grievance coordinator, and peer specialists. The grievance coordinator accepts, investigates and resolves grievances. In addition to OMFA staff, the grievance coordinator has access to clinical staff, the Medical director, the compliance officer, the VP of Quality Management, and others for consultation on grievances. There are additional points of access at each of the community mental health centers (CMHC). Each CMHC has a client/family advocate who accepts, investigates and resolves grievances. This allows members local resolution of the grievance, should they choose. They can also contact the service center via a toll free number if they choose not to file a grievance through the CMHC CHP has an appeal process in place that meets all federal guidelines. All utilization management activities occur at the VOCO service center, so the appeals process is delegated to the VO Office of Member and Family Affairs. The Office of Member and Family Affairs works closely with the clinical department, since the majority of appeals result from utilization management decisions. 1. Members are made aware of their right to use and access to the grievance, appeal and fair hearing process through the member handbook, the websites, postings at community mental health centers and consumer-operated services as well as the "help guides," – for CHP, the CHP Grievance Help Guide.	
Findings: The VO Grievance Process policy described CHP's grievance process. The VO Appeal Process policy described CHP's appeal process and the process for CHP support and assistance to members who wish to access the State fair hearing process. Members were informed via the CHP Member Handbook about the grievance and appeal process and how to access the State fair hearing process. Providers were informed about the processes via the provider		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
manual. The CHP Complaint/Grievance Information for Members brochure (brochure) described certain aspects of the grievance and appeal processes for members. During the on-site interview, CHP staff members reported that the brochure was not intended to include every aspect of the grievance system. CHP may want to consider, however, reviewing the brochure to determine priorities for inclusion, given that the distribution of the brochures is through the CMHCs (the point of service for a large percentage of members).		
Required Actions: None.		
2. The Contractor defines Action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole, or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals. ◆ For a resident of a rural area with only one MCO or PIHP, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: • The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. • The provider is not part of the network, but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not choose to join the network or does not meet the BHO's qualification requirements, the member will be given the opportunity to choose a	**Documents Submitted/Location Within Documents:** 1. 303L_Grievance_Policy- pages 4 and 5, IV, E, 1-6b 2. 305L_Appeal_Policy – pages 4 and 5, IV, C, 1-6 3. NonMedicalNecessityDetermination_Policy_SC_Cl (All) 4. 303LpeerAdvisorAdverseDeterm_Policy_SC_Cl (All) 5. 274LprovisionSvcsOutOfNetworkProvider_Policy_SC_Cl (All) Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) – middle page 18 2. ProviderManual2011OCT01 (Misc. Folder) – Section 9, pages 31-32 and Section 15, page 80 **Description of Process:** The BHO's definition of an action can be found in the grievance policy, section IV, E, 1-6b; the definition can be found in the Appeal Policy, IV, C, 1-6; These are operations policies, so they contain all the elements from the regulations. The policies guide our handling and disposition of grievances & appeals. 203Lmedical NecessityDetermination_Policy_SC_Cl – This policy includes information about notices of action and the standard time frames for determinations. Specifically, Action is defined on pp.1-2, Section IV, #'s 1-6. 303LpeerAdvisorAdverseDeterm_Policy_SC_Cl (All)—Describes	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
participating provider and then will be transitioned to a participating provider within 60 days. *42CFR438.400(b)* *(42CFR438.52(b)(2)(ii)* *State Rule: 8.209.2*	process for peer advisors making adverse determinations. 274LprovisionSvcsOutOfNetworkProvider_Policy_SC_Cl – Policy describes process for authorization of services from an out of network provider through the single case agreement process. Abbreviated versions of the definition are available to members in the member handbook and on the BHO web sites at http://www.coloradohealthpartnerships.com/members/handbook/mbr_hbk_mbr_rights_and_responsibilities.htm for CHP. Providers are made aware of the policies and processes for appeals in Section 9 of the Provider handbook through the websites – for CHP, at http://www.coloradohealthpartnerships.com/provider/handbook/Section9_Reviews_and_Appeals.pdf	
Findings: The VO Grievance Process policy included the definition of action, which was correct except that previous Colorado rule language remained in the policy which indicated exemption from sending notices of action for denial of payment. The VO Appeal Process policy and the VO Medical Necessity Determination policy definitions of action were consistent with the Medicaid managed care definition, as was the definition in the provider manual, the member handbook and the Help Guides (not yet implemented during the review period). The Grievance/Appeals PowerPoint training presentation included effective examples of actions. CHP should consider reviewing its documents to ensure that they contain current Colorado rule language, not in conflict with federal health care regulations. Based on the on-site appeals record review, it was clear that CHP used the required definition of action.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
3. The Contractor defines Appeal as a request for review of an Action. *42CFR438.400(b)* *State Rule: 8.209.2*	**Documents Submitted/Location Within Documents:** 1. 303L_Grievance_Policy – page 2, IV, A 2. 305L_Appeal_Policy - page 4, IV, B Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) – middle page 18 2. VOCO_AppealTraining_2011–Slide #4 **Description of Process:** Whenever a member disagrees with an action, this immediately triggers the member's appeal rights and is handled as an Action. The definition is provided in the Grievance Policy, the Appeals Policy and trainings for staff. For members, the definition is provided in the member handbooks and on the websites.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The definitions of appeal in the VO Appeal Process policy as well as the member handbook, the Appeal Guide and the brochure were all consistent with the Medicaid managed care definition of appeal. The provider manual and the PowerPoint training presentation were also correct.		
Required Actions: None.		
4. The Contractor defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action. *42CFR438.400(b)* *State Rule: 8.209.2*	**Documents Submitted/Location Within Documents:** Policies: 1. 303L_Grievance_Policy – page 4, IV, D Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) – lower page 18 2. CHP_Appeal_PowerPoint.pptx – slide 10 **Description of Process:** The BHO meets all federal and state regulations in its definition of a grievance. The Grievance policy, staff grievance training,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	member handbook and website references define a grievance as an oral or written expression of dissatisfaction about any matter other than an Action.	
Findings: Grievance was defined in the VO Grievance Process policy as an oral or written expression of dissatisfaction about any matter other than an action. Member materials included a definition of grievance that was consistent with the policy definition and at the required readability level. The provider manual and the PowerPoint training presentation both included an accurate definition of grievance.		
Required Actions: None.		
5. The Contractor has provisions for who may file: ◆ A member may file a grievance, a BHO-level appeal, and may request a State fair hearing. ◆ A provider may file a grievance on behalf of a member, given that the State permits the provider to act as the member's authorized representative. ◆ A provider, acting on behalf of the member and with the member's written consent may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member, given that the State permits the provider to act as the member's authorized representative. *42CFR438.402(b)(1)* *State Rule: 8.209.2*	**Documents Submitted/Location Within Documents:** 1. 303L_Grievance_Policy : Page 1, III, D Page 2, IV, C 2. 305L_Appeal_Policy : Page 1, III, A and B Page 2, III, C Page 13, V, E, 4, b Page 14, V, F Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) – pages 18-22 2. CHP_MemberHandbook_2011EQRO (Misc. Folder) – page 19 (addresses bullet 2) 3. CHP_MemberHandbook_2011EQRO (Misc. Folder) – page 20 (addresses bullets 3 and 4) 4. CHP_GrievanceBrochure 5. VO_Authorization_DesignatedClientRepresentative 6. ProviderManual2011OCT01 (Misc. Folder) – Section 9, pages 27 and 30; and Section 15, page 80	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: The BHO allows anyone to act on a member's behalf as long as the member has authorized the individual to act as their Designated Client Representative in writing. Members can designate family, friends, advocates, providers or anyone else to act on their behalf if they sign a DCR form, designating that individual or organization to act on their behalf in the grievance or appeal process. Members are made aware of this in the BHO member handbook, grievance and/or appeal guides, and the BHO websites. The policies, 305L_Appeal_Policy and 303L_Grievance_Policy, define who can file a grievance or appeal. When investigating and resolving a grievance or appeal, the person handling the grievance/appeal verifies the individual is authorized to file. In a telephone call, the member / guardian is asked verification questions to establish the fact we are speaking to the member or guardian. If we are speaking to a DCR, we ask that the DCR fax or scan a copy of the DCR form to verify they are authorized to act as a DCR.	
Findings: The VO Grievance Process policy stated that members or DCRs may file a grievance. The definition of a DCR included a treating health care professional if the appropriate DCR form was signed. The VO Appeal Process policy stated that members or DCRs may file an appeal and request a State fair hearing and also included a treating health care professional in its definition of DCR. The member handbook informed members that they or a DCR may file a grievance or an appeal and informed members of the availability of the State fair hearing process. The handbook also informed members that their provider may be the DCR with the appropriate form signed. Providers were informed via the provider manual of the grievance and appeal processes and that they may act as a member's DCR. There were examples in the on-site appeals record review of appeals having been filed by members, guardians, DCRs, and providers acting on behalf of the member.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
6. The Contractor accepts grievances orally or in writing. *42CFR438.402(b)(3)(i)* *State Rule: 8.209.5.D*	**Documents Submitted/Location Within Documents:** 1. 303L_Grievance_Policy – page 1, III, C and page 8, V, A, 2 Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) - pages 18 and 19 2. CHP_GrievanceForm 3. CHP GrievanceBrochure **Description of Process:** The BHO accepts grievances orally or in writing. Members who call the service center wanting to file a grievance will be transferred to the grievance coordinator. At the service center, customer service staff is trained to triage member calls to ensure they go to the intended staff. Members can also write to us with a grievance. There is no requirement to use a form; however, we make forms available in case the member prefers to use a form to file their grievance. The same process is followed at the mental health centers. Members can file a grievance with the local advocate telephonically or in writing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Grievance Policy stated that grievances are accepted orally or in writing. The member handbook informed members that they may file grievances via telephone, in person, by writing a letter, or using the grievance form. During the on-site interview, CHP staff members reported that grievances may be filed through VO or by contacting advocates at each of the CMHCs.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
7. Members have 30 calendar days from the date of the incident to file a grievance. *42CFR438.402(b)(2)* *State Rule: 8.209.5.A*	**Documents Submitted/Location Within Documents:** Policies: 1. 303L_Grievance_Policy – page 8, V, A, 1 Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) – page 19 2. CHP_GrievanceBrochure 3. VOCO_AppealTraining_2011 **Description of Process:** The BHO follows state and federal regulations for filing deadlines for grievances. Members have 30 calendar days from the date of the event to file a grievance. This time frame is noted in the grievance policy, 303L_Grievance_Policy , page 8, V, A, 1; in the BHO member handbook on page 19; in the grievance brochures, and on the BHO websites for CHP at http://www.coloradohealthpartnerships.com/members/pdf/CHP_Member_Handbook.pdf page 19.Staff is trained in these filing requirement time frames in the grievance training, VOCO appeal training 2011.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Grievance policy stated that the member must file a grievance within 30 calendar days of the date of the incident. The member handbook informed members of the 30-calendar-day filing time frame in easy-to-understand language. The brochure also informed members of the filing time frames.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
8. The Contractor sends written acknowledgement of each grievance within two working days of receipt. *42CFR438.406(a)(2)* *State Rule: 8.209.B*	**Documents Submitted/Location Within Documents:** 1. 303L_Grievance_Policy – page 9, V, A, 5 Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) – page 19 2. CHP_Acknowledgement_Letter 3. 2011DeskAuditToolforVODelegationAgt - Page 8 4. VO_CO_Grievance_Resolution_Work_flow.docx **Description of Process:** The BHO follows state and federal regulations for acknowledgement deadlines for grievances. The date the grievance is received sets the clock for response; this could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened is the date the grievance is filed. This date is logged in the member's grievance file. If the grievance is filed with the service center, the date is entered into the grievance data base. If the date is filed with an advocate or at a local OMFA office, the date is logged in the grievance data base of the facility. CHP uses 2-day acknowledgement letter templates that have been approved by the Department. This template is used to acknowledge the receipt of a grievance. Members are informed about the grievance process, including time frames, in the member handbook. Grievances and Appeals are a delegated function for CHP. During the BHO delegation audit, the auditor reviews grievances to assure that grievances that come to ValueOptions first are acknowledged in a timely manner.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The VO Grievance Process policy included the provision that members are sent a grievance acknowledgement letter within two working days of the receipt of the grievance. Members were informed via the member handbook about the grievance process, including the process of sending the grievance acknowledgement letter. CHP provided a grievance acknowledgement letter template. During the on-site interview, the CHP/VO grievance coordinator reported that acknowledgement letters were sent immediately upon receipt of a grievance by the VO grievance coordinator. The OMFA director confirmed that oversight of the timeliness of acknowledgement letters sent by the advocates at each CMHC was accomplished through delegation oversight.		
Required Actions: None.		
9. The Contractor must dispose of each grievance and provide notice of the disposition in writing as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the BHO receives the grievance. *42CFR438.408(b)(1) and (d)(1)* *State Rule: 8.209.5.D.1, 8.209.5.F*	**Documents Submitted/Location Within Documents:** 1. 303L_Grievance_Policy – page 10, V, A, 10 2. CHP_MemberHandbook_2011EQRO (Misc. Folder) – bottom page 19 3. CHP_Grievance_ResolutionLetter 4. 2011DeskAuditToolforVODelegationAgt - Page 8 **Description of Process:** The BHO follows state and federal regulations for grievance resolution deadlines. The policy, 303L_Grievance_Policy, page 10, V, A, 10, directs the process for handling grievances. The date the grievance is received sets the clock for investigating and resolving the grievance; this could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened. The person handling the grievance works to resolve the issue as quickly as possible, but takes no longer that 15 working days, (unless it is the member's best interest to extend the resolution time frame). The 15 working days is used to gather facts, consult with others and make assessments about the cause of the problem. When a reasonable resolution is found, the person handling the grievance notifies the member by letter.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Members are informed about the grievance process, including time frames, in the member handbook. Grievances and Appeals are a delegated function for CHP. During the BHO delegation audit, the auditor reviews grievances to assure that grievances that come to ValueOptions first are resolved in a timely manner.	
Findings: The VO Grievance Process policy included the provision to resolve each grievance and send the member written notice of the resolution within 15 working days from the day CHP received the grievance. The member handbook informed members of the grievance process including the process to send written notice of resolution within 15 working days of receipt of the grievance. CHP provided a grievance resolution letter template. During the on-site interview, CHP staff reported that oversight of the timeliness of resolution for grievances processed by the advocates at each CMHC was accomplished through delegation oversight. Staff reported that, as part of delegation oversight (VO's oversight of grievance processing by the CMHCs), the director of OMFA reviewed the CMHC's grievance policies and procedures, interviewed the advocates responsible for grievance processing, and reviewed any flyers regarding the grievance system posted at the CMHC sites.		
Required Actions: None.		
10. The written notice of grievance resolution includes: ◆ The results of the disposition/resolution process. ◆ The date it was completed. *State Rule: 8.209.5.G*	**Documents Submitted/Location Within Documents:** 1. 303L_Grievance_Policy – page 2, III, E and page 10, V, A, 10, b and d 2. CHP_Grievance_ResolutionLetter **Description of Process:** CHP uses grievance resolution letter template (CHP_Grievance_ResolutionLetter.doc) that has been approved by the Department. The Grievance policy requires that following the investigation, a resolution letter is mailed to the member/guardian/DCR. The letter contains the date the investigation and resolution was completed and the results. The facts of the resolution are described in the body of the letter in enough detail that the member understands the resolution and is	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	written in lay person language at a low grade reading level. The letter is sent on or before the 15 working day after the "grievance clock" starts.	
Findings: The VO Grievance Process policy stated that the required content of the grievance resolution letters included the results of the process, credentials of the person that reviewed the grievance, and the procedure for requesting a review by the Department. The grievance resolution template letter included all of the required information and the contact information for the Medicaid ombudsman's office.		
Required Actions: None.		
11. Members may file an appeal within 30 calendar days from the date of the notice of action. *42CFR438.402(b)(2)* *State Rule: 8.209.4.B*	**Documents Submitted/Location Within Documents:** Policy: 1. 305L_Appeal_Policy – page 1, III, A and page 6, V, A, 2 2. CHP_MemberHandbook_2011EQRO (Misc. Folder) – page 20 3. CHP_GrievanceBrochure 4. CHP Notice of Action Standard 2010NOV30.doc (Misc. Folder): 5. CHP Notice of Action Timely Svcs_2010NOV30.doc (Misc. Folder): **Description of Process:** The BHO follows state regulations for appeal filing deadlines. The appeal policy, *305L_Appeal_Policy, page 1, III, A and page 6, V, A, 2,* directs the process for handling appeals. The BHO uses letter templates, approved by the Department, to send to members/guardians/DCR's who are filing an appeal. The BHO has 13 variations of appeal letter templates, to respond to the various issues encountered in the appeal process (letter templates are filed in the misc. folder). Staff are guided by the Appeal policy, 305L_Appeal_Policy, page 1, III, A and page 6, V, A, 2, in handling and resolving appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Members are made aware of the time frames in the BHO member handbook, CHP Grievance Help Guide and BHO websites. A summary of the appeal process is also included in some variations of the appeal letter templates. The "appeal clock" starts on the date the Notice of Action is mailed. The member/ guardian/DCR has 30 days from this date to file the appeal.	
Findings: The VO Appeal Process policy included the provision that members may file an appeal within 30 calendar days of the date of the notice of action. The Appeal Training PowerPoint presentation also included the 30-calendar-day filing time frame. Members were notified of the filing time frame via the member handbook. The notice of action template letters also included the 30-calendar-day filing time frame.		
Required Actions: None.		
12. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42CFR438.402(b)(3)(ii)* *State Rule: 8.209.4.F*	**Documents Submitted/Location Within Documents:** 1. 305L_Appeal_Policy – page 1, III, B and pages 6 and 7, V, A, 2 2. CHP_MemberHandbook_2011EQRO (Misc. Folder) – top page 20 3. CHP_GrievanceBrochure 4. CHP Notice of Action Standard 2010NOV30.doc (Misc. Folder): 5. CHP Notice of Action Timely Svcs_2010NOV30.doc (Misc. Folder): **Description of Process:** The BHO follows state regulations for accepting appeals from members/guardians and DCR's. The appeal policy, 305L_*Appeal_Policy, page 1, III, B and pages 6 and 7, V, A, 2,* directs the process for how we can accept appeals. Staff are guided by the Appeal policy, 305L_Appeal_Policy, page 1, III, A and page 6, V, A, 2, in handling and resolving appeals.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	This section of the policy requires that the BHO must accept appeals orally or in writing, but an oral appeal must be followed in writing. OMFA staff can help the member put their appeal in writing if requested by the member/ guardian / DCR. If the member/ guardian / DCR request an expedited appeal, there is no requirement for the member to follow up in writing. Members are made aware of methods for filing an appeal in the BHO member handbook, CHP Grievance Help Guide and BHO websites. A summary of the appeal process is also included in some variations of the appeal letter templates.	
Findings: The VO Appeal Process policy included the provision that members may file appeals either orally or in writing. Members were informed via the notices of action, and the member handbook that appeals may be filed orally or in writing. The on-site appeal record review indicated that appeals were filed both orally and in writing.		
Required Actions: None.		
13. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms required, putting oral requests for a State fair hearing into writing, and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42CFR438.406(a)(1)* *State Rule: 8.209.4.C*	**Documents Submitted/Location Within Documents:** 1. 305L_Appeal_Policy : Page 2, III, D Page 3, III, I Page 7, V, 2 and 3a 2. 303L_Grievance_Policy -, page 1, III, E 3. VOCO_AppealTraining_2011 – slide 27 & 28 4. CHP_MemberHandbook_2011EQRO (Misc. Folder) – page 19 and 20 5. CHP_GrievanceBrochure 6. CHP NOA Templates (Misc. Folder): 7 Various NOA templates 7. LanguageLine_RefGuide_VO_2011APR20.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: Information about assistance for members filing appeals is provided in the member handbook, member denial letter and referenced in the Clinical Appeals policy. Assistance is available through interpreters if needed. *305L_Appeal_Policy, Page 2, III, D, Page 3, III, I and Page 7, V, 2 and 3a* reference assistance to be provided to members/guardians/DCRs in regards to the appeal process, including helping such individuals with putting oral requests into writing, or any other such activity of the appeal process. In addition, *303L_Grievance_Policy, page 1, III, E* also indicates that assistance will be provided to individuals who need help filing a grievance. Information is provided to members in Member Handbook about receiving assistance from OMFA in both the grievance and appeal processes. References to this guidance can be found on pages 19 and 20 in the CHP Member Handbooks. Furthermore, information is provided to members/guardians/DCRs through guidance brochures and help guides (CHP Grievance Help Guide). In each Notice of Action denial letter, the BHO advises members of the assistance they may receive to appeal the decision. For example, the CHP letter contains: ♦ If you need help with the appeal process, you can: • Call the CHP Appeals Coordinator at 1-800-804-5040, • Write to 7150 Campus Drive, Suite 300, Colorado Springs, CO 80920, • Call the Ombudsman for Medicaid Managed Care at 1-877-435-7123 (TTY 1-888-876-8864) 303 E. 17th St.: Denver, CO 80203, e-mail: help123@maximus.com	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Training materials cover the important role of assisting members/guardians/DCRs with the appeal process. In the VOCO appeal training 2011.pptx – slides 27 & 28, the grievance and appeal coordinator responsibilities are outlined and include tasks such as assisting member or DCR, helping Member submit forms, put appeal in writing, obtaining records to be used as evidence, securing translators and interpreters: use Relay for Deaf members, and help in other ways that will enable the member to submit the most effective evidence. Staff are trained using the language line as noted in LanguageLine_RefGuide_VO_2011APR20.pdf	

Findings:
The VO Grievance Process policy and the VO Appeal Process policy included the provision that CHP provides reasonable assistance including completing forms and providing interpreter services. The Appeals Training PowerPoint (appeals training) presentation and the complaints/grievance training both specifically stated that the grievance and appeals coordinator's role included providing assistance to members to put appeals in writing and to secure translators and interpreters. The member handbook informed members of the availability of assistance and interpreter services. The notice of action template letter offered "help" putting the appeal in writing. The Language Line Reference Guide described the process for obtaining Language Line services during telephone calls. During the on-site interview, CHP staff stated that the Language Line Reference Guide was used by any staff that had member contact. Staff also stated that for grievances filed through the member advocates at the CMHCs, the advocates also offered assistance.

Required Actions:
None.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
14. The Contractor sends the member a written acknowledgement of each appeal within two working days of receipt, unless the member or the designated client representative (DCR) requests an expedited resolution. *42CFR438.406(a)(2)* *State Rule: 8.209.4.D*	**Documents Submitted/Location Within Documents:** Policy: 1. 305L_Appeal_Policy – page 4, IV, A and page 8, V, A, 4 Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) – page 21 2. CHP_GrievanceBrochure 3. CHP Appeal Receipt Letter_2010NOV30.doc (Misc. Folder) 4. 2011DeskAuditToolforVODelegationAgt **Description of Process:** The BHO follows state and federal regulations for acknowledgement deadlines for appeals. The date the appeal is received sets the clock for response; this could be the date the phone call is received, the date the fax is received, the letter is opened, or in a few cases, the date the e-mail is opened is the date the appeal is filed. Since appeals can be filed orally, but must be followed with a written appeal, the first date of contact is the date that starts the "appeal clock." If an oral appeal is filed, the date is when the member/guardian/DCR orally filed. This date is logged in the appeals file for tracking purposes. Typically, the first point of contact for an appeal is to the VOCO service center, but sometimes, the first contact is with the local advocate or OMFA director. This is the first contact is the date the "appeal clock" starts. CHP uses 2-day appeal acknowledgement letter templates that have been approved by the Department. This template is used to provide written acknowledgement of the receipt of an appeal.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Members are informed about the appeal process, including time frames, in the member handbook and on the websites. Grievances and Appeals are a delegated function for CHP. During the BHO delegation audit, the auditor reviews appeals to assure that ValueOptions acknowledged the appeal in a timely manner.	
Findings: The VO Appeal Process policy included the provision to send the member a written appeal acknowledgement letter within two working days of receipt of the appeal. The member handbook informed members about the appeal process including the process to send a written acknowledgement within two working days of receipt of the appeal. CHP provided an appeal acknowledgement letter template. The on-site appeals record review demonstrated that the appeal acknowledgement letter was sent to the member within two working days of the receipt of the appeal in 10 of 10 cases reviewed.		
Required Actions: None.		
15. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date). ◆ The member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The contractor must inform the member of the limited time available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents considered during the appeals process. ◆ That included, as parties to the appeal, are: • The member and his or her representative; or • The legal representative of a deceased member's estate.	**Documents Submitted/Location Within Documents:** 1. 305L_Appeal_Policy: Page 1, III, A and B Page 3, III, G and H Page 6, V, A, 2 Pages 7 and 8, V, A, 3, e and f Page 15, V, A, 3, e 2. CHP_MemberHandbook_2011EQRO (Misc. Folder) - page 20 3. CHP_GrievanceBrochure 4. CHP NOA Templates (Misc. Folder): 7 Various NOA templates **Description of Process:** The BHO follows state and federal regulations to ensure that members/ guardians/DCR's can exercise all of their rights in the appeal process and that members have all access to appropriate files, can present evidence to substantiate their appeal, and that	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
42CFR438.406(b) *State Rule: 8.209.4.G, 8.209.4.H, 8.209.4.I*	oral inquiries will be treated as an appeal to establish the earliest filing date. Staff is guided by the appeal policy, 305L_Appeal_Policy. Section III.B provides that oral inquiries about appeals are treated as an appeal to set the earliest possible filing date. If a member calls to ask about an appeal, the staff taking the call will initiate the appeal process and the appeal clock start then. The staff will tell the member that their inquiry is being treated as an appeal, and will ask the member to follow up with a written appeal, document the oral appeal in both the EHR and in the appeal tracking data base. Staff will also offer to help the member/guardian/DCR with any aspect of the process. Section G of the policy provides that Members/ guardians /DCRs have the right to submit verbal or written comments, documents, records, and other information relating to the case. All submitted information will be taken into account in considering the appeal regardless of whether the information was submitted or considered in the initial decision. The Office of Member and Family Affairs collects all the information and forwards it, in a timely manner, to the person who is designated to make a decision on the appeal. Section V.3.f. provides that Members/ guardians /DCRs have the right before and during the appeal process, upon request, to receive copies of the member's BHO case file, including medical records and any other documents and records in the BHO's possession and considered during the appeal process. SectionIII.A. provides that Members/member's guardians or their designated client representatives (DCR) have the right to initiate the appeal of any Medicaid Action …, including adverse medical necessity determinations, up to 30 calendar days from the date of a Notice of Action. For members who are deceased, the member's legal	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	representative can act as a party to the appeal. Appeals are a delegated function for CHP. During the BHO delegation audit, the auditor reviews appeals to assure that ValueOptions upholds the rights of member/guardians/ DCRs in the appeal process. Members are informed about the appeal process, including time frames, in the member handbook, on the websites, for CHP at http://www.coloradohealthpartnerships.com/members/pdf/CHP_Member_Handbook.pdf page 20.	
Findings: The member handbook informed members that appeals may be filed by telephone, and that the member must follow-up in writing. The handbook stated that the OMFA will help with putting appeals in writing. The VO Appeal Process policy included the provisions that oral inquiries seeking to appeal an action are treated as appeals to establish the filing date and that members have the right to submit documents or records as well as receive copies of documents relevant to the appeal. The VO Appeal Process policy described parties to the appeal, as required. The member handbook informed members of the right to provide additional information. The notice of action template letters informed members of the short time available to do so if requesting an expedited resolution. None of the general member materials reviewed (member handbook, brochure, appeals guide) included information that members have the right to request and review records having to do with the appeal. The notice of action template letters, however, did inform members of this right. CHP might want to consider adding this information to the other member materials, as well.		
Required Actions: None.		
16. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: ◆ For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal.	**Documents Submitted/Location Within Documents:** 1. 305L_Appeal_Policy , page 12 and 13, V, D, 1, a-d 2. 2011DeskAuditToolforVODelegationAgt 3. CHP_MemberHandbook_2011EQRO (Misc. Folder) - page 21 4. CHP_GrievanceBrochure 5. CHP Appeal Decision Letter for Standard Appeals_2010NOV30.doc (Misc. Folder in NOA Templates) 6. Provider Manual_2011OCT01_PR (Misc. Folder) -	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42CFR438.408(b)(2)&(d)(2)* *State Rule: 8.209.4.J, 8.209.4.L*	Section 9, page 32 7. NOA_Appeal_Mail_Log.pdf 8. NOA_Appeal_Intranet_Log.pdf **Description of Process:** The BHO follows state and federal regulations for resolving and making decisions about the appeal and informing the member/guardian/DCR. Staff follows 305L_Appeal_Policy to resolve the appeal. Section, V, D, 1, a-d prescribes how we communicate the resolution of the appeal. Written notification of the appeals decision is sent in the form of a resolution letter to the member/guardian/DCR within the following time frames: I. For standard resolution of appeals, within 10 working days from the day the BHO receives the appeal; II. For expedited resolution of an appeal, within 3 calendar days from the day the BHO receives the appeal. The BHO standard is quicker than the standard in 8.209, in order to be compliant with URAC standards. III. The BHO will also make reasonable efforts to provide verbal notification of the appeal decision as soon as the decision is made, but no later than 72 hours. For Standard Appeals, the BHO uses a Department approved appeal decision letter template, CHP Appeal Decision Letter for Standard Appeals_2010NOV30.doc for CHP. Members are informed about the appeal process, including time frames, in the member handbook and on the websites. Providers are informed about the appeal process, including time frames for	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	notification of the resolution in the Provider Manual, (Misc. Folder), Section 9, page 32. Grievances and Appeals are a delegated function for CHP. During the BHO delegation audit, the auditor reviews appeals to assure that ValueOptions communicates of the resolution in a timely manner. The auditor uses 2011DeskAuditToolforVODelegationAgt - to review the appeals process.	

Findings:
Although the on-site appeals record review demonstrated that the resolution time frames for appeals were met in 10 of 10 records reviewed, there were inconsistencies among CHP's documents regarding appeals resolution time frames. The VO Appeal Process policy included the 10-working-day time frame for resolving appeals; however, the member handbook stated that the standard resolution time frame is 10 calendar days. The policy stated that the resolution time frame for expedited appeals is 3 calendar days or 72 hours. The member handbook stated the expedited resolution time frame as 3 working days. The policy included the provision to make reasonable efforts to verbally notify the member for expedited resolution of appeals. The member handbook notified members that they would receive a telephone call for expedited appeals. There were no examples of expedited appeals in the on-site record review samples. During the on-site interview, CHP staff confirmed that CHP's practice is to resolve standard appeals within 10 working days and expedited appeals within 3 calendar days as the 3-calendar-day time frame is related to URAC accreditation and more stringent than 3 working days. (See the Member Information standard, Requirement 13, for scoring specific to the member handbook information about appeal resolution time frames.)

Required Actions:
None.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
17. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: • The right to request a State fair hearing, and how to do so. • The right to request that benefits while the hearing is pending, and how to make the request. • That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action. *42CFR438.408(e)* *State Rule: 8.209.4.M*	**Documents Submitted/Location Within Documents:** Policy: 1. 305L_Appeal_Policy : Page 13, V, E, 1 and 3 Page 13, V, E, 4, c and d Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) – bottom page 22 2. CHP Appeal Decision Letter for Standard Appeals_2010NOV30.doc (Misc. folder NOA Templates) 3. CHP_Appeals_HelpGuide_2011 **Description of Process:** The BHO follows state and federal regulations for written notice to the member/guardian/DCR. Staff follow time frames noted in 305L_Appeal_Policy Page 13, V, E, 1 and 3; Page 13, V, E, 4, c. 1. V.E.1. states, "The written notice includes the results of the determination/resolution process and the date it was completed. 2. V.E.3. states, "For appeals not resolved wholly in favor of the member, the resolution letter includes: a. The reason that the action was upheld. b. The right to request a State Fair Hearing and how to do so. 3. V.4.C. & d. state, "For appeals not resolved wholly in favor of the member, when requested by the provider acting as DCR, the resolution letter includes: c. The right to request that benefits continue while the hearing is pending and how to make the request.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	d. The fact that the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's actions. For Standard Appeals, the BHO uses a Department approved appeal decision letter template, CHP Appeal Decision Letter for Standard Appeals.doc for CHP. This letter contains only the clinical rationale for the decision. In addition to the letter, we send an appeal guide along with the letter which explains all of the additional things members/DCR's/ need to know, including the fact that the right to request that benefits while the hearing is pending, and how to make the request, and member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action. Grievances and Appeals are a delegated function for CHP. During the BHO delegation audit, the auditor reviews appeals to assure that ValueOptions communicates of the resolution in a timely manner. The auditor uses 2011DeskAuditToolforVODelegationAgt - Section "Clinical and Utilization Management," number 4 to review the appeals process.	
Findings: The resolution letters reviewed during the on-site appeals record review included the required information. VO had developed new template resolution letters for appeals related to new requests for service and for appeals related to the termination, suspension, or reduction of previously authorized services. The content of the letters were not consistent with requirements. CHP should review these letters and ensure that they meet requirements prior to implementation. VO Appeal Process policy included the required content of appeal resolution letters; however, the content for letters regarding the request for continuation of previously authorized services and liability for cost if the adverse decision is upheld was listed as required content only if providers requested the appeal on behalf of the member.		
Required Actions: CHP must revise its policy to clearly state that language regarding continuation of previously authorized services is required (if applicable) regardless of whether the member or the provider, acting as the DCR, requested the appeal.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
18. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: ◆ Were not involved in any previous level of review or decision-making. ◆ Have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. *42CFR438.406(a)(3)(ii)* *State Rule: 8.209.4.E, 8.209.5.C*	**Documents Submitted/Location Within Documents:** Policies: 1. 305L_Appeal_Policy - page 5, IV, D 2. 303L_Grievance_Policy - page 10, V, A, 10 3. 203LMedicalNecessityDetermination_Policy_SC_Cl 4. CHP Appeal Decision Letter for Standard Appeals_2010NOV30.doc (Misc. folder NOA Templates) Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) - page 19 2. CHP_Appeal_FlowChart 3. CHP Extension of decision date for Standard Appeal_2010NOV30 – (Misc. Folder, CHP NOA templates) 4. CHP Notice of Action Already Authd Svc_2010NOV30 - (Misc. Folder, CHP NOA templates) 5. VOCO_Grievance_Resolution_FlowChart **Description of Process:** The BHO follows state and federal regulations for ensuring that individuals who made decisions on grievances and appeals were not involved in the original appeal decision or grievance event, and have the expertise to make the final determination, whether it be clinical (for appeals) or administrative or clinical (for grievances). 305L_Appeal_Policy, page 5, IV, D defines the credentials for a peer advisor. Peer advisors are the individuals who review denial decisions. The CHP Appeal Decision Letters contain the peer advisor's credentials and an attestation that the peer advisor was not involved in any decision making relative to the initial denial.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	203LMedicalNecessityDetermination_Policy_SC_Cl.doc describes who can make a medical necessity determination. This is the basis for approving or denying level of care. The CHP Appeal Flow Chart describes the process for making appeal decisions. 303L_Grievance_Policy , page 10, V, A, 10 note that individuals involved in making decisions about the grievance were not involved in the event being grieved and have the appropriate clinical expertise to make the determination. This section covers any grievances involving clinical issues, including grievances regarding the denial of expedited resolutions of appeals are referred to staff who have the clinical expertise to make clinical decisions, such as the Medical Director, Peer Advisor, or Clinical Director. Members are informed of this in the member handbooks page 19.	

Findings:
The VO Appeal Process policy stated that the individual who makes decisions on appeals will have a current, unrestricted license to practice medicine or other health profession and have a same or similar profession as the requesting health care professional. The policy also stated that the individual making appeal decisions will not be the individual or a subordinate to the individual who make the original denial decision. The VO Grievance Process policy included a similar statement. The Appeal Decision Template letter had a field for the individual to describe his or her credentials. The VO Grievance Resolution letter template had a field to enter the credentials of the person consulted with to resolve the grievance. The Grievance Process and the Appeals Process Workflow charts specified routing to someone with appropriate clinical expertise, if needed, and not involved in the previous review level. The on-site appeals record review demonstrated that individuals who made the appeal decision were individuals who had not been involved in the original action and were either the medical director or qualified designee.

Required Actions:
None.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
19. The contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: ◆ The member requests the extension; or ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest. ◆ If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay. *42CFR438.408(c)* *State Rule: 8.209.4.K, 8.209.5.E*	**Documents Submitted/Location Within Documents:** 1. 305L_Appeal_Policy : Pages 2 and 3, III, E and F Page 11, V, C, 5 Page 12, V, D, 1b and 1d 2. 303L_Grievance_Policy - page 11, V, A, 13 Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) - pages 19, 21 and 22 2. CHP_GrievanceBrochure 3. CHP_Grievance_ResolutionExtensionTemplate 4. CHP Extension of decision date for Standard Appeal_2010NOV30 (Misc. folder in NOA Templates) 5. CHP_NOATemplate_InfoNeeded_CHP_2011JAN20_Cl (Misc. Folder) 6. NOA_Appeal_Mail_Log.pdf 7. NOA_Appeal_Intranet_Log.pdf **Description of Process:** CHP follows all state and federal guidelines for extending time frames for resolution of grievances and appeals (both expedited and standard) by 14 calendar days. 303L_Grievance_Policy, page 11, V, A, 13 provides that The time frame for resolution of a grievance may be extended up to 14 calendar days if: (a) The member requests the extension; or (b) In reviewing the grievance, there is a need for additional information and that the delay is in the client's best interest. The organization that is investigating the grievance shall give the member prior written notice of the reason for the delay if the time frame is extended.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	305L_Appeal_Policy V.C.5 provides that If the information provided is inadequate to make a determination, the Reviewer may extend the time frame for the resolution of a standard appeal by up to 14 calendar days if: (a) The member/guardian/DCR requests the extension; or (b) The Reviewer shows that there is a need for additional information and how the delay is in the member's interest. CHP provides written notice that the grievance extension is being requested in CHP_Grievance_ResolutionExtensionTemplate.doc. CHP provides written notice of the appeal decision extension using CHP Extension of decision date for Standard Appeal_2010NOV30.doc for CHP. If the CHP member needs more information, they will receive NOATemplate_InfoNeeded_CHP_2011JAN20_Cl.doc. Members are informed of this process in the member handbook, CHP_MEMBERHANDBOOK_2011EQRO (MISC. FOLDER), pages 19, 21 and 22.	
Findings: The VO Grievance Process policy and the VO Appeal Process policy both included the provision to extend the time frames for resolution of standard and expedited appeals and grievances (as applicable to the policy). The grievance extension letter template and the appeal extension letter template included fields for including the reason for the extension. Members were informed of the extension process via the member handbook. There were two appeal resolution extensions reviewed during the on-site appeals record review. These records included a copy of the required extension letter notifying the member of the reason for the delay.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
20. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action. *42CFR438.402(b)(2)(ii)* *State Rule: 8.209.4.N*	**Documents Submitted/Location Within Documents:** 1. 305L_Appeal_Policy - page 2, III, C Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) - pages 21 and 22 2. CHP_GrievanceBrochure 3. CHP NOA Templates (Misc. Folder): 7 Various NOA templates **Description of Process:** 305L_Appeal_Policy III.C. provides that Members/member's guardians or their designated client representatives (DCR) have the right to be informed that they also have a right to file an appeal to a State Administrative Law Judge (ALJ) for a State Fair Hearing. Members are not required to file an appeal with the BHO prior to filing for a State Fair Hearing. Members may file appeals with both the BHO and the ALJ and in any order. Members may file an appeal with the ALJ without ever filing an appeal with the BHO. 305L_Appeal_Policy III.D. provides that Members/member's guardians or their designated client representatives (DCR) have the right to be informed clearly in writing of their deadline for filing an appeal to the BHO or to the ALJ. Because the member has only 30 calendar days to file either appeal, members will be encouraged to file an appeal with the ALJ immediately in order to preserve this right, even though the member intends to also appeal to the BHO. The Notice of Action Standard letter informs members about their right to make an appeal to the ALJ at any time states: You also have the right make an appeal to an Administrative Law Judge:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	♦ You can also appeal directly to an Administrative Law Judge (ALJ) for a State Fair Hearing without first appealing with CHP. If you appeal first to CHP, you can still appeal to the ALJ. However, you must make each of these appeals by the deadline below. The deadline applies to both your appeal to CHP and to your appeal to an ALJ. We encourage you to file with the Office of Administrative Courts at the same you file with CHP. This way you will not lose your right to a State Fair Hearing. The Member Handbooks tell members about their right to file with the ALJ on page 20 & 21.	
Findings: The VO Appeal Process policy stated that members may file the CHP-level appeal or request a State fair hearing in any order or may request the State fair hearing without using the CHP-level appeal. The member handbook informed members of the 30-calendar-day filing time frame for each and encouraged members to file the CHP-level appeal and request the State fair hearing at the same time. The appeal resolution template letters also provided the time frame and method for requesting a State fair hearing. The appeal resolution letters reviewed on-site during the appeals record review informed members of the 30-calendar-day filing time frame.		
Required Actions: None.		
21. The Contractor maintains an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for	**Documents Submitted/Location Within Documents:** 1. 305L_Appeal_Policy : Page 6, IV, F Page 8, V, A, 5 Page 12, V, C, 6 Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) - page 21 2. CHP Denial of Request for Expedited Appeal_2010NOV30 (Misc. Folder, CHP NOA templates) 3. VOStd_PractitionerAgmt_0809_FINAL_20100708- page 8, section 6.2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice. *42CFR438.410* *State Rule: 8.209.4.P–.R*	**Description of Process:** 305L_Appeal_Policy provides that Members/member's guardians or their designated client representatives (DCR) have the right to be informed that they may also request an Expedited Appeal in situations where the life, safety, or fullest recovery of the member would be put at risk by an appeal resolution that is within the standard time frames. The time frame for resolution of an expedited appeal is 72 hours for verbal notification to be provided to the member or requesting party, to be followed by written notification within 3 calendar days. 305L_Appeal_Policy provides that No punitive action may be taken against a provider, acting as a DCR, who requests an expedited resolution or supports a Member's appeal. And relative to informing the member, If possible, verbal notification of the appeals decision for inpatient services and expedited appeals is given to the Member/DCR and provider on the same day as the decision, and for expedited appeals, no later than72 hours from the time the request was received. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf, page 8, section 6.2 informs providers of this provision. Members are informed about their basic rights to an expedited appeal in the member handbook.	
Findings: The VO Appeal Process policy described the expedited appeal process and included each of the required provisions. The Practitioner Agreement Template stated the VO shall not terminate a practitioner that advocated for a member or filed an appeal or a complaint. The template letter for denial of the expedited process explained the reason for denying the expedition, the standard time frame, and informed members that they may file a grievance if they disagreed with the decision to deny the expedited process. Members were informed about the expedited appeal process via the member handbook. There were no examples of expedited appeals in the on-site record review cases.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
22. The Contractor provides for continuation of benefits while the BHO-level appeal and the State fair hearing are pending if: ◆ The member or the provider files timely*—defined as on or before the later of the following: • Within 10 days of the Contractor mailing the notice of action. • The intended effective date of the proposed action. ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. **This definition of timely filing only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.* *42CFR438.420(a) and (b)* *State Rule: 8.209.4.S*	**Documents Submitted/Location Within Documents:** 1. 305L_Appeal_Policy - pages 8 and 9, V, B, 1-3 Member Handbook: 1. CHP_Memberhandbook_2011EQRO (Misc. Folder) - page 22 2. ProviderManual_2011OCT01_PR, (Misc. Folder) - Section 9, page 31 **Description of Process:** The Appeals Policy , 305L_Appeal_Policy, pages 8 and 9, V, B, 1-3, provides for the following: A. Continuation of Services during the Appeal Process Only under Certain Circumstances 1. Upon member/guardian/DCR request, services will be continued during the appeal of the termination, suspension, or reduction of a *previously* authorized service. For example, if a valid authorization for 30 days of residential services is terminated after only 15 days. 2. In order to obtain continued services, a member appeal must be filed on or before the later of the following: a) Within ten (10) calendar days of the BHO mailing the Notice of Action; or b) Within ten (10) calendar days of the intended date of the BHO's proposed action (i.e., before services actually terminate). 3. Previously authorized services may be continued only if ALL the following criteria are met: a) The member/guardian/DCR or provider with written	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	consent of the member files the appeal timely; b) The services were ordered by an authorized provider; c) The original period covered by the original authorization has not expired; and d) The Member requests extension of benefits (services). 4. If the requested service continues it is for a limited time until one of the following occurs: a) The member withdraws the appeal; b) Ten (10) calendar days pass after the BHO mails the notice providing the resolution of the appeal upholding the original BHO termination, suspension, or reduction of services, unless the member, within a ten (10) calendar day time frame makes a request for a State Fair Hearing with continuation of services until a State Fair Hearing decision is reached; Members are made aware of these requirements through the member handbook and providers are aware through Provider Manual, (Misc. Folder), Section 9, page 31	

Findings:
The VO Appeal Process policy included the provision for continuation of previously authorized services during the appeal or the State fair hearing. The policy, while somewhat awkward, was accurate. The CHP Help Guide for Appeals was incorrect in its description of this right. The help guide stated that the appeal must be filed within 10 calendar days of the notice of action or, "10 calendar days from the day when the treatment is scheduled to stop or change, whichever is later." CHP may want to review and revise policies to clarify the continuation of benefits provision. CHP may also want to consider revising the help guide to combine the timely filing discussion on page 6 with the continuation of services discussion on page 7 for clarity. The policy and the PowerPoint training presentation included an example which illustrated the situation accurately; however, CHP may want to consider clarifying the example to ensure understanding that services would not be terminated without the required 10-day advance notice per 42CFR438.404(c)(1)/

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
42CFR431.211. (See the Member Information standard, Requirement 13, for scoring specific to the member handbook information about continuation of benefits.) Although the Appeals Help Guide had not been sent with the notices of actions for the appeals records reviewed on site, CHP staff stated that CHP was in the process of implementing the process of sending the help guide with notices of action.		
Required Actions: CHP must revise the Appeals Help Guide to state that members may request the continuation of previously authorized services during the appeal or State fair hearing if: ♦ The appeal is filed timely—defined (only for continuing benefits) as within 10 calendar days of the date of the notice of action, or before the intended effective date of the action, whichever is later. ♦ The appeal involves the termination, suspension, or reduction of previously authorized services. ♦ The services were ordered by an authorized provider. ♦ The original period covered by the original authorization has not expired. ♦ The enrollee requests the extension of services.		
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten days pass after the Contractor mails the notice providing the resolution (that is against the member) of the appeal, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. ◆ A State fair hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. *42CFR438.420(c)* *State Rule: 8.209.4.T*	**Documents Submitted/Location Within Documents:** 1. 305L_Appeal_Policy - page 9 and 10, V, B, 4 Member Handbook: 1. CHP_MemberHandbook_2011EQRO (Misc. Folder) - page 22 2. ProviderManual_2011OCT01_PR, (Misc. Folder) - Section 9, page 31 **Description of Process:** Appeals policy, 305L_Appeal_Policy , page 9 and 10, V, B, 4, provides that If the requested service continues it is for a limited time until one of the following occurs: A. The member withdraws the appeal; B. Ten (10) calendar days pass after the BHO mails the notice providing the resolution of the appeal upholding the original BHO termination, suspension, or reduction	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	of services, unless the member, within a ten (10) calendar day time frame makes a request for a State Fair Hearing with continuation of services until a State Fair Hearing decision is reached; C. A State Fair Hearing Office issues a hearing decision adverse to the member; or D. The time period of the previous authorization of the services expires This information is contained in the CHP member handbook on page 22. And in the provider manual Provider Manual, (Misc. Folder), Section 9, page 31.	

Findings:
The VO Appeal Process policy included the provision for continuation of previously authorized services during the appeal or the State fair hearing, which contained the correct information regarding the duration of continued services. The help guide stated that services will continue until one of the following occurs (copied verbatim from the help guide):

- The member withdraws the appeal.
- 10 days pass after the BHO mails the *notice of action* and you have asked for a State fair hearing.
- You have asked for a State fair hearing and their decision is to stop your services.
- The original authorization for your service has expired.

(See the Member Information standard, Requirement 13, for scoring specific to the member handbook information about continuation of benefits.)

Required Actions:
CHP must revise the Appeals Help Guide to state that, if requested, services must be continued until one of the following:

- The member withdraws the appeal.
- Ten days pass after the BHO mails the notice providing *resolution* of the appeal against the member, *unless* the member, within the 10-day time frame, has requested a State fair hearing.
- A State fair hearing officer issues a hearing decision adverse to the member.
- The time period or service limits of the previously authorized service have been met.

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
24. Effectuation of Appeal Resolution: ◆ If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. *42CFR438.420(d), 42CFR438.424* *State Rule: 8.209.4.U–W*	**Documents Submitted/Location Within Documents:** 305L_Appeal_Policy.doc – Pages 8, 12-14 **Description of Process:** *305L_Appeal_Policy.doc*—This clinical policy defines the member's right to appeal any notice of action. It includes time frames for appeal and information about the various routes of appeal, including the State Fair Hearing Process. Section V.B.1 (p. 8)—This portion of the policy indicates that services may be continued during the Appeal Process under certain circumstances: "Upon member/guardian/DCR request, services will be continued during the appeal of the termination, suspension, or reduction of a *previously* authorized service. For example, if a valid authorization for 30 days of residential services is terminated after only 15 days." Section V.E.4.d (p. 13)—For appeals that are not resolved in favor of the member, the Contractor may attempt to recover the cost of the services furnished to the member while the appeal was pending. This information is communicated to the member at the time of appeal and in the appeal resolution letter: "the member may be held liable for the cost of these benefits, if the hearing decision upholds the Contractor's actions." Section V.E.1 (p. 12-13)—Written Notice of Results of Resolution for appeals resolved in the member's favor: "For appeals resolved in the member's favor, the resolution letter will include the actions the BHO has	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	taken [or will take] to fulfill the member's request or to redress the action." Section V.G (p.14)—Implementation of Final Resolution Results: "If the designated Reviewer or Administrative Law Judge upholds the appeal, the [BHO's] Grievance and Appeals Coordinator will insure that the disputed service or resolution is authorized or implemented expeditiously."	
Findings: The VO Appeal Process policy included effectuation language embedded within the context of content of the appeal resolution letter. CHP may want to clarify the policy to describe CHP's processes regarding effectuation of appeal decisions related to the termination, suspension or reduction of previously authorized services. Members were informed via the member handbook that they may have to pay for services that were continued during the appeal or the State fair hearing if the final decision is not in favor of the member.		
Required Actions: None.		
25. The Contractor maintains records of all grievances and appeals and submits quarterly reports to the Department. *42CFR438.416* *State Rule: 8.209.3.C*	**Documents Submitted/Location Within Documents:** Policies: 1. 305L_Appeal_Policy - pages 15 and 16, V, I 2. 303L_Grievance_Policy - pages 12 and 13, V, C 3. CHP_GrievanceDB_Screenshot 4. CHP_GrievanceStateReport_Q4FY11 5. CHP_StateQtrlyReport_Analysis_FINAL_Q4FY11 6. ComplaintSummary_QISC_FY11_FINAL.doc (CHP) 7. Appeals_CHP_Q4FY11_2011APR11 8. NOA_Appeal_Mail_Log.pdf 9. NOA_Appeal_Intranet_Log.pdf **Description of Process:** *305L_Appeal_Policy, pages 15 and 16, V, I* describes the documentation that is maintained by the Grievance and Appeal Coordinator in regards to appeals of a clinical nature or other	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	appeals. *303L_Grievance_Policy, pages 12 and 13, V, C* also outlines reporting, tracking, and trending information for grievances. The BHO maintains a Grievance database in which all relevant information regarding grievances is recorded. This security enabled database is accessible to BHO OMFA staff, including local mental health center advocates, via log in and password. Data recorded includes, but is not limited to, the date the grievance is received, who filed the grievance and contact information, nature of the grievance, resolution, and date of grievance resolution (refer to the Grievance Data Base Screen Shots). The VO Grievance and Appeal Coordinator, with BHO OMFA oversight, compiles the database information and submits the required quarterly reports to the Department within 30 days of the end of the quarter. These quarterly reports also include information required to be reported on appeals. The /Clinical Department maintains an appeal report that captures the nature of the appeal, expedited or standard, the resolution, the number of appeals that resulted in positive outcome for the member and the number of grievances that were denied. This detailed information is compiled by the clinical department. CHP has comprehensive systems to collect grievance/appeals data. This data is used not only to provide reports to the state, but to OMFA, quality, and clinical committees and the executive management boards. The reports are used internally to determine opportunities for improvement of processes, and identify quality of care issues. 305L_Appeal_Policy, pages 15 and 16, V, I provides that the grievance coordinator keeps a record of all appeals and grievances. 303L_Grievance_Policy, pages 12 and 13, V, C provides that the grievance coordinator will track and report on	

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	grievances and describes how they do that. CHP has a unique grievance data base. Grievance data is entered into the data base after a grievance has been resolved. This data base is used to create reports for both the state and the committees. CHP GrievanceDB Screenshot shows screen shots of the data base. A demonstration can be provided on site. Reports are provided to committees, boards, etc. Complaint Summary QISC FY11_FINAL (2).doc (CHP) is the annual summary provided to the CHP boards. Appeals are tracked by the grievance coordinator and the clinical coordinator. Appeals_CHP_Q4FY11_2011APR11.xls is the grievance coordinator's tracking log for CHP. These are used to compile state reports. CHP_StateQtrlyReport_Analysis_FINAL_Q4FY11 is the analysis of the state report for CHP. CHP_GrievanceStateReport_Q4FY11 is the state report for CHP.	
Findings: The VO Appeal Process policy and the VO Grievance Process policy stated that all documentation for grievances and appeals is maintained by the CHP/VO grievance coordinator. The VO Grievance policy stated that the grievance reports are reviewed by the OMFA director for trends. The Quarterly Grievance and Appeal reports submitted to the Department demonstrated CHP's documentation and reporting of grievances and appeals. In addition, CHP produced more detailed grievance and appeal trending reports for internal use and presentation to the quality management committees and the CHP boards, as evidenced by review of reports and committee meeting minutes. The on-site appeals record review and on-site review of the grievance database demonstrated CHP's recordkeeping for both grievances and appeals, and CHP's ability to produce grievance and appeal data for quality improvement purposes.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
26. The Contractor must provide the information about the grievance system specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing. • The rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. • If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The member's right to have a provider file a grievance or an appeal on behalf of the member, with the member's written consent. *42CFR438.414* *State Rule: 8.209.3.B*	**Documents Submitted/Location Within Documents:** ProviderManual_2011OCT01_PR – Sections 9 and 15 **Description of Process:** Providers are informed of the members' right to file grievances and appeals by way of the Colorado Medicaid BHO provider manual. The provider manual includes language on the State fair hearing process, time frames for filing said appeals and the member's right to have a provider appeal on their behalf.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The provider manual included detailed information about the grievance system and CHP's processes, except to notify the provider that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.		
Required Actions: CHP must ensure that providers are notified that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.		

Results for Standard VI—Grievance System							
Total	Met	=	22	X	1.00	=	22
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	26	**Total Score**		=	22

Total Score ÷ Total Applicable	=	85%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has a robust and thorough process, described in written policies and procedures, to evaluate potential providers before they provide care to members, and to reevaluate them periodically thereafter. The Contractor has adopted NCQA credentialing and recredentialing standards and guidelines for provider selection. *42CFR438.214(a)* *Contract: II.G.3.a, Exhibit O: I.A, I.B.3*	**Colorado Health Partnerships (CHP) delegates Standard VII to ValueOptions® as per the following policies:** ♦ **CHP_ProviderNetworkDelegation_Policy.pdf** ♦ **CHP_QMDelegation_Policy.pdf** **Documents Submitted/Location Within Documents:** 1. N203_FacilityCredentialingPolicy_2011OCT01_PR - Entire Policy 2. N201_PracCredentialingPolicy_2011OCT01_PR - Entire Policy 3. N501_PracRecrePolicy_2011OCT01_PR - Entire Policy 4. N502_FacilityRecrePolicy_2011OCT01_PR - Entire Policy 5. N101_OverviewNNS_2011OCT01_PR - Entire Policy **Description of Process:** ValueOptions® reviews providers upon initial credentialing and recredentialing to evaluate providers who participate in the Colorado Medicaid network. Recredentialing occurs on a 3 year, or 36 month cycle. ValueOptions® process meets NCQA guidelines and is reviewed annually to ensure compliance.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The final delegation agreement between CHP and VO (July 2011) specified that CHP delegated credentialing and recredentialing functions to VO, including gathering and entering data about network providers into the credentialing database, reviewing and processing credentialing applications in accordance with NCQA standards, conducting licensure and sanction checks on all providers, conduct credentialing committee meetings, and ensuring provider contacts and site visits are completed. The CHP Credentialing/Recredentialing—Delegation Oversight policy stated that the responsibility of CHP is to evaluate, through an annual audit, the capabilities of the delegate (VO) to adequately perform the requirements of credentialing and recredentialing of practitioners in accordance with the standards and policies of CHP. The policy outlined the procedures for delegation and annual oversight, as well as the criteria for the annual evaluation of the delegate. The VO Overview of National Network Services policy described the role and responsibilities of the corporate-level national network services department in the development and management of a national network of providers, which included credentialing, network adequacy and quality monitoring.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**

The VO Practitioner Credentialing policy outlined the detailed operational procedures for processing a provider application, including the organization and verification of information in the credentialing file by staff, documentation of all information in the Network Connect Credentialing module, administrative review of file information and recommendations for approval, forwarding of clean files to the medical director, and other recommendations to the National Credentials Committee for final determination. The policy specified that the administrative review of file information was based on discipline-specific criteria. The VO Discipline-Specific Credentialing Criteria policy outlined the specific licensure, education, and experience requirements for each practitioner discipline (e.g., psychiatrist, social worker). The VO Practitioner Recredentialing policy specified that recredentialing applications are sent to the provider four months prior to the recredentialing date, which is tracked through the credentialing module. The policy described, in addition to the operational procedures outlined in the VO Provider Credentialing policy, that a credentialing specialist gathers and reviews provider-specific utilization management indicators, quality indicators and complaints for consideration by a peer reviewer and the National Credentials Committee, as necessary.

The VO Facility Credentialing policy and VO Facility Recredentialing policies outlined the procedures related to the credentialing of organizational providers. The policies described the administrative procedures for preparation and verification of applicant information, which were similar to that outlined in the VO Practitioner Credentialing/Recredentialing policies, with the following exceptions: the organizational accreditation status is verified, an on-site visit is performed for nonaccredited facilities, and the administrative review of the file is based on criteria specific to organizational providers. The VO Credentialing Criteria for Facility/Organizational Providers policy outlined requirements for licensure and certifications, accreditation, malpractice history, liability insurance, and program-specific criteria. All credentialing and recredentialing policies stated that approvals were communicated in writing to the provider within 60 days of determination, including an executed provider contract, and denials were communicated in writing within five days of determination, including reason for denial and information concerning the provider appeal process.

During the on-site interview, staff members explained that provider credentialing functions had been delegated by CHP to VO for independent providers and that the partner CMHCs functioned as organizational providers who performed credentialing of the practitioners within their facilities. VO staff members stated that provider credentialing functions and determinations are primarily made at the VO national level after the local credentialing committee (LCC) reviews new applicants against network adequacy information, primary source verification information, and any quality of care committee recommendations. The LCC consists of CHP partners, providers, and staff members who make recommendations to the National Credentials Committee. All credentialing files and related provider information are gathered and maintained in the Network Connect electronic provider file cabinet, which ties all provider information from multiple sources together in one system location. Access to various components of the provider files is allowed through "need to know" security clearances and ensures that provider credentials and performance are tracked and integrated into other functions, such as claims payment and authorization functions. Staff stated that primary source verification, which includes screening of the Office of Inspector General (OIG) and licensure databases, is performed on initial credentialing and monthly for both facilities and independent providers. In addition, recredentialing, performed every 36 months, considers provider quality performance data which accumulates in the automated provider credentialing file. Staff reported that CHP credentialing functions continue to be NCQA-Certified.

Required Actions:
None.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
2. The Contractor has policies and procedures that describe methods of ongoing provider monitoring and that include: ◆ The frequency of monitoring. ◆ How providers are selected to be reviewed. ◆ Scoring benchmarks. ◆ The way record samples will be chosen. ◆ How many records will be reviewed. (The Department encourages a survey checklist for the actual provider visits.) *Contract: Exhibit O: I.A.2*	**Documents Submitted/Location Within Documents:** 1. 306MeasurementofAccessandAvailability_Policy_SC_QM – Section V, Pages 3- 7 2. 309QualityofCareIssuesandOutlierPracticePatterns_Policy_SC_QM – Section V, Pages 4-11 3. IV40312_ProviderTreatmentRecordReviewAnalysisandReporting_Policy_SC_QM.docx – Sections III, IV, and V, Pages 1-4 4. 403PractitionerOutptTxRecRevAttachmentA_Policy_SC_QM – Entire attachment 5. 403PractitionerOutptTxRecRevAttachmentB_Policy_SC_QM – Entire attachment 6. AuditTool_ClinicalClaimsScores_3BHO_2011Apr13 – Entire document 7. FY2010_ContractCompliance_FINAL_auditor.xlsx – Entire document 8. 259LEnhancedCLMgmtofOPServices_Policy_SC_Cl_Sept2011 (2).docx – Section V, Pages 2-7 9. Acute_Inpatient_Treatment.doc – Section VI, Page 4 **Description of Process:** CHP conducts a variety of provider monitoring activities, including access to services data gathering and emergent call testing, quality of care investigations, and treatment record audits and follow-up. These activities are described in policies: ◆ 306MeasurementofAccessandAvailability, ◆ 309QualityofCareIssuesandOutlierPracticePatterns, and ◆ 403PractitionerOutptTxRecRevAnalysis&Rptg (including Attachments A and B). Detailed information on the number and frequency of routine treatment record audits, selection of records, and scoring	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	benchmarks are included in attachment A to Policy 403. A medical record audit tool (excel spreadsheet titled AuditTool_ClinicalClaimsScores) is included as well. In addition, CHP conducts mental health center contract compliance audits annually to review compliance with applicable Medicaid contract requirements. The FY2010 Contract Compliance Audit Tool is included for review as an example of the areas monitored. In addition, policy *259LEnhancedCLMgmtofOPServices_Policy_SC_Cl* identifies the criteria for enhanced clinical management of clinical and utilization management outliers. Higher level of care services are monitored for continued medical necessity according to the frequency identified in the Level of Care Guidelines (e.g., Acute Inpatient Treatment, at least every 7 days; see *Acute_Inpatient_Treatment.doc)*	

Findings:
The VO Practitioner Recredentialing policy stated that recredentialing is conducted for each provider every three years and includes review of provider-specific performance indicators and thresholds for performance in utilization management, quality, and grievances . Specific measures and thresholds were defined in the policy.

The VO Treatment Record Documentation Audit policy specified that two records per independent provider were audited for five treatment record components with a scoring benchmark of 80 percent, and that frequency of follow-up audits was dependent on the pass/fail outcome of the initial audit. The VO Provider Treatment Record Review, Analysis and Reporting policy stated that VO conducts regular treatment record audits of service providers, which may be based on a random sample of members by provider or provider volume, service type, quality initiative, quality of care review, or other selection criteria. The policy described routine review as a random sampling of records to review appropriateness of documentation and adherence to clinical practice/treatment guidelines, and follow-up review as a re-review if the criterion of 80 percent was not met. The Audit Tool Clinical Claims Scores document listed multiple criteria for treatment record evaluation and the scoring methodology for the tool. The Residential Treatment Center Discharge Plan audit specified the number of records audited, how the sample was selected, the criteria applied, and the results. The VO Enhanced Clinical Management of Outpatient Services policy described monitoring of provider treatment records for justification of services beyond a specified number of treatments or clinical evidence to support the diagnosis for several pre-defined categories of patients. The criteria and methods of selecting records for review were outlined.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
The VO Measurement of Access and Availability policy stated that VO systematically and scientifically assesses the accessibility of behavioral health services and implements corrective actions when indicated. The policy described that partner CMHCs track and submit data quarterly to VO regarding appointment availability for emergent, urgent, and routine appointments. Independent providers are monitored through open shopper calls, and calls to monitor the 15-minute emergency call response time frame. These calls are conducted quarterly for a sample of providers. Client satisfaction surveys regarding access to services are conducted semiannually, and grievances regarding access are tracked, for review in the quality improvement committees. The VO Quality of Care Issues and Outlier Practice Patterns policy described the investigation of adverse events on an individual case basis as identified through grievances or other methods and trending of quality of care concerns based on the adverse event assessments.		
Required Actions: None.		
3. The Contractor monitors covered services rendered by provider agreements for: ◆ Quality ◆ Appropriateness ◆ Patient outcomes ◆ Compliance with: • Medical record requirements • Reporting requirements • Applicable provisions of the BHO's contract with the Department. *Contract: II.G.10.a.3–4*	**Documents Submitted/Location Within Documents:** 1. N701_ProviderCompliance_2011OCT01_PR – Entire document 2. ChrtAudResults_ReportQ2FY11_CHP_2011Feb23_QM.docx – Entire document 3. PhelpsM(CanasA&BorregoJ)_PassAudLtr_CHP 2011Jun08_QM.docm – Entire document 4. FY2010ContractComplianceAudit_Results_AspenPointe_2010Nov12_QM.xlsx – Entire document 5. FY10ContractComplianceCover_Letter_AspenPointe_2010Nov12_QM.doc – Entire document 6. CHPFY11_411_AuditSummary_HSAG.docx – Entire document 7. SF12_Report_2011Aug_BHO_updated.xlsx – Entire document 8. CHPQ4FY11_IPNemergencyAccesstoCare_Calls_2011May_QM.xlsx – Entire document 9. CHPQ1FY12_IPNemergencyAccesstoCare_Calls_2011Sept_QM.xlsx – Entire document 10. CY11CCARUpdate_Letter_CHP_2011Sep27_QM 11. DPAuditResults_Report_VO_2011Aug09_QM.docx – Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	12. ProvAdverseIncident_Report.pdf – Entire document 13. ECM_Prov_Cover_Letter_IPN_3BHO.pdf – Entire document 14. ECM_Prov_Report_Template_2011Sep27_3BHO.pdf – Entire document 15. ECM1_CHP.pdf – Entire document **Description of Process:** Evidence and examples of provider monitoring are included as follows: ♦ Chart Audit Results (*Quality, Appropriateness, Compliance with Medical Record Requirements*) ♦ PhelpsMPassAudLtrCHP 2011Jun08 (*Quality, Appropriateness, Compliance with Medical Record Requirements*) ♦ FY2010ContractComplianceAudit_Results_AspenPointe_2010Nov12_QM.xlsx, FY10ContractComplianceCover_Letter_AspenPointe_2010Nov12_QM.doc, *(Compliance with applicable provisions of the BHO's contract with the Department*) ♦ CHP FY11 411 Audit Summary for HSAG (*Compliance with medical record requirements, applicable provisions of the BHO's contract with the Department*) ♦ SF-12 Report 29 Aug 11 BHO updated (*Patient Outcomes*) ♦ CHP_Q4_FY11_IPNemergencyAccesstoCare_Calls_2011May_QM.xlsx, ♦ CHP_Q1_FY12_IPNemergencyAccesstoCare_Calls_2011Sept_QM.xlsx ♦ (*Compliance with applicable provisions of the BHO's contract with the Department*) ♦ DPAuditResults Report VO 2011 Aug 09_3BHO_QM	

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	(*Compliance with Medical Record Requirements, Applicable provisions of the BHO's contract with the Department [appointment following discharge]*) ♦ Prov Adverse Incident Rpt (*Quality, Compliance with reporting requirements for adverse incidents*) ♦ CY11CCARUpdate_Letter_CHP_2011Sep27_QM.pdf (*Compliance with reporting requirements for CCAR*) ♦ ECM_Prov_Cover_Letter_IPN_3BHO.pdf ♦ ECM_Prov_Report_Template_2011Sep27_3BHO.pdf ♦ ECM1_CHP.pdf (example of completed form returned by provider) ♦ *(Quality, Appropriateness, Compliance with reporting requirements for ECMs)*	

Findings:
The VO Provider Manual described the overall scope of the quality management programs, which included utilization management, care process and outcomes measurement, clinical record evaluation, access to care, adverse event evaluation, fraud and abuse, and performance improvement activities. The manual stated that providers are expected to comply with requests for member records for documentation reviews, quality of care reviews, Medicaid audits, or verification of services billed. The provider manual outlined the Colorado Client Assessment Record (CCAR) and VO medical records documentation requirements. The VO Practitioner Agreement also outlined this requirement. The VO Provider Treatment Record Review, Analysis and Reporting policy described the review and evaluation of treatment records to ensure compliance with documentation requirements, to validate claim and encounter submissions, to evaluate or investigate potential quality of care issues, and for other quality- and compliance-related purposes, and stated that provider participation is a condition of network participation. The VO Provider Compliance policy outlined the procedures for identification and review of any quality of care concerns and the types of sanctions that may be applied to correct any identified issues.

The Audit Tool Clinical Claims Scores document outlined numerous detailed criteria for evaluation of medical records, which included key administrative elements (i.e., member demographics, forms signed and completed), clinical assessment requirements, treatment plan requirements, progress note requirements, and encounter submission requirements. The independent provider network (IPN) chart audit results report documented the summarized scored results for a sample of providers by practitioner, by record, and by analysis category. The report included a statement of areas needing attention, and a planned re-audit date.

The CMHC Contract Compliance audit tool, used in annual audits of the CMHCs, included assessment of the CMHC's compliance with access to care standards and participation in the quality improvement program. Areas assessed included evidence of quality improvement (QI) activities designed to

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improve care, having conducted member satisfaction surveys, having participated in a performance improvement project, having reviewed utilization management policies and procedures, evidence of care coordination activities, and use of utilization review criteria and clinical guidelines. Additional evidence of provider monitoring included: ♦ The audit results letter to an independent provider, which informed the practitioner of a passing score in the clinical, claims documentation, and progress note categories with an explanation of the results. ♦ The Contract Compliance Results for Aspen Point, which provided the written results of the audit on the compliance audit form with recommendations for improvement. The report cover letter documented the required areas of corrective action. ♦ The CHP 411Audit Summary report, which included sample records for CMHCs and the independent provider network. The report included analysis of incomplete or inaccurate records (by type), evaluation of medical records documentation to substantiate the claim, and comparison to previous year's results. The report also included a summary of findings and corrective action plans. ♦ The CHP SF12 report included provision for the monitoring of partner CMHCs for compliance with access to care standards, evidence-based practices, performance improvement projects, utilization management, and coordination of care requirements. ♦ The CHP Emergency Access to Care Calls report documented the audit results of test calls to providers regarding emergency care and the amount of time required for the provider to respond. ♦ The CHP CCAR Update Letter reminded individual providers of the need to complete annual CCARs which were due to expire. ♦ The DP Audit Results report outlined sampling methodology and pass/fail results of records audited for outpatient appointment follow-up within seven days of discharge from a residential treatment center. During the on-site interview, staff members explained that current quality management program activities included participation in a focus study on the coordination between behavioral and physical health providers and development of a new SF-12 outcomes measurement report. Staff also stated that performance measures are reviewed quarterly by the CMHCs. The Clinical Advisory/Utilization Management (CAUM)/Quality Improvement Steering Committee (QISC) meeting minutes, reviewed by HSAG on-site, reflected reporting to the committee on access to care measures and quarterly performance measures, including CMHC-specific comparative results for inpatient discharges per 1000, inpatient days per 1000, average length of stay, recidivism, ambulatory follow-up, and emergency visits.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
4. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the provider take corrective action. *Contract: II.G.10.a.5*	**Documents Submitted/Location Within Documents:** 1. Provider_Newsletter_Spring2011– Page 1, Colorado Client Assessment Record (CCAR) News, Pages 3-4, Compliance Corner, Page 4, Access to Care Standards for Inpatient and Residential Services 2. Provider_Newsletter_Summer2011– Pages 1-2, Tips for Avoiding Repayments to ValueOptions®, Page 2 – Reporting Adverse Incidents 3. ChalonerB(JacksonCChapinA)_FailClinFailClaims_CAP Request_CHP_2011Sep16_QM.docm – Entire document 4. CoenM(JensenT)_FailAuditLtr_CAPRequest_2011June01 _QM.docm – Entire document 5. FY10ContractComplianceCover_Letter_AspenPointe_201 0Nov12_QM.doc – Entire document 6. QualityofCare_CAPLog_CHP_NBHP.pdf– Entire document 7. QofCare_CAPExample_CHP.pdf – Entire document **Description of Process:** CHP conducts several types of provider monitoring reviews for deficiencies and areas for improvement, and if identified, CHP initiates the corrective action plan process. Included are examples of corrective actions in several areas: treatment record audits, mental health contract compliance audits, and quality of care issues. Also included is a copy of the Quality of Care Corrective Action Log that is used to track CAP requests and receipt of CAPs. In addition to provider-specific corrective actions, newsletter articles based on identified deficiencies are often included in the provider newsletter to clarify and remind providers about requirements. Copies of the Provider Newsletters for Spring and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	Summer 2011 are included that contain several articles (cited above) pertaining to required provider documentation and reporting.	

Findings:
The VO Enhanced Clinical Management of Outpatient Services policy described supervisory interaction with the provider regarding audit results and alternative treatment options based on criteria, with BHO oversight to assure compliance with the procedures set out in the policy. The VO Provider Compliance policy outlined the procedures for identifying and reviewing any quality of care concerns and the types of sanctions that may be applied to correct any identified issues including consultation, written warning, ongoing monitoring, or suspension/disenrollment.

CHP provided sample letters to individual providers, which summarized results of chart audits for documentation of assessment, medical necessity, treatment plans with goals and time frames, and progress notes with interventions to support claims. The letters provided pass/fail scores, noted specific deficiencies, requested corrective action plans from the providers, and scheduled a re-audit. The Contract Compliance Audit cover letter (Aspen Pointe) highlighted the results of the audit which required corrective action and requested the provider to review the findings and recommendations and return a corrective action plan to CHP within a specified time. The Discharge Plan Audit Results report stated that each facility was informed in writing of the results of the audit, advised of the standard which must be met, and informed that a re-audit was scheduled for the facilities that did not meet the standard.

The Corrective Action Plan (CAP) tracking log included documentation of follow-up to quality of care concerns, including dates of issuing corrective action requests, due dates from providers, and acceptance and completion dates of CAPs.

Required Actions:
None.

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Requirement	**Evidence as Submitted by BHO**	**Score**
5. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: ◆ Discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. ◆ Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42CFR438.12(a)(1) and (2)* *42CFR438.214(c)* *Contract: II.G.3.b, II.G.4.a*	**Documents Submitted/Location Within Documents:** 1. N101_OverviewNNS_2011OCT01_PR – Page 1 & 2 2. COMedicaidAddendum _2011OCT01_PR.pdf – Page 1 3. N401_PrimarySourceVerif_2011OCT01_PR – Page 1 & 2 **Description of Process:** ValueOptions® does not discriminate against providers for acting within the scope of their license or providing services to members that require costly treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Overview of National Network Services (NNS) policy stated that NNS was responsible on a corporate level for credentialing, network adequacy, and quality monitoring of a national provider network. The policy stated that provider credentialing and eligibility determinations were based on objective, non-discriminatory requirements for education, licensure, professional standing, service availability, quality and utilization performance, and were not based on race, national identity, gender, age, sexual orientation, or the type of procedure or patient in which the practitioner specializes. The policy outlined monitoring procedures for discriminatory credentialing decisions and stated that the National Credentialing Committee members were required to sign a statement of non-discrimination. The Colorado Medicaid Addendum stated that VO will not prohibit or restrict providers from acting on behalf of the member, including those providers serving high-risk members or specialized conditions that may be costly.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
6. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: ◆ The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. ◆ Any information the member needs in order to decide among all relevant treatment options. ◆ The risks, benefits, and consequences of treatment or non-treatment. ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42CFR438.102(a)* *Contract: II.E.1.h.1*	**Documents Submitted/Location Within Documents:** 1. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf – Page 8 2. COMedicaidAddendum _2011OCT01_PR.pdf – Page 1 3. N101_OverviewNNS_2011OCT01_PR – Page 1 & 2 **Description of Process:** ValueOptions® does not discriminate against providers who act within the scope of his/her license for advising or acting on the behalf of members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The VO Practitioner Agreement stated that the practitioner shall always exercise best medical judgment in the treatment of members and that VO does not prohibit or penalize communication between the provider and member regarding treatment options and medically necessary care. The VO Colorado Medicaid Addendum to the practitioner agreement stated that VO will not prohibit or restrict a provider, acting within the scope of his/her license and practice, from advising or advocating on behalf of the member.

The Member Rights and Responsibilities policy outlined the member's right to participate in decisions regarding their health care including the right to refuse treatment, receive information on available treatment alternatives, and participate in a candid discussion with their provider(s) regarding appropriate treatment options for their conditions, regardless of cost or benefit coverage. The CHP Member Handbook listed these member rights.

The member appeals section of the VO Provider Manual stated that providers may advocate for the member in an appeal situation with the written permission of the member.

Required Actions:
None.

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Requirement	**Evidence as Submitted by BHO**	**Score**
7. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: ◆ To the State. ◆ To member before and during enrollment. ◆ To members within 90 days after adopting the policy with respect to any particular service. *42CFR438.102(b)* *Contract: II.E.1.h.2*	**Documents Submitted/Location Within Documents:** 1. CHP Provider Network Delegation Policy – entire policy 2. CHP Member Handbook (Misc folder) – Page 9 3. 310L_NonDiscrimination_SC.doc **Description of Process:** ValueOptions® does not deny services on moral or religious grounds. This is clearly stated in the member handbook which is distributed upon enrollment. Any discrimination is covered under policy 310L_NonDiscrimination_SC.doc. If, in the unlikely event this would occur in the future, CHP would then look at developing policies and procedures to protect members and providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The CHP Member Handbook stated that CHP does not deny services based on moral or religious grounds. The VO Non-Discrimination of Member policy stated that VO staff members and providers would not deny a member any covered service based on the grounds of race, color, creed, religion, age, sex, military status, national origin, marital status, sexual orientation, or physical or mental disability. The VO Member Rights and Responsibility policy stated that the member has a right to be free of discrimination and that the provision of services is based on the clinical needs of the individual and what will best assist him or her in recovery.		
Required Actions: None.		
8. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act (This requirement also requires a policy). *42CFR438.214(d)* *Contract: II.G.3.e*	**Documents Submitted/Location Within Documents:** 1. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf 2. COMedicaidAddendum _2011OCT01_PR.pdf 3. CHP Credentialing Recredentialing Delegation Policy – Page 2, V.4. 4. N401_PrimarySourceVerif_2011OCT01_PR – page 4 5. CHP Sanction Screening Delegation Policy – page 2 #9 6. Final_Delegation_Agreement_2011July01_COM – page 2, section 4.02 7. CHP OIG Sanction Screening 2011Oct03 8. Final Management Services_Agreement_CHP_2011July01_COM, page 2, 4.2, e.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: CHP delegates the management of provider network and the credentialing/recredentialing process to ValueOptions®. CHP and ValueOptions® do not employ or contract with providers who are excluded for participation in federal healthcare programs. Through Credentialing and Recredentialing procedures, ValueOptions® staff conducts the Primary Source Verification (PSV) process where providers are checked for any sanctions in relation to participation of federal healthcare programs on a monthly basis. Also on a monthly basis all CHP employees and Board Members are checked for exclusion, or disbarment.	

Findings:
The CHP Credentialing /Recredentialing—Delegation Oversight policy stated that the delegate (VO) must have policies and procedures that ensure the delegate does not employ or contract with providers excluded from participation in federal health care programs, and that the delegate receives practitioner sanction information before making a credentialing decision. The CHP Sanctions Screening policy (approved by the CHP Board of Directors, October 2011) stated that CHP would not engage in a business relationship with an individual or entity with history of a healthcare-related criminal offense or with any individuals or entities under sanction or exclusion by the OIG or other federal or state agency or licensing authority. The policy outlined the procedures for screening of prospective individuals or entities against the List of Excluded Individuals/Entities (LEIE), the List of Parties Excluded from Procurement and Non-procurement Program (EPLS), the National Practitioner Data Bank (NPDB), and Colorado Department of Regulatory Agencies (DORA) databases, and for monthly screening of existing relationships against the LEIE and EPLS. The CHP Compliance Plan stated that CHP, VO, and partner MHCs were required to conduct criminal background checks and initial and monthly screening against the LEIE for all employees, board members, owners (of more than 5 percent), subcontractors, officers, or consultants.

The VO Primary Source Verification policy outlined the responsibility of the credentialing specialist to use numerous databases in the verification of sanctions or restrictions of providers, including the OIG database for Medicare/Medicaid sanctions, the NPDB for license restrictions, and the Government Services Agency (GSA) database for the federal excluded parties list. The VO Practitioner Credentialing and Recredentialing policies and VO Facility Credentialing and Recredentialing policies stated that one of the procedural steps in the process was primary source verification through various Internet databases, including the verification of provider sanctions through the OIG database.

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Requirement	**Evidence as Submitted by BHO**	**Score**
The VO Practitioner Agreement stated that the practitioner represents that he/she is not excluded from or ineligible for participation in any government-sponsored health care program. The VO Colorado Medicaid Addendum to the practitioner agreement stated that the provider agrees to notify VO immediately if the provider is disbarred or excluded from government-sponsored health care programs. The provider manual described the practitioner credentialing requirements and described the providers' responsibility to immediately report revocation, suspension, restriction, termination, or relinquishment of any of the licenses, authorizations, or accreditations whether voluntary or involuntary. During the on-site interview, staff members stated that the CMHCs perform sanction screening of the practitioners within their facilities and that the annual contract compliance audit of the CMHCs includes review of the facility's related policies and procedures and documentation of evidence that the screening has been performed. The VO contract compliance audit tool confirmed that verification of these processes was included in the audit.		
Required Actions: None.		
9. The Contractor may not knowingly have a director, officer, partner, employee, consultant, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549. *42CFR438.610* *Contract: II.G.6*	**Documents Submitted/Location Within Documents:** 1. Final Management Services_Agreement_CHP_2011July01_COM, page 2, section 4.2, e. 2. CHP OIG Sanction Screening 2011Oct03 3. COMedicaidAddendum _2011OCT01_PR.pdf, page 2, D.1.a-d 4. CHP Sanction Screening Delegation Policy – page 2, #9 **Description of Process:** The Management Services Agreement and the Colorado Medicaid Addendum states that CHP will not employ nor contract with persons who are debarred or excluded. An OIG check is done on a monthly basis to make sure that this requirement is met. ValueOptions® does this through the PSV process for providers. ValueOptions® does this for all employees and ValueOptions®-Colorado does this for all CHP employees and board members on a monthly basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The CHP Sanctions Screening policy (approved by the CHP Board of Directors, October 2011) stated that CHP would not employ any individuals or seat a board member under sanction or exclusion by the OIG or other federal or state agency or licensing authority or who has any healthcare-related criminal		

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Requirement	**Evidence as Submitted by BHO**	**Score**
offense. The policy stated that CHP would not knowingly have a director, officer, partner, employee, consultant, or owner who is debarred or excluded from participation in federal programs. The policy also outlined the procedures for screening of prospective individuals or entities against the LEIE, EPLS, NPDB, and DORA and described monthly screening of existing relationships against the LEIE and EPLS. The CHP Management Services Agreement with VO specified that VO must report any exclusions by a state or federal agency of an officer, director, owner, manager, or subcontractor. The VO Practitioner Agreement stated that the practitioner and VO respectively represent that neither knowingly employs or contracts with individuals or entities excluded from or ineligible for participation in any government-sponsored health care program. The VO Colorado Medicaid Addendum to the practitioner and facility agreements stated that the provider represents that he/she does not have employees, agents, or owners who have committed crimes related to Medicare/Medicaid services or have been disbarred or excluded from participation in government programs. Staff reported that VO screens all employees, board members, and providers monthly against the OIG database for debarment or exclusions. VO staff members provided sample OIG search results for providers and management staff.		
Required Actions: None.		
10. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. *42CFR438.12(a)(1)* *Contract: II.G.4.b*	**Documents Submitted/Location Within Documents:** 1. CLCCDenyPreApp_Ltr_BHO_2011Jan01_PR 2. EmailClarification_HCPF_2011OCT01_PR **Description of Process:** All provider requests to join the network are evaluated by ValueOptions®. Should ValueOptions® decline to include the provider in the network, then a letter indicating the reason for the decision is sent to the provider. The Department has indicated they do not wish to receive copies of notifications to providers unless there is a complaint or concern expressed directly to the Department. See attached email.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: During the on-site interview, staff members reported that the VO provider relations department performs a pre-credentialing network adequacy assessment of each practitioner application to determine whether the provider contributes to the expertise of the network, the geographic coverage of the network, is seeing a high-enough volume of Medicaid participants, and is willing to meet Medicaid requirements. If the provider applicant does not meet these criteria, the LCC notifies the practitioner in writing that there is not an access need in the network. Staff also stated that if there is a problem in the credentialing screening		

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Requirement	**Evidence as Submitted by BHO**	**Score**
process which results in denial of the application, the provider is notified in writing of that reason. The VO/Colorado Medicaid Provider Network Assessment and Recruitment Workflow diagram described the process for pre-credentialing assessment of network need for a provider applicant based on the specialty, cultural experience, language, and location of the applicant compared to existing network area providers to confirm the need for the provider in the network. A sample provider notification letter (September 2011) indicated pre-application review by the LCC and stated a reason for denying inclusion in the network.		
Required Actions: None.		
11. The Contractor must have administrative and management arrangements or procedures that are designed to guard against fraud and abuse and include: ◆ A mandatory compliance plan approved by the Contractor's CEO and Compliance officer. ◆ Submission of the compliance plan to the Department for review. ◆ Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards. ◆ Provisions for internal monitoring and auditing. ◆ Provision for prompt response to detected offenses and for development of corrective action initiatives. ◆ Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste, and abuse including mechanisms to identify and report suspected instances of upcoding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided. ◆ The designation of a compliance officer and a compliance committee that are accountable to senior management. ◆ Effective training and education for the compliance officer and the Contractor's employees. ◆ Effective lines of communication between the compliance officer and the Contractor's employees	**Documents Submitted/Location Within Documents:** 1. Final Management Services_Agreement_CHP_2011July01_COM-entire document 2. ComplianceOversightPlan_CHP_2011Oct12_COM – entire document 3. FalseClaimsFraudAbuse_Policy- entire document 4. Review and Monitoring of Medicaid Fraud Abuse- entire document 5. Aug11 COG Annual Training MIN 6. Code of Conduct Policy 7. Code of Conduct AS and KV **Description of Process:** CHP has written policies and procedures, as indicated above, that clearly describe CHP's commitment to comply with federal and state standards; designated compliance officer and committee who are accountable to the senior management; and delineate training and education for the compliance officer and CHP's employees. Communication between the compliance officer and employees can occur through the hotline or by contacting the compliance officer directly. Procedures are in place for monitoring and auditing which includes audits of claims/encounters and clinical record reviews. Specific procedures are in place for investigating and reporting fraud and abuse. If fraud is suspected the VO-Special Investigation Unit will investigate as well.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Enforcement of Standards through well-publicized disciplinary guidelines. ◆ Effective processes to screen all provider claims, collectively and individually, for potential fraud waste or abuse. • Reporting: o The Contractor immediately reports indications or suspicions of fraud by giving a verbal report to the Contract manager. The Contractor shall then investigate its suspicions and submit its written findings to the contract manager within three business days of the verbal report. If the investigation is not complete within three business days, the Contractor shall continue to investigate and submit a final report within 15 business days (further extension may be approved by the contract manager). o The Contractor reports known, confirmed intentional incidents of fraud and abuse to the contract manager and to the appropriate law enforcement agency, including the Colorado Medicaid Fraud Control Unit. *42CFR438.608* *Contract:II.G.5.d, II.G.5.g–l*	CHP's Compliance plan was submitted to the Department for review on August 12, 2010. Per our Compliance Plan we are required to immediately reports indications or suspicions of fraud by giving a verbal report to our Contract manager. CHP then investigates its suspicions and submit its written findings to the contract manager within 3 business days of the verbal report. If the investigation is not complete within 3 business days, CHP continues to investigate and submit a final report within 15 business days. If CHP needs an extension we contact our Contract Manager to ask for an extension. We also report the appropriate law enforcement agencies. Our Contract Manager reports indications or suspicions of fraud, waste or abuse to the Medicaid Fraud and Control Unit.	

Findings:
The CHP Compliance Oversight Plan stated that CHP, through the Compliance Oversight Group, would oversee compliance activities to assure compliance with state and federal regulations, policies and procedures, and contract requirements. The plan stated that each partner CMHC and VO had its own compliance plan and processes that included reporting to the CHP compliance officer (CO), which is the CHP executive director. The compliance officer reports information to the Compliance Oversight Group, which meets quarterly and reports to the CHP Board of Directors. The plan stated that each CMHC and VO conducted its own activities, maintained documentation, and implemented corrective action to comply with requirements, and that VO performed an

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annual audit of compliance activities. The CHP Delegation Agreement with VO confirmed that compliance monitoring and related corrective actions were delegated to VO and compliance activities are reported to the CHP Compliance Officer.

The CHP Compliance Oversight Plan also stated that:

- CHP maintains a toll-free hotline for anonymous reporting of suspected fraud and abuse, and the number is published in newsletters and on the CHP Web site.
- When hired, officers, employees, and contractors received mandatory compliance training, and periodically thereafter.
- Periodic internal or external audits of compliance were conducted, as determined by the CO.
- Potential problems were identified through grievances, the hotline, claims screening, requests for clinical review, and analysis of performance data.
- Suspect situations are investigated with Department notification of a potential fraud and abuse immediately, followed by a verbal report within 3 business days and a final written report within 15 days of initial notification.
- The CO reports credible evidence of legal violations to the appropriate legal authority, including the Colorado Medicaid Fraud Control Unit.

All CHP compliance policies stated that the purpose of the policy was to ensure CHP compliance with applicable federal and state regulations. The CHP Review and Monitoring of Medicaid Fraud and Abuse policy defined the process of investigating and reporting potential fraud. Methods for identifying potential concerns included initial investigation through the CMHCs or VO. The policy addressed the timelines for referral to the CO and reporting to the Department; however, the timelines may have been inconsistent with the timelines described in the compliance plan. During the on-site interview, staff members reported that CHP first confirms reported suspicions, then notifies the Department and initiates an internal investigation through the Special Investigations Unit (SIU). CHP may want to review documents to ensure consistency between documents related to the timelines for reporting suspected incidents to the Department.

The national VO Compliance Plan stated that VO employees are expected to comply with the VO Code of Conduct and company policies that comply with federal and state laws concerning fraud and abuse. The plan addressed:

- Training of all staff members within 90 days of hire and annually thereafter concerning fraud and abuse, whistleblower regulations, privacy and confidentiality, and the Code of Conduct, including a post-test and certification of training retained in employee files.
- Designation of a national CO and an SIU and designated compliance leads in the local VO service centers.
- Staff reporting requirements of potential violations through multiple channels.
- Investigation of reports through the SIU.
- Disciplinary actions specified in human resource policies for employees who violate compliance policies or the Code of Conduct.
- Internal monitoring activities, which may include on-site visits, interviews of personnel, or analysis of claims, clinical, or complaint data.
- Investigations and corrective actions, and reporting of investigations to appropriate government authorities.

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Requirement	**Evidence as Submitted by BHO**	**Score**
The VO Compliance Program Activities policy outlined the procedures for training employees within 90 days of hire and annually thereafter, and stated that completion of training was tracked through a database maintained by the Human Resource Department. The policy stated that failure to complete training, post-tests or the Code of Conduct attestation statement may result in disciplinary action or termination. The policy also outlined areas of internal auditing and monitoring, which included employee completion of training and screening for sanctions. The policy addressed employees' duty to report suspected violations. The policy also addressed identification of potential violations through claims edits, analysis of clinical reviews and paid claims reports, as well as through review of reports from external sources and the VO fraud and abuse hotline. The policy also addressed (1) procedures for prompt investigation of alleged violations by providers, vendors, members, or VO staff, and (2) options for corrective actions when areas for improvement are identified. The CHP Code of Conduct and the VO Code of Conduct addressed the standards for moral, ethical, and legal conduct of employees, directors, and contractors, including non-discrimination, confidentiality, respect for other employees and members, anti-trust and bidding for proposals, conflict of interest, gifts, promotional activities, kickbacks, accurate financial accounting, false claims or billing, copyrights, personal use of corporate resources, and political donations. The CHP Code of Conduct policy stated that it was the responsibility of staff to act in a manner consistent with the code of conduct, that employees would receive Code of Conduct orientation and sign an acknowledgement form upon hire and annually, and that employees were expected to report incidents and that failure to report could result in disciplinary action. The policy also stated that noncompliance with the Code of Conduct could result in termination. CHP provided samples of current signed employee acknowledgement forms. The CHP False Claim/Fraud and Abuse policy defined fraudulent claims activities with examples, including upcoding, unbundling, lack of medical necessity, billing for services not rendered, etc. The policy stated that potential violations were investigated, corrective action was taken and reported to the CO, and potentially fraudulent activity was reported to the Department. The policy stated that there would be no adverse action against employees or contractors that reported potential problems, and the legal penalties for violation of various fraud and abuse acts were outlined. The VO Health Care Claims Fraud and Abuse Investigations policy outlined the detailed procedures for corporate SIU investigation of suspected fraudulent or abusive billing practices, including record sampling, requesting provider medical record documentation, coordination of all applicable internal departments (e.g., claims, clinical operations, provider relations), database documentation, and tracking of all investigation results. The policy also outlined possible corrective actions, including recovery of claims payments, National Credentialing Committee review, notification of legal authorities, notification of state licensing agencies, ongoing monitoring of provider claims, and disciplinary action. During the on-site interview, staff members explained that claims are processed at the national level of VO and are screened through front-end edits incorporated into the automated claims system for coding errors, duplication of charges and numerous other errors. In addition, the national audit and recovery team runs routine reports to identify cases of unbundling of charges and other prohibited billing practices. Written procedures for SIU and the Audit and Recovery Team described data mining of claims for detecting inappropriate billing patterns, and audit and recovery of overpaid claims. The procedures described examination of claims for patterns of inappropriate coding combinations, excessive use of high-level codes, multiple units of the same codes, high-dollar claims, multiple family members treated same day, group vs. individual therapy, etc.		

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During the on-site interview, staff members described that the CHP Compliance Committee included the COs from all CHP partner entities and that CHP had engaged a national consultant to evaluate systems and conduct training on compliance issues, which also resulted in improvement to audit tools and compliance-related policies and procedures. Staff stated that the revised CHP Compliance Plan was approved by the CO/CHP executive director and the CHP Board of Directors in October 2011and would be forwarded to the Department. CHP Class A Board meeting minutes (October 2011) confirmed the approval of the plan. Staff stated that there were no cases of suspected or confirmed fraud and abuse within the review period.		
Required Actions: None.		
12. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor's debts in the event of the Contractor's insolvency. ◆ Covered services provided to the member for which the State does not pay the Contractor. ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. ◆ Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42CFR438.106* *Contract: II.G.11*	**Documents Submitted/Location Within Documents:** 1. Provider Handbook (Misc folder) – Section 3 Page 12 2. COMedicaidAddendum _2011OCT01_PR.pdf – Page 3 3. VOStd_PractitionerAgmt_0809_FINAL_20100708.pdf – Page 21 **Description of Process:** ValueOptions® provider agreements and provider handbooks clearly state members cannot be held liable for payments for covered services or for the Contractor's debts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Compensation Amounts and Responsibility section and the No Balance Billing section of the VO Practitioner Agreement stated that under no circumstances, including non-payment by VO/payor, insolvency of VO/payor, or breech of the agreement, will the provider seek payment for covered services from the member or member representatives. The agreement specified that VO has the right to take action, such as offsetting provider reimbursement or legal action, for violations. The VO Provider Manual, which is incorporated in full into the VO Practitioner Agreement, stated that Medicaid members are not subject to co-payments and that any collection of fees, including fees for non-covered services or missed appointments, from a member may result in		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
provider termination. The CHP Member Handbook stated that there is no charge to members and no co-pay for covered Medicaid services, and instructed members to call CHP (contact information provided) if they receive a bill for any services. During the on-site interview, staff members stated that grievances from members regarding charges by providers were used to identify providers who are inappropriately billing members. Staff reported that if the provider is a contracted provider, provider relations staff members contact the provider and remind him or her of the terms of the contract and the need to refund monies to the member. CHP staff members also stated the if the provider is a non-contracted provider, VO staff explains that Medicaid members may not be billed and attempts to obtain a single case agreement with a goal to eventually contract with the provider to join the network. Staff also stated that denial of authorization letters to members included a reminder that the "provider will not bill you."		
Required Actions: None.		
13. The Contractor has a written agreement with each provider. *Contract: II.G.10.a.2*	**Documents Submitted/Location Within Documents:** 1. COMedicaidAddendum _2011OCT01_PR.pdf 2. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf **Description of Process:** All providers are contracted and enter into an agreement with ValueOptions® in order to supply services to eligible Medicaid members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: CHP provided current signed mental health facility contracts for eight CMHCs. The term of the original agreements, all signed in 2007, was one year with automatic one-year renewals until either party chooses non-renewal or either party terminates the contract per the termination provisions. The VO Practitioner Agreement template for independent practitioners also stated that the term of the contract was one year with automatic one-year renewals until either party chooses to terminate the contract. The Colorado Medicaid Addendum, incorporated into all practitioner and facility agreements, included additional provisions applicable to the Colorado Medicaid program. During the on-site interview, staff members stated that all facilities and independent providers sign a provider agreement, which includes the Colorado Medicaid Addendum, and explained that the Facility Membership Agreement, signed with CHP owner partners, includes an operating agreement. Staff stated that the Network Connect database, which serves as an electronic provider file cabinet, contains any changes, updates, performance data, and other information pertinent to the provider, and is used by the provider relations department to track the status of contracting with providers.		
Required Actions: None.		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
14. Written provider agreements specify: ◆ The activities to be performed by the provider. ◆ Reporting responsibilities of the provider. ◆ Provisions for revoking the provider agreement or imposing other sanctions if the provider's performance is inadequate. ◆ Provisions for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53 *Contract: II.G.10.a.2,7*	**Documents Submitted/Location Within Documents:** 1. COMedicaidAddendum _2011OCT01_PR.pdf – Entire Agreements, Page 2 for the DHHS 2. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf – Entire Agreement, Pages 6, 19 for the DHHS **Description of Process:** Written provider agreements specify the activities to be performed by the provider, the responsibility of reporting, what may constitute as revocation of the agreement, and the provision of access to records of the DHHS.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:

The VO Practitioner Agreement and CHP Member Participation Agreements, together with the Colorado Medicaid Addendum to the agreements described:

- The activities to be performed by the provider, including the provision of covered mental health and substance abuse services to members. The services provided are non-discriminatory, within the scope of the practitioner's license, medically necessary, and in accordance with VO policies and procedures. Additional activities included maintenance of medical records, claims filing per requirements, and compliance with quality, utilization, and grievance and appeals procedures.
- Reporting responsibilities, which included any legal actions involving the provider, licensure actions and renewals, loss of privileges, changes in credentialing information, and reporting of data to comply with quality management and other VO policies and procedures.
- The provision for timely access to records by HHS, OIG, Government Accountability Office (GAO), Centers for Medicare & Medicaid Services (CMS), or other regulatory agencies or their designees.
- Provisions for termination, including without cause, for breach of agreement, loss of licensure, or for criminal or credentialing issues
- Actions which may be taken against the provider for failure to carry out provisions of the agreement or cooperate with VO policies and procedures.

The VO Provider Manual, incorporated in its entirety into the provider agreements, also included a description of provider activities, reporting responsibilities, and access to records.

Required Actions:

None.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
15. The Contractor provides a copy of its claims filing requirements to every participating provider upon acceptance of the provider into the Contractor's network, and to every provider within 15 calendar days after any change in the standard form or requirements. *Contract: II.G.10.c.17*	**Documents Submitted/Location Within Documents:** 1. COMedicaidAddendum _2011OCT01_PR.pdf – Page 4 2. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf – Pages 5 & 6 3. Provider Handbook (Misc. folder) – Section 13, Pages 42-73 **Description of Process:** Providers are given the claims filing requirements as per their contract with ValueOptions®.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The VO Practitioner Agreement and the Colorado Medicaid Addendum to the Practitioner Agreement stated the requirement for the submission of clean claims (components defined) within a specified time period, and according to the guidelines specified in the provider manual. The agreements stated that compensation would be made by VO in accordance with the Medicaid rate schedule, which was attached. The VO Provider Manual outlined claims filing requirements, including: required forms and formats, time frames for filing, required fields, submission methods, detailed instructions for completion of each field on the claim form, coding definitions, claims appeal process, and claims adjustment and resubmission instructions. During the on-site interview, staff members stated that there had been no changes in claims filing requirements during the audit period.

Required Actions:
None.

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	15	**Total Score**		=	15

Total Score ÷ Total Applicable	=	100%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. *42CFR438.230(a)(1)* *Contract: II.B.1*	**Documents Submitted/Location Within Documents:** 1. Final Management Services_Agreement_CHP_2011July01_COM – page 2, section 2, 2.1 2. Final_Delegation_Agreement_2011July01_COM – entire agreement 3. B Board Delegation 2011– entire document 4. COMedicaidAddendum _2011OCT01_PR.pdf, page 1, C. **Description of Process:** As described in the Final_Delegation_Agreement_2011July01_COM CHP has specific reporting requirements for monitoring delegation responsibilities. The Class B Board reviews delegated reports. CHP performs an audit of delegated functions on an annual basis.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Management Services Agreement between CHP and VO stated that the parties agree that CHP shall maintain ultimate responsibility over all functions delegated. The site visit report providing results of the evaluation of VO and the resulting corrective action plan demonstrated CHP's ultimate accountability for functions delegated to VO. The Contract Compliance Audit of CMHC's responsibilities (performed by VO as the administrative service organization [ASO]) included review of grievance processes (a delegated activity). The list of all VO reports submitted to the CHP boards provided evidence of ongoing monitoring of VO's delegated administrative services.		
Required Actions: None		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
2. Before any delegation, the Contractor evaluates (and documents in writing that it has) the prospective subcontractor's ability to perform the activities to be delegated. *42CFR438.230(b)(1)* *Contract: II.B.2, Exhibit S—II.A*	**Description of Process:** This delegation between CHP and ValueOptions® goes back to 2005 therefore there was no pre-delegation assessment. It was assumed to be a continuation of our contract.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: During the on-site interview, CHP staff members reported that CHP had not considered or entered into additional delegation agreements during the review period. In addition, staff reported that additional delegation relationships had not been anticipated at the time of the on-site review. CHP may want to consider developing a process should it consider additional delegation in the future.		
Required Actions: None.		
3. The Contractor has written policies and procedures for the monitoring of subcontractor performance, monitors the subcontractor's performance on an ongoing basis, and subjects it to a formal review according to the periodic schedule established by the State. *42CFR438.230(b)(3)* *Contract: II.B.2, Exhibit S—I.A, IV.A*	**Documents Submitted/Location Within Documents:** 1. Final_Delegation_Agreement_2011July01_COM – entire document 2. Final Management Services_Agreement_CHP_2011July01_COM, page 2, section 1.3 and 2.1 3. B Board Delegation 2011– entire document 4. DeskAuditTool for Vo Delegation Agt – entire document 5. DeskAuditTool for VO Delegation Agt 2 – entire document 6. Delegation Review Summary – entire document 7. CAP_Delegation CAP_BHO_2011Sept07_COM 8. Proposed Corrective Action Plan 9. CAP_Delegation CAP_BHO_2011Oct3_COM **Description of Process:** CHP has conducted a formal annual review of the delegate's performance in 2010 and 2011 and will continue to do so every year. CHP monitors ValueOptions® performance through this on-going Delegation Review.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The CHP Credentialing/Recredentialing Oversight policy and the CHP Quality Management policy both described ongoing monitoring (periodic review of reports specified in the agreement) and formal review (annual oversight audits). CHP's delegation agreement with VO specified that CHP will engage in ongoing monitoring by: ♦ Review of regular reports submitted to CHP by VO. ♦ Regular meetings between CHP and VO. ♦ Review of the performance of VO managers and directors. The agreement also specified that CHP will engage in formal review by: ♦ Review or audit of VO records including financial records. ♦ Annual on-site visit of VO Service Center. The Class B Board Delegation Oversight document consisted of a list of periodic reports submitted by VO for review by the CHP boards. Review of CHP's Class A and Class B Board meeting minutes demonstrated review of each of the listed reports and considerable discussion constituting ongoing monitoring. The meeting minutes also demonstrated regular CHP review and approval of VO policies and procedures. The CHP Class A and Class B boards were composed of representatives of the partnership (the CHP CEO, representatives from VO, and representatives from each partner CMHC).		
Required Actions: None		
4. The Contractor ensures that work further subcontracted by a subcontractor is monitored by the delegating subcontractor. *Contract: II.B.2, Exhibit S—IV.B*	**Documents Submitted/Location Within Documents:** 1. CMHC Grievance Audit 2010 **Description of Process:** CHP conducts a review of all grievances that are delegated to the MHCs. These are presented to the Board for approval.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Management Services Agreement between CHP and VO specified that CHP must approve all delegated activity to be further delegated and that VO must require its contractor to comply with requirements of the Medicaid managed care contract. The Member Participation Agreements between CHP, VO, and the partner CMHCs included the provision that the CMHCs comply with the requirements of CHP's Medicaid managed care contract with the Department. The Member Participation Agreements subdelegated grievance processing to the CMHCs and specified oversight by VO. The annual delegation audit performed by VO reviewed grievance processing accomplished by the CMHC's. Ongoing review of reports submitted to the CHP boards included grievance information submitted by the CMHCs.		
Required Actions: None.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
5. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action. *42CFR438.230(b)(4)* *Contract: II.B.2, Exhibit S—IV.C*	**Documents Submitted/Location Within Documents:** 1. Final_Delegation_Agreement_2011July01_COM – entire document 2. Final Management Services_Agreement_CHP_2011July01_COM – entire document 3. Delegation Review Summary – entire document 4. CAP_Delegation CAP_BHO_2011Sept07_COM 5. Proposed Corrective Action Plan 6. CAP_Delegation CAP_BHO_2011Oct3_COM **Description of Process:** CHP's Delegation Agreement and Management Service Agreement specify procedures for corrective action if there are deficiencies in the delegate's performance. As indicated in the attached documentation we have submitted Corrective Action Plans for areas that the BHO has determined to be deficient and these have been accepted by the BHO.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Based on the June 2011 audit of the VO service center, two areas were identified as requiring improvement (one in provider network management and one in credentialing). VO submitted a CAP to the CHP Board for approval. CHP approved the plan and provided evidence of follow-up until corrective actions were completed.		
Required Actions: None.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
6. There is a written agreement with each delegate. *42CFR438.230(b)(2)* *Contract: II.B.2, Exhibit S—III.A*	**Documents Submitted/Location Within Documents:** 1. Final Management Services_Agreement_CHP_2011July01_COM – entire document 2. Member Participation Agreements – all documents CWRMHC MWMHC PPMHC SEMHS SLVMHC SPMHC SWCMHC WCMHC 3. Final_Delegation_Agreement_2011July01_COM – entire document **Description of Process:** CHP has a written agreement with each entity that is performing any delegation functions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
CHP provided the following signed, executed agreements:

- Management Services Agreement between CHP and VO
- Delegation Agreement between CHP and VO
- Member Participation Agreements between CHP, VO, and the following CMHCs:
  - Colorado West Regional Mental Health Center (CWRMHC)
  - Midwestern Colorado Mental Health Center (MWCMHC)
  - Pikes Peak Mental Health Center (PPMHC)
  - Southeast Mental Health Services (SEMHS)
  - San Luis Valley Comprehensive Mental Health Center (SLVMHC)
  - Spanish Peaks Mental Health Center (SPMHC)
  - Southwest Colorado Mental Health Center (SWCMHC)
  - West Central Mental Health Center (WCMHC)

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
Required Actions: None.		
7. The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. ◆ Specifies that the subcontractor shall comply with the standards specified in the Contractor's agreement with the Department. ◆ Requires at least semi-annual reporting of progress and findings to the Contractor. ◆ Describes the process which the Contractor will use to evaluate the subcontractor's performance. ◆ If the subcontractor will perform utilization management, the agreement provides that the compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services (reference 42CFR438.12(e). ◆ Includes a provision that the subcontractor shall maintain complete files of all records, documents, communications, and other materials which pertain to the operation of the subcontract or to the delivery of services under the subcontract sufficient to disclose fully the nature and extent of services/goods provided to each member and to document all activities and services under the agreement.	**Documents Submitted/Location Within Documents:** 1. Final Management Services_Agreement_CHP_2011July01_COM, Exhibit A 2. Final_Delegation_Agreement_2011July01_COM – entire document 3. CHP Credentialing Recredentialing Delegation Policy – entire policy 4. B Board Delegation 2011– entire document 5. BA Agreement, page 22 section 7.5 (*Part of Final Management Services Agreement*) **Description of Process:** CHP has a written agreement with the delegate; both the Management Services Agreement and the Delegation Agreement include all the required elements listed under this requirement. In addition, specific requirements for Credentialing are included in the agreements.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Includes provisions permitting duly authorized agents of the Department, State and federal government to access the subcontractor's premises during normal business hours to inspect, audit, monitor, or otherwise evaluate the quality, appropriateness, timeliness, or any other aspect of the subcontractor's performance of subcontracted services. ◆ Provides for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. ◆ Requires the subcontractor and any other subrecipients to notify the Department when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. *42CFR438.230(b)(2)* *Contract: II.B.2, Exhibit S—III.B–M*		
Findings: The two agreements between CHP and VO contained each of the required provisions except the clause to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. The Member Participation Agreements with the CMHCs also included each of the required provisions except the clause to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.		
Required Actions: CHP must revise delegation agreements to require reporting of federal expenditures from all sources equal to or in excess of $500,000.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
8. The Contractor provides a description of the grievance, appeal and fair hearing procedures, approved by the Department, and time frames to all Subcontractors at the time the subcontractor enters into a contract with the Contractor. The description includes: ◆ The member's right to file grievances and appeals. ◆ The requirements and time frames for filing grievances and appeals. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers that the member can use to file a grievance or an appeal by telephone. ◆ The member's right to a State fair hearing for appeals: • The method to obtain a State fair hearing • The rules that govern representation at the hearing ◆ The fact that, when requested by the member: • Benefits will continue if the member files an appeal or a request for a State fair hearing within the time frames specified for filing. • The member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the member. *Contract: II.B.2, Exhibit S–V*	**Documents Submitted/Location Within Documents:** 1. CHP_MemberHandbook_2011EQRO (Misc. folder), page 18-22 2. Section9_Reviews_and_Appeals from the Provider Handbook – entire section **Description of Process:** Providers can refer to the CHP Member Handbook and they can also refer to the Network Specific Provider Handbook where all the required elements are listed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: As the ASO for CHP, VO prepared and distributed the provider manual and the member handbook, both of which included information about the grievance system. As providers, each of CMHC's also had access to the provider manual and worked with and distributed the member handbook. (The specific accuracy of the provider manual content related to grievances and appeals is scored in Standard VI, Requirement 26, and the specific content of the member handbook is scored in Standard V, Requirement 13.)		
Required Actions: None.		

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	6

Total Score ÷ Total Applicable	=	86%

Appendix B. Appeals Record Review Tool

for Colorado Health Partnerships, LLC

The completed record review tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Colorado Health Partnerships, LLC

Review Period:	January 1, 2011–September 30, 2011
Date of Review:	November 21, 2011–November 22, 2011
Reviewer:	Barbara McConnell
Participating BHO Staff Member:	Amie Adams

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
1	*****	2/28/2011	3/2/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	3/22/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments: CHP mailed an extension letter on 3/4/2011.												
2	*****	8/3/2011	8/3/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	8/9/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
3	*****	4/27/2011	4/27/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	5/10/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
4	*****	7/27/2011	7/29/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	8/9/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
5	*****	3/28/2011	3/29/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	4/11/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
6	*****	4/4/2011	4/5/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	4/18/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
7	*****	8/25/2011	8/25/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	8/30/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
8	*****	1/20/2011	1/21/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	1/27/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
9	*****	6/15/2011	6/16/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	7/8/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments: CHP mailed an extension letter on 6/27/2011.												

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Colorado Health Partnerships, LLC

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
10	*****	2/10/2011	2/11/2011	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	2/21/2011	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
	# Applicable Elements			10	10	10				10	10	10
	# Compliant Elements			10	10	10				10	10	10
	Percent Compliant			100%	100%	100%				100%	100%	100%

Note: M = Met, N = Not met, U = Unknown, Y = Yes, N = No

Total # Applicable Elements	**60**
Total # Compliant Elements	**60**
Total Percent Compliant	**100%**

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

Table C-1 lists the participants in the FY 2011–2012 site review of **CHP**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Katherine Bartilotta, BSN	Project Manager
CHP Participants	**Title**
Steve Coen, PhD	Clinical Peer Advisory
Haline Grublak	Vice President, Office of Member and Family Affairs
Maggie Tilley	Contract Compliance Officer
Stacey Thompson	Quality Director (VO/NBHP)
Erica Arnold-Miller	Vice President of Quality
Leslie Moldauer, MD	Associate Medical Director
Arnold Salazar	Executive Director, CHP
Steve Holsenbeck	Medical Director
Chet Phelps	Information Systems
Amie Adams	Clinical Director
Michelle Denman	Provider Relations Director
Department Observers	**Title**
Matthew Ulrich (telephonically)	Contract Performance and Operations Specialist
Jerry Ware (telephonically)	Quality Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2011–2012 for Colorado Health Partnerships, LLC

If applicable, **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 required action, the BHO 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**
	If applicable, the 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 to HSAG and the Department. The BHO will submit the CAP using the template provided. 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 or HSAG 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 CAP, 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 or HSAG 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 or HSAG 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 federal Medicaid managed care regulations and contract requirements.

The template for the CAP follows.

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP		
Standard V—Member Information		
Requirement	**Findings**	**Required Actions**
Requirement 5: The Contractor notifies all members (at least once a year) of their right to request and obtain the required information, upon request [information required at 438.10(f)(6) and 438.10(g)(and (h)].	The VO Member Information Requirements policy stated that members "would be informed of their right to receive the required member information on an annual basis." The CHP Member Handbook provided information on all elements of information specified in 42 CFR 438.10(f)(6) and 438.10(g)and (h) and informed members that they may obtain a copy of information at any time by contacting the OMFA and included the telephone number. The CHP 2010 annual member letter and the proposed December 2011 annual member letter summarized the type of information available in the CHP Member Handbook; however, erroneously stated that members had a right to receive information once a year.	CHP must review and/or revise member materials and policies to clarify the requirement for CHP to provide annual notice to members of the right to request information at any time and receive it upon request.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP		
Standard V—Member Information		
Requirement	**Findings**	**Required Actions**
Requirement 13: The member information materials sent following enrollment also include the following information regarding the grievance, appeal, and fair hearing procedures: ◆ The right to file grievances and appeals. ◆ The requirements and time frames for filing a grievance or appeal (including oral filing). ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing, and the rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing, and the service authorization has not expired. • The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The right that providers may file an appeal on behalf of the member with the member's written consent.	The time frames for resolving appeals, depicted in the member handbook, were incorrectly listed as 10 *calendar* days for a standard appeal and three *working* days for expedited appeals. While particular time frames would be in compliance, if accurately representative of CHP's practices, CHP's other documentation and staff members confirmed that the correct time frames are 10 *working* days to resolve a standard appeal and three *calendar* days to resolve an expedited appeal. The member handbook addressed the provision to continue previously authorized services during the appeal or State fair hearing; however, some of the details provided regarding timelines were confusing and inaccurate. On page 20 of the handbook the "on time" filing was depicted as, "from within 10 calendar days from when CHP sent the notice or 10 calendar days before the treatment was scheduled to stop or change—whichever is later." The other conditions for requesting continued services were accurate in this section as well as on page 22, although it may be less confusing for members if CHP revised the two lists to mirror each other. The duration of continued services on page 20 was described accurately and in easy-to-understand language; however, on page 22, the same list was inaccurate and confusing. The second bullet stated that services would continue until 10 days pass after the notice of *action* (which should read notice	CHP must revise the member handbook to accurately describe resolution time frames. CHP must also clarify in the member handbook that members may request that previously authorized services continue during the appeal or State fair hearing if the appeal is filed within 10 calendar days of the notice of action, or before the intended effective date of the action, whichever is later. In addition, CHP must clarify page 22 of the handbook to describe the duration of continued benefits to be until one of the following occurs (as is stated on page 20 of the handbook): ◆ The member withdraws the appeal. ◆ Ten days pass after CHP mails the notice of appeal *resolution*, unless within these 10 days, the member requests a State fair hearing with continued services. ◆ The State fair hearing officer issues a decision adverse to the member. ◆ The original period authorized by CHP has been met.

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP		
Standard V—Member Information		
	of *appeal resolution*). The continuation of previously authorized services, while may be described separately in the appeal section or State fair hearing section, is the same set of regulations; and the language need not change.	
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP		
Standard VI—Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 17: The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: • The right to request a State fair hearing, and how to do so. • The right to request that benefits while the hearing is pending, and how to make the request. • That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action.	The resolution letters reviewed during the on-site appeals record review included the required information. VO had developed new template resolution letters for appeals related to new requests for service and for appeals related to the termination, suspension, or reduction of previously authorized services. The content of the letters were not consistent with requirements. CHP should review these letters and ensure that they meet requirements prior to implementation. VO Appeal Process policy included the required content of appeal resolution letters; however, the content for letters regarding the request for continuation of previously authorized services and liability for cost if the adverse decision is upheld was listed as required content only if providers requested the appeal on behalf of the member.	CHP must revise its policy to clearly state that language regarding continuation of previously authorized services is required (if applicable) regardless of whether the member or the provider, acting as the DCR, requested the appeal.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP		
Standard VI—Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 22: The Contractor provides for continuation of benefits while the BHO-level appeal and the State fair hearing are pending if: ◆ The member or the provider files timely*—defined as on or before the later of the following: • Within 10 days of the Contractor mailing the notice of action. • The intended effective date of the proposed action. ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. **This definition of timely filing only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.*	The VO Appeal Process policy included the provision for continuation of previously authorized services during the appeal or the State fair hearing. The policy, while somewhat awkward, was accurate. The CHP Help Guide for Appeals was incorrect in its description of this right. The help guide stated that the appeal must be filed within 10 calendar days of the notice of action or, "10 calendar days from the day when the treatment is scheduled to stop or change, whichever is later." CHP may want to review and revise policies to clarify the continuation of benefits provision. CHP may also want to consider revising the help guide to combine the timely filing discussion on page 6 with the continuation of services discussion on page 7 for clarity. The policy and the PowerPoint training presentation included an example which illustrated the situation accurately; however, CHP may want to consider clarifying the example to ensure understanding that services would not be terminated without the required 10-day advance notice per 42CFR438.404(c)(1)/ 42CFR431.211. (See the Member Information standard, Requirement 13, for scoring specific to the member handbook information about continuation of benefits.) Although the Appeals Help Guide had not been sent with the notices of actions for the appeals records reviewed on site, CHP staff stated that CHP was in the process of implementing the process of sending the help guide with notices of action.	CHP must revise the Appeals Help Guide to state that members may request the continuation of previously authorized services during the appeal or State fair hearing if: ♦ The appeal is filed timely—defined (only for continuing benefits) as within 10 calendar days of the date of the notice of action, or before the intended effective date of the action, whichever is later. ♦ The appeal involves the termination, suspension, or reduction of previously authorized services. ♦ The services were ordered by an authorized provider. ♦ The original period covered by the original authorization has not expired. ♦ The enrollee requests the extension of services.

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP
Standard VI—Grievance System
Planned Interventions:
Person(s)/Committee(s) Responsible and Anticipated Completion Date:
Training Required:
Monitoring and Follow-up Planned:
Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP		
Standard VI—Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 23: If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten days pass after the Contractor mails the notice providing the resolution (that is against the member) of the appeal, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. ◆ A State fair hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met.	The VO Appeal Process policy included the provision for continuation of previously authorized services during the appeal or the State fair hearing, which contained the correct information regarding the duration of continued services. The help guide stated that services will continue until one of the following occurs (copied verbatim from the help guide): ♦ The member withdraws the appeal. ♦ 10 days pass after the BHO mails the *notice of action* and you have asked for a State fair hearing. ♦ You have asked for a State fair hearing and their decision is to stop your services. ♦ The original authorization for your service has expired. (See the Member Information standard, Requirement 13, for scoring specific to the member handbook information about continuation of benefits.)	CHP must revise the Appeals Help Guide to state that, if requested, services must be continued until one of the following: ♦ The member withdraws the appeal. ♦ Ten days pass after the BHO mails the notice providing *resolution* of the appeal against the member, *unless* the member, within the 10-day time frame, has requested a State fair hearing. ♦ A State fair hearing officer issues a hearing decision adverse to the member. ♦ The time period or service limits of the previously authorized service have been met.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP		
Standard VI—Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 26: The Contractor must provide the information about the grievance system specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing. • The rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. • If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The member's right to have a provider file a grievance or an appeal on behalf of the member, with the member's written consent.	The provider manual included detailed information about the grievance system and CHP's processes, except to notify the provider that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.	CHP must ensure that providers are notified that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP
Standard VI—Grievance System
Planned Interventions:
Person(s)/Committee(s) Responsible and Anticipated Completion Date:
Training Required:
Monitoring and Follow-up Planned:
Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP		
Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Actions**
Requirement 7: The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. ◆ Specifies that the subcontractor shall comply with the standards specified in the Contractor's agreement with the Department. ◆ Requires at least semi-annual reporting of progress and findings to the Contractor. ◆ Describes the process which the Contractor will use to evaluate the subcontractor's performance. ◆ If the subcontractor will perform utilization management, the agreement provides that the compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services (reference 42CFR438.12(e). ◆ Includes a provision that the subcontractor shall maintain complete files of all records, documents, communications, and other materials which pertain to the operation of the subcontract or to the delivery of services under the subcontract sufficient to disclose fully the nature and extent of services/goods provided to each member and to document all activities and services under the agreement.	The two agreements between CHP and VO contained each of the required provisions except the clause to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. The Member Participation Agreements with the CMHCs also included each of the required provisions except the clause to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.	CHP must revise delegation agreements to require reporting of federal expenditures from all sources equal to or in excess of $500,000.

Table D-2—FY 2011–2012 Corrective Action Plan *for* CHP		
Standard IX—Subcontracts and Delegation		
◆ Includes provisions permitting duly authorized agents of the Department, State and federal government to access the subcontractor's premises during normal business hours to inspect, audit, monitor, or otherwise evaluate the quality, appropriateness, timeliness, or any other aspect of the subcontractor's performance of subcontracted services. ◆ Provides for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. ◆ Requires the subcontractor and any other subrecipients to notify the Department when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

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 to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the dates 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 to discuss the FY 2011–2012 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions 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 BHOs were prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the federal Medicaid managed care regulations (the BBA) and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tool, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific managed care regulations or contract requirements. ◆ HSAG considered the Department's responses when determining compliance and analyzing findings.
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 review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the "evidence as submitted by the BHO" section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected 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 2011–2012 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 federal Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2011–2012 Site Review Report. ◆ HSAG submitted the site review report to the BHO and the Department for review and comment. ◆ HSAG incorporated the BHO's and Department's comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.