Colorado Medicaid
Community Mental Health Services Program

FY 2012–2013 Site Review Report
for
Colorado Health Partnerships, LLC

February 2013

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

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HSAG HEALTH SERVICES ADVISORY GROUP

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Overview of FY 2012–2013 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 Colorado's behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the ninth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2012–2013 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 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 BHO's administrative records were also reviewed to evaluate implementation of National Committee for Quality Assurance (NCQA) Standards and Guidelines related to credentialing and recredentialing. 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 practitioners who had been credentialed or recredentialed in the previous 36 months. For the record review, the BHO received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. Compliance with federal regulations was evaluated through review of the four standards. 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 2012–2013 site review activities for the review period—January 1, 2012, through December 31, 2012. 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 2011–2012 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 credentialing and recredentialing record reviews. 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 2012–2013 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, NCQA Credentialing and Recredentialing Standards and Guidelines, 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 2012–2013 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 V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

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 BHOs (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, NCQA Credentialing and Recredentialing Standards and Guidelines, 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 requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for enhancement for some 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	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
III	Coordination and Continuity of Care	8	8	8	0	0	0	100%
IV	Member Rights and Protections	5	5	5	0	0	0	100%
VIII	Credentialing and Recredentialing	49	47	46	1	0	2	98%
X	Quality Assessment and Performance Improvement	16	16	16	0	0	0	100%
	Totals	**78**	**76**	**75**	**1**	**0**	**2**	**99%**

Table 1-2 presents the scores for **CHP** for the record reviews. Details of the findings for the record reviews are in Appendix B—Record Review Tools.

Table 1-2—Summary of Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Credentialing Record Review	80	62	62	0	18	100%
Recredentialing Record Review	80	63	62	1	17	98%
Totals	160	125	124	1	35	99%

Overall Summary of Performance

Colorado Health Partnerships (**CHP**) is a partnership between ValueOptions (VO), a national behavioral health provider and management organization, and local community mental health centers (CMHCs) providing behavioral health care throughout western and southwestern Colorado. Although VO is a partner in **CHP**, **CHP** has (at the request of the Department) entered into delegation agreements with VO, in addition to the Management Services Agreement, for the performance-specific activities required under the Colorado Medicaid Contract (e.g., management of care coordination and credentialing programs and maintenance of the Office of Member and Family Affairs [OMFA]).

For the four standards reviewed by HSAG, **CHP** earned an overall compliance score of 98 percent. **CHP** earned 100 percent in three of the four standards reviewed (Coordination and Continuity of Care, Member Rights and Protections, and Quality Assessment and Performance Improvement). **CHP**'s 96 percent score for the Credentialing and Recredentialing Standard related to a missing provision in the delegation agreement between VO and **CHP**, which did not impact compliance with NCQA-required processes. **CHP** demonstrated strong performance overall and a clear understanding of federal regulations and Medicaid contract requirements.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

CHP requires the primary therapist to be responsible for coordination and continuity of care for each member. VO Care Management staff provides additional care coordination and continuity of care activities for complex cases. Each network CMHC also uses discharge planners to facilitate transition from higher levels of care (e.g., inpatient, residential treatment center [RTC]) to ongoing care through the CMHC. When required, **CHP** engages the medical director and a team of professionals to create a treatment plan and coordinates care among multiple providers and agencies.

CHP presented three care coordination cases (one individual with complex medical and behavioral needs, one individual with complex behavioral needs involving wraparound services, and one individual residing in a long-term nursing facility). These cases demonstrated active coordination of information and services; performance of comprehensive assessments; and development of treatment plans with goals, progress monitoring, and follow-up revisions to the plans. **CHP** monitored provider compliance with these requirements through the audit of treatment records using a comprehensive audit tool that assessed all of the required components specified in the standard; however, the number and frequency of records **CHP** reviewed was minimal. HSAG recommended that **CHP** consider auditing a wider sample of provider treatment records to ensure that providers are consistently meeting the assessment, treatment planning, and coordination of care requirements.

In addition, case presentations did not clearly identify the assessment of transportation needs for the members. HSAG recommended that **CHP** include a field in the assessment form (or elsewhere in the medical record, as appropriate) to document assessment of transportation needs.

CHP had a very robust program and employee training to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other privacy laws in the conduct of coordination of care and other internal operations.

Summary of Strengths

CHP's, partnership with VO is a clear strength for **CHP** with corporate support, processes and software for tracking members and responding to their needs. Local staff was well qualified, experienced, and familiar with Colorado requirements and the distinct needs of Colorado's Medicaid population. The **CHP** team demonstrated leadership and administrative skill in coordinating care for members with complex medical and behavioral health needs. **CHP** has planned innovative programs to improve the effectiveness of care coordination programs, such as the expansion of the peer specialist program to enhance the effectiveness of transitioning members from hospitalization to outpatient services. The care managers appeared well connected to the CMHC staff, as well as other providers and community service organizations that were participating in a member's care team. The care coordination process was well documented in the member's treatment record, as well as the electronic care coordination system.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

CHP delegated distribution of member materials and maintenance of policies and procedures related to member rights and protections to VO. Policies included all of the rights listed in 42CFR438.100 and as described in the Colorado Medicaid Managed Care contract. The VO/**CHP** provider manual and provider agreements listed member rights and described the provider's responsibility for ensuring those rights. **CHP** also included member rights under both the provider and member tabs of its Web site. **CHP** provided evidence of monitoring VO contracted providers and the CMHCs for compliance with requirements related to member rights.

Summary of Strengths

Ongoing communication between the BHO and the CMHCs regarding member rights was accomplished by the OMFA representatives on-site at each of the CMHCs. The BHO's Director of OMFA provided ongoing support and met periodically with the CMHCs' OMFA directors to clarify policies and assist with member needs.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

VO, on behalf of **CHP**, had policies and procedures that thoroughly described the credentialing and recredentialing processes and demonstrated compliance with National Committee for Quality Assurance (NCQA) requirements. The policies described the processes for making credentialing and recredentialing decisions and delineated the roles of national VO and local **CHP** staff. Provider directories were generated directly from the credentialing database. Printed versions of the provider directory were updated monthly. Staff reported that the online searchable database is updated within 48 hours of a change to the provider database. VO policies described NCQA-compliant procedures for assessing organizational providers. On-site review of credentialing and recredentialing files for individual and organizational providers demonstrated that VO followed its processes, as delineated in its policies.

CHP provided an annual audit report completed by an independent contractor on behalf of **CHP**. The audit evaluated all activities delegated to VO, including credentialing and recredentialing. The audit process included a file review for compliance with NCQA standards. Both the Management Services Agreement and the Delegation Agreement between **CHP** and VO included the provision to require corrective action for inadequate performance of the delegated activities. **CHP** provided evidence of having required corrective actions and following up until corrected.

Summary of Strengths

VO's corporate policies and processes bring extensive experience and knowledge of NCQA requirements to **CHP**. VO's database for maintaining documents obtained for credentialing and recredentialing provides secure recordkeeping, while providing easy access to staff for processing and accessing provider files, as needed. VO's assignment of two credentialing specialists designated for Colorado provider applications ensured that Colorado-specific requirements were met.

CHP's site visit tools and procedures for both individual practitioners and organizational providers were comprehensive and incorporated both NCQA and Colorado-specific requirements. **CHP**'s credentialing committee, which served as the VO local credentialing committee, incorporated VO staff members and CMHC providers and included a variety of provider types.

Summary of Required Actions

Although a delegation agreement may not be required because VO is a **CHP** partner, since there is a delegation agreement, it must be complete. The delegation agreement between VO and **CHP** did not include a provision that **CHP** retains the right to approve, suspend, and terminate individual practitioners and providers. This provision was present in the delegation agreement submitted for the 2010 external quality review organization (EQRO) site visit, but it had been removed from the most recently signed agreement. **CHP** must either revise the delegation agreement or use an addendum to include the required provision that **CHP** retains the right to approve, suspend, and terminate individual practitioners and providers.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

CHP had a comprehensive quality improvement (QI) program that incorporated a variety of mechanisms to monitor quality and appropriateness of care. Mechanisms included ongoing monitoring of performance indicators, access to care measures, adverse incidents, grievances, and quality of care concerns. The program also incorporated clinical care guidelines, focused performance improvement projects, member surveys, and practitioner medical record audits. The program was well documented through the annual program description, annual evaluation, and annual work plan, with review and oversight by the combined Quality Improvement Steering Committee/Clinical Advisory Utilization Management Committee (QISC/CAUMC). Corrective actions and focused QI projects were implemented when necessary. Well-developed health information systems collected pertinent information, had mechanisms to ensure accuracy of information, and produced numerous reports for utilization and quality monitoring. HSAG's review identified opportunities for improvement resulting in recommendations, but no required actions.

HSAG recommended that the documentation of continued quality of care concerns and recommendations for the subsequent year's QI Work Plan be more clearly identified in the annual QI Evaluation report to clarify ongoing areas for improvement from one year to another. In addition, **CHP** should ensure that there is a reporting mechanism in place for CMHCs to consistently report their findings back to the QISC/CAUMC when information is referred to the CMHCs for analysis.

HSAG recommended that the VO Colorado policy regarding clinical treatment guideline development incorporate all of the required elements from the VO corporate policy (of the same name) to ensure that the local policy includes all required elements.

Summary of Strengths

The **CHP**/VO support staff and systems were supported by the national VO organization, thereby enhancing the experience and expertise available to **CHP** for QI activities. In addition, local staff was experienced and had longevity with **CHP**. The QI process engaged many participating providers and departments in the component activities, as well as the functions of the QISC/CAUMC. Minutes of the QISC/CAUMC documented substantive discussion of the analysis and recommendations related to the review of a comprehensive base of QI activities and data.

Summary of Required Actions

There were no corrective actions required for this standard.

Methodology

As a follow-up to the FY 2011–2012 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 2011–2012 compliance monitoring site review.

Summary of 2011–2012 Required Actions

As a result of the 2011–2012 site review, **CHP** was required to address seven partially met scores. **CHP** was required to 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** was required to revise its member handbook and its Appeals Help Guide to accurately describe appeal resolution time frames and to clarify 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. Furthermore, **CHP** was required to 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. **CHP** was required to revise its policy to state that language regarding the continuation of previously authorized services is required, regardless of whether the member or the provider, acting as the designated client representative (DCR), requested the appeal.

Finally, **CHP** was required to revise its agreements with VO and the CMHCs to include a clause that requires the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.

Summary of Corrective Action/Document Review

CHP submitted its CAP to HSAG and the Department in March 2012. HSAG and the Department reviewed the plan and determined that, if implemented as written, **CHP** would achieve full compliance with requirements for which required actions were necessary. **CHP** submitted documents to HSAG and the Department in June 2012. After careful review, HSAG and the Department determined that **CHP** had sufficiently completed all required actions. HSAG sent confirmation that CHP had completed all required actions resulting from the 2011–2012 review.

Summary of Continued Required Actions

CHP had no required actions continued from FY 2011–2012.

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

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination of the provision of Covered Services to its members and to ensure: ◆ Service accessibility. ◆ Attention to individual needs. ◆ Continuity of care to promote maintenance of health and maximize independent living. Contract: II.E.1.g.1	**Documents Submitted/Location Within Documents:** 1. MedicalNecessityPolicy_202L—Entire policy with particular emphasis on sections noted in narrative, below. 2. MedicalNecessityDeterminationLackofInformationandNotificationTimelinesPolicy_203L—Entire policy with particular emphasis on sections noted in narrative, below. 3. PrimaryTherapistResponsibofCCPolicy_262L—Entire policy 4. ProvisionofServicesbyanOutofNetworkProviderPolicy_274L— page 2, Section IV, number 3 and 9b. 5. ContinuityofCareAmongProvidersandLevelsofCarePolicy_254L—Entire policy **Description of Process:** “MedicalNecessityPolicy_202L” provides a standard definition for medical necessity (Section IV.A) which takes into account that services are provided at the most appropriate and least restrictive level of care and is intended to best maintain the member’s health. It describes the sources of information that are used in making medical necessity determinations (Section IV.B). This policy also describes the procedures for review by Clinical Care Managers (Sections V.A-F.).The focus of reviews for medical necessity is on individual needs of the member and determining the level of service appropriate to meet these needs. “MedicalNecessityDeterminationLackofInformationandNotificationTimelinesPolicy_203L” is a key document, which describes the Contractor’s procedures for making medical necessity determinations, the timeframes for these determinations, and the notifications to members. This policy is applicable in its entirety, yet the reviewer should particularly note the sections related to decision timeframes (Section V.C) and the definitions for urgent, routine and emergency services (Section IV). Timelines and monitoring of these timelines insure the accessibility of services to our members	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	"PrimaryTherapistResponsibofCCPolicy_262L" defines the provider's responsibility for coordinating care for Medicaid beneficiaries. This entire policy is applicable to this requirement and to the other coordination of care requirements in this Standard. "ProvisionofServicesbyanOutofNetworkProviderPolicy_274L" describes how continuity of care is maintained for Medicaid members. Page 2, Section IV, number 3 and number 9-b describe how a new Medicaid member's existing treatment can be continued through Medicaid coverage. VO Clinical Care managers work to facilitate timely communication to promote continuity of care when multiple providers are involved in care or a member is transitioning to different levels of care, and this is outlined in "ContinuityofCareAmongProvidersandLevelsofCarePolicy_254L."	

Findings:

Coordination and Continuity of Care functions were delegated to ValueOptions (VO), a partner in Colorado Health Partnerships (CHP). The ValueOptions—Colorado (VO-CO) Coordination of Care policy stated that it is the primary therapist's responsibility to assess member needs, coordinate care among multiple providers and agencies, make referrals, and share information, as appropriate. The VO Coordination of Care with Physical Health Providers and the VO Continuity of Care Among Providers and Levels of Care policies further delineated the responsibility for communicating information between physical health and behavioral health providers, as applicable, as well as procedures for the case manager to facilitate the sharing of information among multiple providers. CHP also submitted policies concerning the procedures for making timely decisions for authorization of medically necessary services.

During on-site interviews, staff stated that the service authorization process is conducted by VO care managers and that each participating community mental health center (CMHC) has discharge planners who facilitate coordination of care between the hospital and the CMHC, both of which enable CHP to identify members most in need of coordination of care with multiple service providers. CHP provided a case example of a high-risk member identified through the Care Management authorization process. Staff stated that the member's individual needs are identified and a treatment team is involved when complex cases are identified. Staff also stated that the CHP medical director is involved with the treatment team for complex cases and reviews members in transition every 10 days. In addition, CHP staff members stated that CHP is considering expanding the Peer Specialist program to assist members being discharged from the hospital in becoming routinely engaged with a CMHC for follow-up care.

Required Actions:

None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. The Contractor has policies and procedures that address, and the Contractor provides for the coordination and provision of Covered Services in conjunction with: ◆ Any other MCO or PIHP. ◆ Other behavioral health care providers. ◆ Physical health care providers. ◆ Long term care providers. ◆ Waiver services providers. ◆ Pharmacists. ◆ County and State agencies. ◆ Other provider organizations that provide wraparound services. ◆ The Single Entry Point (SEP) care manager, as applicable. *42CFR438.208(b)(2)* Contract: II.E.1.g.1—3	**Documents Submitted/Location Within Documents:** 1. PrimaryTherapistResponsibofCCPolicy_262L—Section II.D.1-10 (p.2) 2. 2012AuditToolTemplate_3BHO, Sections C8 and F1-F5 **Description of Process:** "PrimaryTherapistResponsibofCCPolicy_262L" defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. The specific entities are listed in Section II.D.1-10 (p.2). Providers are monitored on compliance with this policy through existing audit procedures. Please see "2012AuditToolTemplate_3BHO", Sections C8 and F1-F5.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The VO-CO Coordination of Care policy outlined the responsibility of the primary therapist (or designated care coordinator) to coordinate services and share relevant information, as clinically appropriate, among all of the entities listed in Requirement 2. The Audit Tool template (used for auditing medical records for compliance with requirements) included an element to verify that the provider documented services provided by other providers/agencies involved in the member's care and that the provider coordinated care with these providers. Staff stated that the audit tool is used to monitor providers for compliance with coordination of care policies and medical record requirements. Sample audit tools provided evidence that records of a sample of independent network providers were audited quarterly. Given that VO audits two medical records for each provider within the sample, and that the sample is relatively small, a small number of records are reviewed quarterly. HSAG recommends that CHP consider auditing a wider sample of provider treatment records to ensure that providers are consistently meeting the assessment, treatment planning, and coordination of care requirements. During the on-site interview, staff provided an overview of three care coordination cases: one individual with complex medical and behavioral needs, one individual with complex behavioral needs involving wraparound services, and one individual in a long-term nursing facility. These cases demonstrated active coordination of information and services with each of the entities involved, as appropriate.

Required Actions:
None.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary (behavioral health) care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. *42CFR438.208(b)(1)* Contract: None.	**Documents Submitted/Location Within Documents:** 1. PrimaryTherapistResponsibofCCPolicy_262L—Section II.E (p.3) 2. CoordinationofCarewithPrimaryHealthProviderPolicy_278L—Entire policy 3. ServiceforDeafandHardofHearingClientsPolicy_238L—Entire policy 4. 2012AuditToolTemplate_3BHO, Sections C8 and F1-F5 5. InpatientATUConcurrentReviewProcess_workflow_2010OCT14_CL—Entire document **Description of Process:** “PrimaryTherapistResponsibofCCPolicy_262L” defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. The requirement that each member has an ongoing source of primary care is addressed in Section II.E (p.3). Additionally, the Coordination of Care with Primary Health Provider Policy [CoordinationofCarewithPrimaryHealthProviderPolicy_278L] addresses this requirement specifically. The entire policy is applicable. Member’s individual needs are taken into account in referrals to care, making sure the care is appropriate to his or her needs and the following policy is an example of how this is accomplished for deaf and hard of hearing members: “ServiceforDeafandHardofHearingClientsPolicy_238L.doc.” Providers are monitored on compliance with this requirement through existing audit procedures. Please see “2012AuditToolTemplate_3BHO”, Sections C8 and F1-F5. When members are admitted to higher level of care services, coordination of care to insure that appropriate sources of behavioral health care are in place to assist the member with their recovery and ongoing treatment becomes even more important and the VO Care Managers work closely with hospitals and CMHC staff to make sure plans are in place. This is demonstrated in the following document: “InpatientATUConcurrentReviewProcess_workflow_2010OCT14_CL” which is utilized in training VO Care Managers, Hospitals and CMHC staff about the required process of communication to coordinate care.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

<table>
<tr><th colspan="3">Standard III—Coordination and Continuity of Care</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the BHO</th><th>Score</th></tr>
<tr><td colspan="3">Findings:
The VO-CO Coordination of Care policy stated that the primary therapist (or designated staff care coordinator) is responsible for care coordination when multiple providers are involved with the member. In addition, the primary therapist is responsible to ensure that members have an ongoing source of primary medical care. CHP provided other policies and procedures that outlined mechanisms for coordination between the behavioral health and physical health provider, as well as integration of complex behavioral health needs at higher levels of care. The Audit Tool template included verification that the BHO provider made a referral to a PCP for a medical exam, obtained a release of information for communication with the PCP, and evidenced that the PCP was notified of the member's participation in services, diagnosis, and medications.

The on-site presentation of three care coordination cases demonstrated that the members had an assigned primary therapist and a PCP. Staff stated that VO care managers also assist the primary therapist with coordination of care for complex cases.</td></tr>
<tr><td colspan="3">Required Actions:
None.</td></tr>
<tr><td>4. Contractor ensures that each member accessing services receives an individual mental health assessment and individual needs assessment.

The mental health assessment addresses:
◆ Member demographics.
◆ Cultural and racial affiliations.
◆ Language and reading proficiency.
◆ Personal and family health history.
◆ Self-perceived health status to predict the member's likelihood of experiencing the most common mental illnesses.
◆ Personal health characteristics, including but not limited to:
• Mental illness.
• Alcohol consumption.
• Substance use disorders.</td><td>Documents Submitted/Location Within Documents:
1. 2012AuditToolTemplate_3BHO-- Sections B1-B20
2. TreatmentPlanning_Policy223L—Entire policy
3. EQROProviderManual_2012Sept_PR-- pages 86-88 (*MISC folder)

Description of Process: The Provider Audit Tool, “2012AuditToolTemplate_3BHO” addresses this requirement for an individual mental health assessment. See Sections B1-B20.

Treatment planning for our members must be done after an individualized assessment for each member, as outlined in “TreatmentPlanning_Policy223L.”

Providers are required to follow the requirements of the Provider Manual, and Section 17, Medical Records Requirements listed in “EQROProviderManual_2012Sept_PR” pages 86-88 outlines that these elements of assessment are required parts of the treatment record for each member.</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
</table>

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The individual needs assessment evaluates: ◆ Special transportation needs. ◆ Cultural and linguistic needs. *42CFR438.208(c)(2)* Contract: II.F.7		
Findings: The VO-CO Treatment Planning policy stated that the treatment plan is based on a thorough assessment of the member's needs, including each of the required elements. The medical record documentation standards included in the provider manual stated that each treatment record would include an assessment that included the elements outlined in the Treatment Planning policy. The Audit Tool template used for monitoring of provider treatment records included verification of the required assessment components. During the on-site interview, staff provided evidence that records of a sample of independent network providers were audited quarterly In addition, staff stated that the CMHCs perform similar routine audits of a representative sample of CMHC medical records. The presentation of care coordination cases, as well as samples of completed medical record audit tools, demonstrated that the requirements were addressed, with the exception of clearly documented transportation needs. On-site, CHP staff were able to describe how therapists worked with members and were aware of members' methods of transportation (e.g., Medicaid vendor, facility van, family); however, HSAG recommends that CHP include a field in the assessment form (or elsewhere in the medical record, as appropriate) to document assessment of transportation needs.		
Required Actions: None.		
5. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: II.F.7.g	**Documents Submitted/Location Within Documents:** 1. PrimaryTherapistResponsibofCCPolicy_262L—Section II.C, D and F. **Description of Process:** "PrimaryTherapistResponsibofCCPolicy_262L" defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. The purposes are specifically noted in Sections II.C, D, and F.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO-CO Coordination of Care policy explained that the primary therapist will share the results of his or her assessment with other providers to prevent duplication of services and reduce the potential for fraud, waste, and abuse. The policy outlined the procedures for obtaining a release of information and sharing of information with other involved providers and the primary care provider (applicable to all members).		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The presentation of care coordination cases demonstrated that pertinent assessment information was shared with medical and other providers based on the release of information from members. Staff stated that care managers involved in complex case management also facilitate the sharing of pertinent information with other providers. Staff emphasized that information sharing is selective based on the "need to know" policies in response to the Health Insurance Portability and Accountability Act (HIPAA) and other Colorado privacy laws concerning behavioral health information.		
Required Actions: None.		
6. Each member has an individualized service plan (treatment plan/care plan) that includes: ◆ Measurable goals. ◆ Strategies to achieve the stated goals. ◆ Mechanism for monitoring and revising the service plan as appropriate. The service plan is developed by the member, the member's designated client representative (DCR) and the provider/treatment team and is signed by the member. (If a member chooses not to sign his/her service plan, documentation shall be provided in the member's medical record stating the member's reason for not signing the plan.) Service planning shall take place annually or if there is a change in the member's level of functioning and care needs. *42CFR438.208(c)(3)* Contract: II.F.9	**Documents Submitted/Location Within Documents:** 1. Treatment PlanningPolicy_223L.doc—Entire policy 2. 2012AuditToolTemplate_3BHO, Sections C1-C14 3. MemberHandbook_CHP-Page 8, pp.18-19*Misc 4. EQROProviderManual_2012Sept_PR" p.87 *Misc **Description of Process:** "TreatmentPlanningPolicy_223L" addresses this requirement and is applicable in its entirety. Sections V.A-D describes the procedures related to this requirement. Providers are monitored on compliance with this policy through existing audit procedures. Please see 2012AuditToolTemplate_3BHO", Sections C1-C14. Members are educated about their role in treatment planning through our Member Handbook in the following documents: MemberHandbook_CHP-Page. 8, pp.18-19 *Misc Involvement of the member/DCR in treatment planning is outlined in "EQROProviderManual_2012Sept_PR" p.87	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO-CO Treatment Planning policy stated that the treatment plan is based on the individual needs assessed, and includes the goals, relevant therapies, and involvement of pertinent providers/agencies. The policy stated that the treatment plan should be revised regularly and is monitored periodically. The policy defined "member" and "designated client representative" (DCR), described provider involvement in care planning, and described the process to obtain the		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
member's signature on the care plan (or to note the reason for not signing). The member handbook and provider manual addressed member involvement in treatment planning. The Audit Tool template verified that the treatment plan is audited for all of the required elements, including signatures of members and providers and an update of the plan every six months. During the on-site interview, staff provided evidence that records of a sample of independent network providers (two records per provider) were audited quarterly, with scheduled re-auditing or corrective action, as required, for practitioners who fail to pass the audit. In addition staff stated that the CMHCs perform similar routine audits of a representative sample of CMHC medical records. Presentation of care coordination cases, as well as samples of completed medical record audit tools, demonstrated that the required elements of the treatment plan were addressed.		
Required Actions: None.		
7. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. In all other operations as well the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224* Contract: II.E.1.g.1, VII.S	**Documents Submitted/Location Within Documents:** 1. PrimaryTherapistResponsibofCCPolicy_262L—Section II.F 2. ContinuityofCareAmongProvidersandLevelsofCarePolicy_254L.", Section V, A, 1 and 2 **Description of Process:** "PrimaryTherapistResponsibofCCPolicy_262L" defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. Member privacy protection is addressed in Section II.F (p.3). In communications with providers to insure continuity of care, VO Care Managers protect member rights under HIPAA. This is addressed in the following policy: "ContinuityofCareAmongProvidersandLevelsofCarePolicy_254L.", Section V, A, 1 and 2."	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: CHP submitted several VO-CO Care Coordination policies that addressed the need for communication of pertinent information among providers involved in the member's care. The policies addressed the need to ensure that communications with other providers are protected in accordance with State and federal (i.e., HIPAA) requirements regarding release of protected health information (PHI) and defined the procedures for obtaining a signed consent for release of information. During the on-site interview, staff stated that therapists shared pertinent assessment information with medical and other providers based on the release of information signed by the member. Staff also stated that VO care managers involved in complex case management also facilitate the sharing of pertinent information with other providers. Staff emphasized that information sharing is based on the "need to know" policies in response to HIPAA and other Colorado privacy laws concerning behavioral health information. Staff provided evidence of annual employee training concerning HIPAA privacy and security, which included job-related access and use of PHI, disclosure of PHI, physical and electronic security of information, and related penalties and disciplinary actions. Staff stated that CHP has a robust system of internal monitoring for compliance with HIPAA and other privacy policies. Staff stated that coordination of care is sometimes difficult given the strict laws concerning privacy of behavioral health information, especially related to substance abuse information.		
Required Actions: None.		
8. The Contractor may require nursing facility residents who are able to travel to a service delivery site to receive their mental health services at a service delivery site. The Contractor shall arrange for transportation for the member between the nursing facility and the service delivery site, but shall not be responsible for the cost of transportation. However, the Contractor shall provide medically necessary mental health services on-site in the nursing facility if transportation cannot be arranged. Contract: II.E.3	**Documents Submitted/Location Within Documents:** 1. SvcsForResidentsNursingFacilityPolicy_275L—Entire policy **Description of Process:** "SvcsForResidentsNursingFacilityPolicy_275L" addresses this requirement. The entire policy is applicable to this requirement.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO-CO Services for Residents in Nursing Facilities policy described the provision of mental health services for residents of nursing facilities, including the arrangement for transportation for members traveling to a CMHC for services.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the BHO**	**Score**

During on-site review, staff provided an overview of coordination of services for residents in a nursing facility, which demonstrated that mental health services were provided both on-site at the nursing facility and at the CMHC. The member treatment record did not clearly document arrangement of transportation services, but staff stated that both the CMHC and the nursing facility had a van for transporting members to appointments.

Required Actions:
None.

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	8	X	1.00	=	8
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	8	**Total Score**		=	8

Total Score ÷ Total Applicable	=	100%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: II.F.3.a	**Documents Submitted/Location Within Documents:** 1. 304LMemberRandR_Policy_VOCO.doc - Entire Policy 2. 310LNonDiscrimination_Policy_VOCO.doc - Entire Policy **Description of Process:** The Member Rights and Responsibilities Policy, 304LMemberRandR_Policy_VOCO.doc and the Non-Discrimination Policy, 310LNonDiscrimination_Policy_VOCO.doc are two policies that guide our position on protecting member rights. The Non-Discrimination policy is the foundation for all member rights policies. The Members Rights and Responsibilities policy meets all state and federal regulations and contract requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: CHP delegated distribution of member materials and maintenance of policies and procedures related to member rights and protections to VO, a partner within CHP. The VO Member Rights and Responsibilities policy included each of the rights at 42CFR438.100 and as described in the Colorado Medicaid Managed Care contract. The policy also described the procedures for notifying members of these rights. VO also had policies that described how member materials, which included explanation of member rights, were distributed to members.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: II.F.3.a	**Documents Submitted/Location Within Documents:** 1. FacilityContract_VOCO – Section Page 27 of 28, G.1 (n); Page 7 of 28 - 5.4 (a) 2. IPN_Contract_VOCO– Section 5.4 (a); page 26 0f 27, G.1 (n) 3. ProviderHandbook_Section15_OMFA_VOCO.pdf. - paragraph 1, 3, 5, 12, bullet 3 4. ProviderHandbook_Member_Rights_CHP Section15.8 5. Provider_Training_Presentation_3BHO.pptm - Pages 67-71 6. MemberHandbook_CHP – Pages 16-19 *Misc **Description of Process:** There are a variety of methods in place to ensure that network and affiliated providers and staff are knowledgeable about member rights and responsibilities and the requirement to uphold those rights. Both FacilityContract_VOCO.pdf - and the IPN_Contract_VOCO.pdf describe providers' or facilities responsibility for upholding and respecting member rights. Providers are encouraged to post the downloadable member rights poster in the provider handbook is encouraged to be posted in providers' offices and given to members. The Provider	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Handbook, ProviderHandbook_Section15_OMFA_VOCO.pdf references member rights, how members contact an advocate if member has a grievance or how to access other OMFA services that are offered. ValueOptions does a minimum of four face-to-face provider forums where an overview of member rights is presented in the **Provider**_Training_Presentation_3BHO.ppt. Member handbooks are made available to providers. MemberHandbook_CHP is available to be distributed to members at intake or when member rights and responsibilities are discussed.	
Findings: The VO/CHP Provider Manual (provider manual) described provider responsibilities for ensuring member rights, and described the responsibilities of the VO/CHP Office of Member and Family Affairs (OMFA). Both of the VO provider agreement templates informed providers that the list of member rights can be found in the provider manual and informed providers of the expectation that providers take members' rights into account when furnishing services. The template agreements also included the provider's responsibilities for informing members of their rights. The online provider manual included a downloadable member rights poster. During the on-site interview, CHP staff reported that providers are asked to either post the member rights poster (in CMHCs and larger offices) or distribute the list of rights during the first treatment session. Provider forums were developed for the target audience of independent network providers and included member rights and OMFA information. CHP staff reported that each CMHC has an OMFA representative responsible for training staff and providers at each network CMHC. VO, as the partner responsible for provider and network monitoring, conducted annual on-site monitoring of the CMHCs that included reviewing evidence of training (e.g., agendas, sign-in sheets) at each CMHC. CMHC training related to member rights was required at initial employee orientation and annually.		
Required Actions: None.		
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available	**Documents Submitted/Location Within Documents:** **Bullet Point 1:** Members are given information in accordance with the requirements stated in 42CFR438.10. 1. ScreenShot_OMFA_MemberRights_CHP http://www.coloradohealthpartnerships.com/members/mbr_your_rights.htm 2. MHC_contract_compliance_audit_tool_CHP - item 1 3. ProviderHandbook_Section15_OMFA_VOCO- Entire document http://www.coloradohealthpartnerships.com/provider/handbook/Section15_OMFA.pdf 4. 306LMemberMaterials_Policy_VOCO.doc-sections III.A-E; IV.B; V.A.1-4 5. 307LMemberInfoReq_Policy_VOCO.doc- Entire Policy *Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
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, and the right to a second opinion. ◆ 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 requirements for access and quality of services (42CFR438.206 and 42CFR438.210). Additional member rights, include 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	**Description of Process:** Members are given information in accordance with the requirements stated in 42CFR438.10. In the ScreenShot_OMFA_MemberRights_CHP, this document contains all of the various member rights, including policies, complaints and grievances, non-discrimination and other rights protections. Furthermore, MHC_contract_compliance_audit_tool_CHP item 1 review CHP mental health centers for their policies on member rights. Moreover, ProviderHandbook_Section15_OMFA_VOCO.pdf instructs providers of their requirement to uphold member rights, and what is required to be posted. Finally, policies 306LMemberMaterials_Policy_VOCO.doc III.A-E; IV-b; V.A.1-5- describes requirements in developing and distributing member materials to make them consistent with 42CFR438.10 and policy 307LMemberInfoReq_Policy_VOCO.doc- entire policy describes all of the content required to be included in member materials according to 42CFR438.10 **Bullet Point 2:** Be treated with respect and with due consideration for his or her dignity and privacy 1. 304LMemberRandR_Policy_VOCO.doc -section III.A.3, 5 2. MemberHandbook_CHP - Inside cover, pages 18 -26; page 17 *Misc **Description of Process:** The Members Rights and Responsibilities policy, 304LMemberRandR_Policy_VOCO.doc - III.A.3, 5, is the policy that guides our position on protecting member rights. All CHP members receive an annual member handbook, MemberHandbook_CHP- inside cover, pages 18-26; page 17 where it explains what action members can take if they feel their rights have not been respected, as well as confidentiality and how member's personal health information is protected. **Bullet Point 3:** Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand 1. 304LMemberRandR_Policy_VOCO.doc –section III.A.7 2. MemberHandbook_CHP– Page 9 & 10 *Misc **Description of Process:** Members Rights and Responsibilities policy, **304LMemberRandR_Policy_VOCO.doc – III.A.7** discusses the right of members to	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
disabilities or for non-English-speaking members. ◆ Prompt notification of termination or changes in services or providers. ◆ Express an opinion about the Contractor's services to regulatory agencies, legislative bodies, or the media without the Contractor causing any adverse effects upon the provision of Covered Services. *42CFR438.100(b)(2) and (3)* Contract: II.F.1, II.F.4.j.3	participate in discussion with their provider(s) regarding appropriate or medically necessary treatment options. **MemberHandbook_CHP– Page 9 & 10** talk about developing a treatment plan collaboratively, and how to ask for alternative treatments and what to do if a member has a disability. **Bullet Point 4:** Participate in decisions regarding his or her healthcare, including the right to refuse treatment, and the right to a second opinion, 1. 304LMemberRandR_Policy_VOCO.doc –section III.A.14 2. ProviderHandbook_Section6_SecondOpinion_CHP.pdf 3. Member Handbook_CHP – page9, 14 *Misc 4.ScreenShot_LevelofCareGuidelines_CHP.docx 5. ScreenShot_AchieveSolutions_CHP.docx **Description of Process:** Members Rights and Responsibilities policy, 304LMemberRandR_Policy_VOCO.doc – III.A.14. states that members have the right to a second opinion. Member rights to a second opinion are also described in HandbookProviderHandbook_Section6_SecondOpinion_CHP. Members' rights to a second opinion and contact information to do so are described in Member_Handbook_CHP -page 14. MemberHandbook_CHP - page 9 describes how decisions are made about care and how a member can get copies of level of care guidelines which explains medical necessity. Members are offered easy access to level of care and clinical guidelines through ScreenSHot_LevelofCareGuidelines_CHP.docx, which are used to help make informed care decisions. ScreenShot_AchieveSolutions_CHP.docx is a member and provider education tool that is available to our membership and offers a variety of topics on mental health, services, help to make decisions and offers other tools that enable members to take part in their care decisions. **Bullet Point 5:** Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, 1. 304LMemberRandR_Policy_VOCO.doc –section III.A. 19	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: Members Rights and Responsibilities Policy, 304LMemberRandR_Policy_VOCO.doc – .III.A. 19, defines members right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. **Bullet Point 6:** Request and receive a copy of his or her medical records and request that they be amended or corrected. 1. LMemberRandR_Policy_VOCO.doc –section III.A. 21-27 2. Notice_of_Privacy_Practices_CHP.doc– Entire Document 3. Notice_of_Privacy_Practices _Spanish_CHP.doc– Entire Document 4. LC400MemberPrivacyRights_Policy_VOCO.pdf; Section V.B.1., V.C.1.,V.D.1.,V.E.1.,V.F.1. **Description of Process:** Member Rights and Responsibilities Policy, 304LMemberRandR_Policy_VOCO.doc – .III.A. 21-27, informs members of their right to get a copy of their protected health information subject to certain limitations. Members are also informed through, Notice_of_Privacy_Practices_CHP.doc- Entire Document and Notice_of_Privacy_Practices _Spanish_CHP.doc– Entire Document, on how they can request to see and get copies of their medical records and make changes or additions to their record. MemberPrivacyRights_VO.pdf; section V.B.1., V.C.1.,V.D.1.,V.E.1.,V.F.1 **Bullet Point 7:** Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210) 1. 304LMemberRandR_Policy_VOCO.doc –page 4,10,11,12,13,14,15 2. ProviderHandbook_Section3_Provider_Assistance_and_Referrals_VOCO.pdf – pages 3-6 3. MemberHandbook_CHP - page 4, 5 *Misc 4. ProviderDirectory_2012SEP_3BHO.pdf - Entire Document http://www.coloradohealthpartnerships.com/members/pdf/ValueOptions_Colorado_Partnerships_Provider_Directory.pdf 5. N201_Practitioner Credentialing _Process_Policy_VOCO.pdf	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: 304LMemberRandR_Policy_VOCO.doc – 4,10,11,12,13,14,15 is the guiding policy for ensuring health care services are furnished in accordance with requirements for access and quality of services (42CFR438.206 and 42CF438.210). ProviderHandbook_Section3_Provider_Assistance_and_Referrals_VOCO.pdf , pages 3-6, describes access standards for providers; that providers cannot provide different hours or a different standard of service for Medicaid members than for other clients; requirements for routine, urgent and emergency services and follow up. MemberHandbook_CHP_- page 4, 5 explain access standards for mental health services. ProviderDirectory_2012SEP_3BHO.pdf - Entire Document is also distributed to all new enrollees in hard copy format and is downloadable from the CHP websites at: http://www.coloradohealthpartnerships.com/members/pdf/ValueOptions_Colorado_Partnerships_Provider_Directory.pdf Furthermore, N201_Practitioner Credentialing _Process_Policy_VOCO.pdf describes the credentialing process all providers are subject to ensure they meet the rigorous credentialing standards. Once in the network a member can select a provider by viewing online provider directory using the referral connect tool on the web site or by calling a clinical services assistant. **Bullet Point 8:** Have an independent advocate, 1. 304LMemberRandR_Policy_VOCO.doc - .III.A. 9 2. MemberHandbook_CHP– page 6, 18, 19, 20 *Misc 3. SCREENSHOT_ADVOCACY_CHP-Entire document **Description of Process:** Member Rights and Responsibilities Policy, 304LMemberRandR_Policy_VOCO.doc - .III.A. 9, specifies that members can be represented by a person of their choosing in their interactions with ValueOptions Colorado. MemberHandbook_CHP - page 6 describes the fact that members can have an independent advocate to help them in their service planning and pages 18, 19 & 20 describe how to use an advocate in the grievance and appeal process. Member can have an advocate in any dealings with the BHO or their provider. SCREENSHOT_ADVOCACY_CHP.docx is a web page that describe how to reach advocates.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Bullet Point 9: Request that a specific Provider be considered for inclusion in the Provider network 1. 304LMemberRandR_Policy_VOCO.doc –III.A.13 2. MemberHandbook_CHP - page 16 *Misc 3. ProviderHandbook_Section5_ClientChoice_of_Providers_CHP- Entire document **Description of Process:** Value Options Members Rights and Responsibilities policy, 304LMemberRandR_Policy_VOCO.doc –III.A.13 is the guiding policy that ensures members can request that a specific Provider be considered for inclusion in the Provider network. The list of member rights are in the MemberHandbook_CHP- on page 16, which include that a specific Provider be considered for inclusion into the Provider network, as well as included in ProviderHandbook_Section5_ClientChoice_of_Providers_CHP.pdf **Bullet Point 10:** receive a second opinion 1. 304LMemberRandR_Policy_VOCO.doc – III.A. 14 2. MemberHandbook_CHP– page 14 *Misc 3. ProviderHandbook_Section6_SecondOpinion_CHP- Entire document **Procedures:** As noted in requirement four above, a member has the right to request a second opinion from a network provider. **Bullet Point 11:** Receive culturally appropriate and competent services from participating providers 1. 304LMemberRandR_Policy_VOCO.doc Section– III.A.15, III.A 20 **Description of Process:** As noted in the provider handbook, we expect providers to consider cultural factors in their care of the member. OMFA conducts webinars and can provide training in cultural competence, as noted in ProviderHandbook_Section_15_OMFA, Page 2. The CHP Cultural Competence Plan is posted at http://www.coloradohealthpartnerships.com/members/pdf/Cultural_Competency_Plan_2010.pdf	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Bullet Point 12: Receive interpreter services for members with communication disabilities or for non-English speaking members 1. ProviderHandbook_Section15_OMFA_VOCO.pdf. – paragraphs 2,. 2. MemberHandbook_CHP– page 8(entire section), 10 *MISC **Description of Process:** Members have the right to get interpreter services if needed. We have a list of interpreters and are constantly expanding the list of qualified interpreters. A member, advocate or family member can request an interpreter. We will make arrangements for the interpreter to be present at the therapy sessions. We will coordinate the appointment so that the interpreter, the therapist and the member are present. In no case do we allow family members or friends to act as interpreters when a member is getting clinical services. **Bullet Point 13**: Prompt notification of termination or changes in services or providers 1. 304LMemberRandR_Policy_VOCO.doc – III. A. 16 2. ProviderTermination_Letter_Template_CHP- Entire document **Description of Process:** The service center has policies and procedures to ensure we notify members when a provider terminates from the network. This includes voluntary termination, involuntary termination, or any other reason the provider stops seeing members. The OMFA Department receives notice from provider relations that a provider will be disenrolled from the network. This notification comes to us between 40-50 days of the termination date. The OMFA Department gets a list of all members the provider is currently seeing, or has seen in the last 6 months. We send each member a letter informing the member that the provider is being terminated, the date of the termination, and how to reach the service center to find another provider. The member may ask us to find a provider, or may just ask for a list of providers and will look for themselves.. **Bullet Point 14**: Express an opinion about the Contractor's services to regulatory agencies, legislative bodies or the media without the Contractor causing any adverse effects upon the provision of Covered Services 1. 304LMemberRandR_Policy_VOCO.doc – III. A.17	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: Members are informed about their rights through a variety of mechanisms. Member rights are contained in the member handbook, the welcome letter, posted on the web site and listed. Providers and staff are informed about their responsibility to uphold member rights through the provider contracting process, in the provider handbook, provider forums and provider webinars. Staff is instructed about member rights during their staff orientation. Value Options also highlights in their staff training the fact that members should not be retaliated against if and when they file a grievance. As part of Value Options recovery training members are encouraged to advocate for themselves whether it be to providers, legislatures or other decision makers. Value Options also monitors the grievance process to determine whether or not members' rights have been violated as a result of members voicing complaints.	
Findings: The VO Member Rights and Responsibilities policy included each of the member rights. The list of member rights was available on the CHP Web site under both the provider and member tabs. CHP provided evidence of monitoring VO contracted providers and the CMHCs for compliance with requirements related to member rights. The provider manual included each of the member rights and described provider responsibilities related to member rights.		
Required Actions: None.		
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. *42CFR438.100(c)* Contract: II.F.1.h	**Documents Submitted/Location Within Documents:** 1. ProviderHandbook_Section15_OMFA_VOCO.pdf. - pages 1-3 2. MemberHandbook_CHP- – page 24 & throughout the member handbook *Misc 3. Screenshot_OMFA_Description_RightsProtection_CHP-Entire Document 4. 304LMemberRandR_Policy_VOCO.doc –section III. A.17 **Description of Process:** The Office of Member and Family Affairs (OMFA) is tasked with the responsibility to uphold member rights without retaliation to the member. This is done through member and provider education and through the grievance process. 304LMemberRandR_Policy_VOCO.doc is the guiding policy to ensure members rights and responsibilities are upheld. ProviderHandbook_Section15_OMFA_VOCO.pdf discusses member rights and responsibilities and the importance of members being able to exercise those rights. The MemberHandbook_CHP explains to members how they can exercise their rights without retaliation through the grievance process as well as,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Screenshot_OMFA_Description_RightsProtection_CHP.docx. Value Options recovery training encourages members to advocate for themselves.	

Findings:
The VO Member Rights and Responsibilities policy included the right to free exercise of rights that does not affect how providers or the BHO treat the member. This right was also listed in the CHP Member Handbook (member handbook). The member handbook and the CHP Web site informed members about the OMFA and the role of OMFA to ensure member access to the grievance and appeals processes. The provider manual informed providers that filing a grievance or an appeal should not restrict or compromise member access to mental health services. During the on-site interview, CHP staff reported that members are encouraged on an ongoing basis by therapists and during member groups, such as member advisory groups, to access their rights and use processes available to them, such as the grievance and appeals processes.

Required Actions:
None.

Requirement	Evidence as Submitted by the BHO	Score
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)* Contract: VII.T	**Documents Submitted/Location Within Documents:** 1. 310LNonDiscrimination_Policy_VOCO.docx – entire policy 2. 304LMemberRandR_Policy_VOCO.doc -section III.A.4 3. MemberHandbook_CHP– inside cover *Misc **Description of Process:** Members are informed of our non-discrimination policy in the member handbook under the listing of member rights and on inside cover of the MemberHandbook_CHP. This information is also clearly detailed in policies and procedures, 310LNonDiscrimination_Policy_VOCO.docx and 304LMemberRandR_Policy_VOCO.doc. Rights violations are monitored through the grievance process. Value Options nondiscrimination policy was developed based on federal regulations which address discrimination.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The VO Nondiscrimination policy described the rights associated with each of these legislations. The policy described examples and forms of discrimination and the process for using the grievance system tracking to detect possible discrimination. Nondiscrimination was on the list of rights in the member handbook, and a statement of nondiscrimination and related rights was found on the inside cover of the handbook. Staff reported that these nondiscrimination legislations were addressed in new employee orientation and in annual training at the VO service center as well as at the CMHCs.

Required Actions:
None.

Results for Standard IV—Member Rights and Protections							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	5	**Total Score**		=	5

Total Score ÷ Total Applicable	=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. NCQA CR1	**Documents Submitted/Location Within Documents:** 1. N101_Overview_of_National_ Networks_Policy – Entire policy 2. N201_Practitioner_ Credentialing _Process – Entire policy 3. N203_Facility_ Provider_ Credentialing Process – Entire policy 4. N501_Practitioner_ Recredentialing _Process – Entire policy 5. N502_Facility_ Program_ Clinic _Recredentialing_ Process – Entire policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions carefully evaluates the credentials of each applicant seeking network participation based on uniform, objective criteria detailed in our Credentialing and Primary Source Verification processes and policies.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: VO, on behalf of CHP, had several policies and procedures that thoroughly described the credentialing and recredentialing processes and demonstrated compliance with NCQA requirements. During the on-site interview, VO/CHP staff reported that VO had applied for credentialing verification organization (CVO) status through NCQA and was scheduled for an NCQA site visit.		
Required Actions: None.		
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers,	**Documents Submitted/Location Within Documents:** 1. N301_Development_of_Credentialing_ Criteria – Page 1 2. N205_Discipline_Specific_Credentialing_Criteria_for_ Practitioners – Entire Policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions maintains a network of mental health providers. The delegate has specific policies (N301) and procedures that detail the types of mental health (non-physician) practitioners and medical practitioners it will credential.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
psychiatric nurse specialists, and or licensed professional counselors.) *42CFR438.214(a)* NCQA CR1—Element A1		
Findings: The VO Discipline Specific Credentialing Criteria for Practitioners policy described each type of practitioner credentialed for CHP.		
Required Actions: None.		
2.B. The verification sources used. NCQA CR1—Element A2	**Documents Submitted/Location Within Documents:** 1. N401_Primary_Source_Verification_Policy – Entire policy 2. N401A_Sample_Primary_Source_Verification_Report-Entire Policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions requires potential and current providers to provide specific information to meet the minimal criteria for inclusion in the provider network. This information is detailed in the N401 Primary Source Verification policy and procedure.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The primary verification sources described in the VO policy met NCQA requirements for primary source verification. VO (on behalf of CHP) used primary sources such as the Colorado Department of Regulatory Agencies (DORA) to verify State licenses, and the federal OIG database to verify eligibility to participate in federal health care programs.		
Required Actions: None.		
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents Submitted/Location Within Documents:** 1. N205_Discipline_Specific_Credentialing_Criteria_for_ Practitioners – Entire Policy 2. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Entire Policy 3. N501_Practitioner_ Recredentialing _Process – Entire policy 4. N502_Facility_ Program_ Clinic _Recredentialing_ Process – Entire policy	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: As described in the attached policies, ValueOptions maintains specific criteria for credentialing and recredentialing.	
Findings: The VO Discipline Specific Credentialing Criteria for Practitioners policy described the credentialing criteria for each type of practitioner that VO credentials and recredentials on behalf of CHP.		
Required Actions: None.		
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents Submitted/Location Within Documents:** 1. N101_Overview_of_National_Networks_Policy – Entire policy 2. N201_Practitioner _Credentialing_Process – Entire policy 3. N501_Practitioner_Recredentialing_Process - Entire policy 4. N203_Facility_Provider_Credentialing_Process – Entire policy 5. N502_Facility_Program_Clinic_Recredentialing_Process – Entire policy 6. N601_Role_of_National_Credentialing_Committee– Entire policy 7. N604_Role_of_Local_Credentialing_Committee – Entire policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions has policies that detail the credentialing and recredentialing decision process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Credentialing Process and the VO Practitioner Recredentialing Process policies described VO's processes for making credentialing and recredentialing decisions and delineated the roles of national VO and local CHP staff members. During the on-site interview, VO staff stated that the credentialing specialist who performs primary source verification and manages the applicant's file is located at VO's national office. Staff reported that two specific credentialing specialists are assigned to Colorado applications and are provided a spreadsheet that includes specific Colorado requirements and processes.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents Submitted/Location Within Documents:** 1. N202_Organization_of_Practitioner _Credentialing_ &_ Recredentialing_ File – Entire policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions has a policy and procedure that clearly outlines the management and organization of credentialing and recredentialing files. All of these files are maintained electronically and include a minimum set of information on all providers who submit an application to be included in the provider network.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The processes used for managing CHP provider credentialing and recredentialing files, as described in VO policies, met NCQA requirements. On-site review of credentialing and recredentialing records demonstrated compliance with VO policies and procedures and NCQA standards and guidelines.		
Required Actions: None.		
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documents Submitted/Location Within Documents:** 1. CredentialingandRecredentialingDelegationPolicy_CHP-Entire Policy 2. Final Management Services Agreement2011July01COM_CHP – entire policy 3. DelegationAgree2011_CHP-Entire Policy *Misc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions (refer to CHP Credentialing/Recredentialing Delegation Policy and the management services and delegation agreement).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP Credentialing and Recredentialing Delegation policy described processes for delegation and delegation oversight of VO in credentialing and recredentialing CHP practitioners.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes). NCQA CR1—Element A7	**Documents Submitted/Location Within Documents:** 1. N101_Overview_of_National_Networks_Policy – Pg. 2, Section IV, B and C 2. BiAnnual_Audit_2012_Sample-- Entire document **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N101 clearly states that credentialing and recredentialing decisions are made in a non-discriminatory manner.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Nondiscrimination practices described in VO's policies included audits to ensure nondiscrimination and processes to respond to audit findings or any complaints received. CHP provided an example of a completed nondiscrimination audit. During the on-site interview, CHP/VO staff members reported that the audit provided as an example did not necessarily include Colorado providers, as the sampling was taken from the national provider database to evaluate VO processes in general. The sample for this type of audit is not weighted by state.		
Required Actions: None.		
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	**Documents Submitted/Location Within Documents:** 1. N207_Practitioner_Rights_and _Notification_ Policy – Page 3, Section V.B. **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that providers are notified if staff identify discrepancies during the credentialing or recredentialing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The VO Practitioner Rights and Notification policy included the process for clarifying discrepancies in information gathered for the credentialing and recredentialing process.		
Required Actions: None.		
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the committee's decision. NCQA CR1—Element A9	**Documents Submitted/Location Within Documents:** 1. N201_PractitionerCredentialing_Process_Policy_VOCO– Page 1, Section V, G 1, 2b 2. N601_Role_of_National_Credentialing_Committee – Page 2, Section V, F1 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N201 and N601states that practitioners are notified of the credentialing/recredentialing decision within 60 days.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Credentialing and Recredentialing Process policy described processes for notifying applicants within 5 days of adverse decisions, and within 60 days of decisions to include the applicant in the provider network.		
Required Actions: None.		
2.J. The medical director's or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	**Documents Submitted/Location Within Documents:** 1. N601_Role_of_National_Credentialing_Committee - Page 3, Section V, F1 2. N604_Role_of_Local_Credentialing_Committee – Page 2, Section V, B, C, E **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies on the National and Local Credentialing Committees state that the Chief Medical Officer or the designated Medical Director has direct credentialing responsibilities	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: VO's policies stated that the local medical director (i.e., the CHP medical director) is the chair of the local credentialing committee and that the medical director may sign off on clean files that meet VO's criteria for participation in the network. During the on-site interview, VO staff members clarified VO's process. Staff reported that the medical director sign-off refers to the VO national medical director; and although the policy indicates that the medical director may sign off on		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
clean files, the medical director makes a recommendation and sends a report with recommendations to the national credentialing committee (NCC). The NCC approval is the credentialing date.		
Required Actions: None.		
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process, except as otherwise provided by law. NCQA CR1—Element A11	**Documents Submitted/Location Within Documents:** 1. N409_Confidentiality_of_Provider_Other_Credentialing Information – Entire Policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N409 indicates that all information that is provider-specific in the provider's credentialing file is confidentially maintained. Furthermore, it is ValueOptions policy that any information in the provider's credentialing file will not be released without explicit consent from the provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Confidentiality procedures described in the policies included limited electronic and physical access based on job category and need for the information. Need for the information was related to completion of the credentialing/recredentialing process. Limited physical access included receiving hard copy applications in a locked mail room and scanning documents directly from the mailroom. Electronic security included password protections based on job category. Other processes described included staff training and a required attestation/agreement to maintain confidentiality for staff members involved in the credentialing process. Staff reported that VO performs an annual review of staff electronic access based on job category to ensure appropriate access.		
Findings: None.		
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documents Submitted/Location Within Documents:** 1. N412 Provider_Directory_and_Other_Enrollee_Information– Page 1, Section III **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy indicates that any information listed in the provider directory comes directly from the provider credentialing database. Information in the provider credentialing database may not be altered and is quality-checked by the credentialing specialist and/or the credentialing manager.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: VO's policies stated that provider directories are printed directly from the credentialing database. The policies described the process to update the database as changes occur. On-site, staff members reported that provider directories for member eligibility mailings are printed monthly. Only the number of directories needed are printed to ensure that the most recent information is sent to new members. Staff members reported that the online searchable database has updated provider information within 48 hours of a change to the national provider database. Staff also reported that the .pdf copy of the provider directory placed on the CHP Web site is updated monthly when the hard copy provider directories are printed for member mailings.		
Required Actions: None.		
2.M. The right of practitioners to review information submitted to support their credentialing or recredentialing application, upon request. NCQA CR1—Element B1	**Documents Submitted/Location Within Documents:** 1. N207_Practitioner_Rights_and_ Notification_ Policy – Page 2, Section V, A **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that practitioners have the right to review information submitted to support their credentialing application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Rights and Notification policy described the process for providing information to applicants upon request. Staff members reported that applicants are provided the toll-free provider support number with application materials; therefore, requests are handled at the VO national office. If applicants call the Colorado VO service center, a warm transfer can be done.		
Required Actions: None.		
2.N. The right of practitioners to correct erroneous information. NCQA CR1—Element B2	**Documents Submitted/Location Within Documents:** 1. N207_Practitioner_Rights_and _Notification_ Policy – Page 3, Section V.B. **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that practitioners have the right to correct erroneous information in their credentialing application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Rights and Notification policy addressed the applicant's right to correct erroneous information.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.O. The right of practitioners, upon request, to receive the status of their application. NCQA CR1—Element B3	**Documents Submitted/Location Within Documents:** 1. N207_Practitioner_Rights_and _Notification_ Policy – Page 4, Section V.C **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that practitioners have the right to request information regarding the status of their credentialing application and be provided that information.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Rights and Notification policy stated that applicants may request and receive the status of their application either verbally or in writing.		
Required Actions: None.		
2.P. The right of applicants to receive notification of their rights under the credentialing program. NCQA CR1—Element B4	**Documents Submitted/Location Within Documents:** 1. N207_Practitioner_Rights_and _Notification_ Policy – Page 4, Section V.D **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policy N207 states that practitioners who have submitted a credentialing application are to be notified of their rights to review information in their credentialing application, correct erroneous information, and to request information about the status of their application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings The policy stated that the provider welcome packet describes how to obtain the provider manual online or in hard copy. The provider manual included applicant rights under the credentialing program. In addition, the Colorado standard provider application informed applicants of their rights under the credentialing program.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure. ◆ Collecting and reviewing complaints. ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR9—Element A	**Documents Submitted/Location Within Documents:** 1. N710_Ongoing_Monitoring_of_Provider_Sanctions – Entire Policy 2. Sanction_Review_Log_2012-- Entire document 3. N703_Involuntary_Suspension_Quality_of_ Care – Entire Policy 4. Q314_Identification_and_Monitoring_of_Potential_Quality_of_Care_Issues_and_Trends – Pages 4-6 5. Q317_Investigation_of_Adverse_Incidents – Pages 3-4 6. NCC_Minutes_012412 – Sample –Entire Document 7. CLCC_Minutes_2012Aug_PR – Page 2; New Issues 8. CLCC_AdvisoryForum_2012AUG_PR – Entire Document **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. Monitoring of sanctions, complaint and adverse events occurs locally for the initial review and recommendations; these issues are then referred to the Local Credentialing Committee for review and on to ValueOptions' National Credentialing Committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Ongoing Monitoring of Provider Sanctions policy stated that required Web sites are searched 30 days after the regular release of sanction information on that Web site. On-site, CHP/VO staff members provided examples of monthly database searches for sanctions to compare to the Colorado provider list. Staff members confirmed a monthly search of the federal database (OIG), National Practitioner Data Bank (NPDB), and DORA.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.R. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR10—Element A1	**Documents Submitted/Location Within Documents:** 1. N701_Practitioner_and_Provider_ Compliance – Pages 2-4, Section V 2. N703_Involuntary_Suspension_Quality_of_ Care – Pages 3-4, Section V, E and G 3. N705_Practitioner_Disenrollments – Entire Policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies detail the actions available to manage network providers who do not meet minimum standards of quality. Policy N701 details the written warning, monitoring, and consultation process. Policies N703 and N705 detail the process for involuntary suspension and disenrollment from the provider network.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner and Provider Compliance policy described a wide range of actions possible against a practitioner for noncompliance or quality reasons, based on the type of compliance issue identified. Actions to be taken (as described in the Involuntary Suspension policy and the Practitioner Disenrollments policy) included training, increased monitoring, suspension, or disenrollment, as appropriate. On-site, staff members provided examples of actions taken for selected providers. Staff members reported that in the past, one provider was removed from the network due to loss of license and that one audit based on quality of care complaints was in process at the time of the site review.		
Required Actions: None.		
2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR10—Element A2 and B	**Documents Submitted/Location Within Documents:** 1. N703_Involuntary_Suspension_Quality_of_ Care – Entire Policy 2. N705_Practitioner_Disenrollments – Page 4, Section V, B8 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies detail the actions available to manage network providers who do not meet minimum standards of quality. Included are policies that address procedures for taking action against providers and reporting those actions to the appropriate authorities.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: VO's policies addressed reporting to NPDB and, as required, to State regulatory agencies, if appropriate. Staff members confirmed that decisions to report sanctions or terminations are made by the NCC, the agencies reported to are determined on a case-by-case basis, and DORA may be notified as appropriate.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2.T. A well-defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR10—Element A3and C	**Documents Submitted/Location Within Documents:** 1. N606_Provider_Appeal_Process – Entire policy 2. N607_Fair_Hearing_Process – Entire policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies detail the process available to practitioners if they choose to formally appeal decisions of the ValueOptions®' National Credentialing Committee.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: VO's policies described the appeal process for providers for whom VO has taken action or changed the conditions of the provider participation based on quality of care issues. Appeal processes included all the required processes.		
Required Actions: None.		
2.U. Making the appeal process known to practitioners. NCQA CR10—Element A4	**Documents Submitted/Location Within Documents:** 1. EQRO ProviderManual_2012Sept_PR –Page 37 & 38 *Misc 2. Disenrollment_Letter-Entire Document **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions process for informing practitioners of the appeal process is detailed in the Colorado Medicaid and National Provider Handbooks and in the Practitioner Agreement.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: VO's credentialing and recredentialing policies stated that applicants are notified of the appeal process in writing when notified of the adverse decision. CHP provided an example of a disenrollment letter sent by VO, which informed the provider of how to appeal the decision. The provider manual also informed providers of their right to appeal and to a fair hearing, in cases of sanctions or disenrollment from the provider network. The provider manual was incorporated into the provider agreement by reference.		
Required Actions: None.		
3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A	**Documents Submitted/Location Within Documents:** 1. N601_Role_of_National_Credentialing_Committee – Entire Policy 2. N604_Role_of_Local_Credentialing_Committee – Entire Policy 3. NCC_Minutes_082112- Page 1 4. Minutes_CLCC_2012Aug10-Page 1 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions uses a peer-review process via the Local Credentialing Committee and a National Credentialing	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Committee to make credentialing/recredentialing decisions. The committee's membership includes a range of participating providers from specific disciplines indicating a peer review process is used.	
Findings: VO policies described the roles of the local credentialing committee (LCC), which is the CHP-level committee, and the NCC. The LCC roster and minutes demonstrated adequate local professional representation and use of the peer review process to make recommendations to the NCC.		
Required Actions: None.		
4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioners who do not meet established thresholds. ◆ Medical director or equally qualified individual review and approval of clean files. NCQA CR2—Element B	**Documents Submitted/Location Within Documents:** 1. NCC_Minutes_082112,-Page 4 2. Minutes_CLCC_2012Aug10- Page 2 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. Minutes from the National and Local Credentialing Committees reflect the review of provider credentials who do not meet minimum thresholds and that the medical director (or equally qualified designee) review/approve practitioner files.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: LCC and NCC meeting minutes demonstrated review of credentials for selected practitioners and review and approval of practitioners recommended (by report) by the national medical director to the NCC for inclusion in the network. On-site, staff members clarified that the local credentialing committee is a single committee for the VO Colorado network, which includes three BHOs. Each BHO is represented on the committee by participation of each BHO's medical director and selected providers and/or quality improvement staff.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification [board certification time limit = 180 calendar days]). ◆ Work history (verification time limit = 365 calendar days) (non-primary verification—most recent 5 years). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the	**Documents Submitted/Location Within Documents:** 1. N401_Primary_Source_Verification_Policy – Entire policy 2. N401A_Sample_Primary_Source_Verification_Report -Entire Report **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. The attached policies and checklist detail the verification process and elements reviewed during the credentialing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
practitioner (verification time limit = 180 calendar days). NCQA CR3—Elements A and B		
Findings: The VO Primary Source Verification policy described the processes to conduct timely primary source verification. CHP provided a sample verification report used to track the process for individual practitioners and ensure that the information is verified within the required time frames. On-site review of credentialing records demonstrated that all primary source verification was completed within the required time frames.		
Required Actions: None.		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums = physician—.5mil/1.5mil; facility—.5mil/3mil). ◆ The correctness and completeness of the application.	**Documents Submitted/Location Within Documents:** 1. N201_PractitionerCredentialing_Process_Policy_VOCO–Page 3, Section V E 2. N501_Practitioner_Recredentialing_Process – Page 3, Section V E 3. CO_Standard_Cred_Application-Page 17, Section X, Page 19, Section A, Page 20 Section C, F and G, Page 21 Section 1, Page 25 Section 3, 4, Page 26 Section 1, 2, Page 40 pp1, **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. It is ValueOptions policy that any practitioner who applies for inclusion into the Colorado Medicaid provider network must complete an application that includes a current attestation that addresses the following issues: reasons for inability to perform essential functions, lack of illegal drug use, any loss of license, any felony convictions, any loss or limitation of privileges, proof of malpractice insurance, and to the correctness/completeness of their application.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
NCQA CR4—Element A NCQA CR7—Element C C.R.S.—13-64-301-302		
Findings: On-site review of credentialing and recredentialing records demonstrated that VO requires the Colorado standard credentials application. Each record contained the completed application. The application included the required content and required the applicant to attest to the accuracy and completeness of the information provided. VO used a VO supplement to the application that informed providers the amount required for malpractice/liability insurance. On-site review of credentialing and recredentialing records demonstrated that providers met or exceeded the requirements for malpractice insurance amounts.		
Required Actions: None.		
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR5—Element A NCQA CR7—Element D	**Documents Submitted/Location Within Documents:** 1. N401_Primary_Source_Verification_Policy – Entire Policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. Per ValueOptions policy N401 on the credentialing process, the credentialing committees receive information on provider sanctions prior to making a credentialing decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Primary Source Verification policy included the processes used to query for sanction activity using NCQA-compliant sources. Each of the credentialing and recredentialing records reviewed on-site contained evidence of query for sanction activities using the OIG, DORA, and/or the NPDB as applicable.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR6—Element A	**Documents Submitted/Location Within Documents:** 1. N406A_Practitioner_Site_Visit – Entire policy 2. Practitioner_Site_Visit_Tool Entire Document 3. N406B_Facility_Organization_Site_Visit – Entire policy 4. Facility_Organization_Site_Visit_Tool - Entire Document 5. Site_Visit_Example1-Entire Document 6. Site_Visit_Example2-Entire Document **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions has policies that detail minimum standards for office space and medical record documentation criteria. In addition, ValueOptions® has policies that explain how these standards are monitored via the site review process.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Site Visit policy stated that VO's criterion for complaints that trigger a site visit (for individual practitioners) is two complaints within a six-month period. The Practitioner Site Visit Tool was thorough. During the on-site interview, staff members reported that there had been no individual practitioners in Colorado that met the criterion for requiring a site visit. Staff also reported that VO uses a national vendor for site visits, but if deemed appropriate, Colorado provider support staff could do a site visit in response to complaints.		
Required Actions: None.		
9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds.	**Documents Submitted/Location Within Documents:** 1. N406A_Practitioner_Site_Visit – Entire policy 2. Practitioner_Site_Visit_Complaint_Reports 3. NCC_Minutes_012412 – Sample **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions policies state that required follow-up activities are triggered by the site review process or member complaints. These policies include corrective actions and the continued monitoring of member complaints. Complaints reports are run every six months and presented to the NCC. To date, there have been no practitioner sites that meet the criteria to require a Site Visit be conducted.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ Monitoring member complaints for all practitioner sites at least every six months. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR6—Element B		
Findings: These required steps were adequately described in the VO policy. During the on-site interview, staff members stated that if noncompliance with standards (such as medical record requirements) are discovered through clinical quality audits, corrective actions are required, the first step usually being individualized training. All training and subsequent interactions are maintained in the provider's file and are reviewed during the recredentialing process.		
Required Actions: None.		
10. The Contractor formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit = 180 calendar days). ◆ A valid DEA or CDS certificate (effective at the time of recredentialing). ◆ Board certification (verification time limit = 180 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the	**Documents Submitted/Location Within Documents:** 1. N501_Practitioner_Recredentialing_Process – Entire Policy 2. N502_Facility_Program_Clinic_Recredentialing_Process – Entire Policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions formally recredentials its providers every 36 months. This process utilizes information verified from primary sources and is specifically detailed in policies N501 and N502.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
practitioner (verification time limit = 180 calendar days). NCQA CR7—Elements A and B NCQA CR8— Element A		
Findings: The VO Practitioner Recredentialing Process policy described recredentialing independent practitioners, at least every 36 months, using primary source verification and all required processes. On-site review of recredentialing records demonstrated that NCQA-approved primary sources were used. One provider in the record review was recredentialed at 37 months instead of 36 months. The provider was non-responsive to initial requests for recredentialing information. The file included documentation of numerous attempts at contacting the provider, both in writing and verbally, and working with the provider until the required documentation was obtained. No required actions or recommendations are necessary related to this finding.		
Required Actions: None.		
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms that the provider is in good standing with State and federal regulatory bodies. NCQA CR11—Element A1	**Documents Submitted/Location Within Documents:** 1. N203_Facility_Provider_Credentialing_Process – Page 3, Section V. I 2. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Page 1, Section III, Page 2, Section IV.A.1 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. During the credentialing process, ValueOptions staff confirms that organizational providers are in good standing with state and federal regulatory bodies.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Facility Provider Credentialing Process policy described VO's NCQA-compliant procedures for assessing organizational providers. On-site review of organizational provider records demonstrated that VO verified licensure and queried the OIG database to verify eligibility to participate in federal health care programs.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
11.B. The Contractor confirms that the provider has been reviewed and approved by an accrediting body. NCQA CR11—Element A2	**Documents Submitted/Location Within Documents:** 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Page 2 Section V. A 4 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions credentialing criteria, as stated in policy N206, for organizational providers confirms whether the provider has been reviewed and approved by an accrediting body.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO policy described verification of whether the organizational provider has been reviewed and approved by an accrediting body. On-site record review demonstrated that VO verified accreditation status for accredited organizations. Accrediting bodies found in organizational provider files reviewed included the Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF).		
Required Actions: None.		
11.C. The Contractor conducts an on-site quality assessment if there is no accreditation status. NCQA CR11—Element A3	**Documents Submitted/Location Within Documents:** 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Page 2, Section IV.4 2. N406B_Facility_Organization_Site_Visit – Entire policy 3. Site_Visit_Example1 - Entire Document 4. Site_Visit_Example2 – Entire Document **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. If during the credentialing criteria for organizational providers ValueOptions is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO policy described the procedure for on-site quality assessment for non-accredited organizational providers. CHP provided two examples of completed site review forms. CHP performed annual contract compliance site reviews for network CMHCs, which included review of credentialing requirements. This exceeded the requirement to perform site visits at the time of recredentialing. All nonaccredited organizational provider records reviewed included a site visit.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
11.D. The Contractor confirms at least every three years that the organizational provider continues to be in good standing with State and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider has no accreditation status. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** 1. N502_Facility_Program_Clinic_Recredentialing_Process– Entire Policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions credentialing criteria for organizational providers confirms whether the provider has been reviewed and approved by an accrediting body and confirms that the organization continues to be in good standing with state and federal regulatory bodies at minimum every 3 years. If ValueOptions is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Facility/Program//Clinic Recredentialing Process policy included reassessment of organizational providers at least every 3 years. One organizational provider reviewed on-site was 3 months late. The record contained adequate documentation of numerous contacts with the facility beginning 5 months prior to the 36-month due date. The provider was non-responsive to initial requests for information. No required actions or recommendations are necessary related to this finding.		
Required Actions: None.		
11.E. The Contractor's policies list the accrediting bodies the Contractor accepts for each type of organizational provider. (If the Contractor only contracts with organizational providers that are accredited, the Contractor must have a written policy that states it does not contract with nonaccredited facilities.) NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Page 2, Section V A 4 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions accepts accreditation as per the ValueOptions policy. If ValueOptions is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The VO Credentialing Criteria for Facility/Organizational Providers policy listed acceptable accrediting organizations as NCQA, TJC, CARF, Council on Accreditation (COA), American Osteopathic Association (AOA), Healthcare Facilities Accreditation Program (HFAP), Accreditation Association for Ambulatory Health Care (AAAHC), Det Norske Veritas (DNV), or Community Health Accreditation Program (CHAP). Two of the organizational providers reviewed on-site were accredited: one by TJC, and one by CARF.		
Required Actions: None.		
12. The Contractor has a selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Pages 3-14, Section V. C. 2. N406B_Facility_Organization_Site_Visit – Page 2, Section V B **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. ValueOptions credentialing criteria for organizational providers confirms whether the provider has been reviewed and approved by an accrediting body and confirms that the organization continues to be in good standing with state and federal regulatory bodies. If ValueOptions is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions® conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Credentialing Criteria for Facility/Organizational Providers policy described the criteria for each type of organization to be included in the network.		
Required Actions: None.		
13. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Entire policy 2. Facility_Organization_Site_Visit_Tool – Page 2 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. The ValueOptions organizational site review process includes a review of	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	provider credentials for its practitioners. This information is detailed in policy N206 and in ValueOptions Facility Environmental Site Review.	
Findings: VO's policy and site visit tool included processes to ensure that organizational providers credential their individual practitioners. Completed site review tools were reviewed in organizational provider files.		
Required Actions: None.		
14. If the Contractor chooses to substitute a CMS or State review in lieu of the required site visit, the Contractor must obtain the report from the organizational provider to verify that the review has been performed and that the report meets its standards. (CMS or State review or certification does not serve as accreditation of an institution.) A letter from CMS or the applicable State agency which shows that the facility was reviewed and indicates that it passed inspection is acceptable in lieu of the survey report if the organization reviewed and approved the CMS or State criteria as meeting the organization's standard. NCQA CR11—Element A	**Documents Submitted/Location Within Documents:** 1. N406B_Facility_Organization_Site_Visit – Page 2, Section V A and Page 4, Section V M 2. Site_Visit_Example1 – Entire Document 3. Site_Visit_Example2 – Entire Document **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. If a provider indicates a state level or CMS review is completed, ValueOptions reviews the site visit to ensure criteria is met and the organization passed inspection.	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: The VO Credentialing Criteria for Facility/Organizational Providers policy indicated that a CMS or State certification could substitute for a site visit for non-accredited organizations. While VO obtained and reviewed Department of Behavioral Health (DBH) site reviews conducted at the CMHCs, and addressed any issues therein, VO also performed its own annual site reviews for network CMHCs.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
15. The Contractor's organizational provider assessment policies and process includes assessment of at least: ◆ Inpatient facilities. ◆ Residential facilities. ◆ Ambulatory facilities. NCQA CR11—Element B	**Documents Submitted/Location Within Documents:** 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers – Entire policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions. The ValueOptions organizational site review policies and process include a review of the following facilities: inpatient, residential, and ambulatory. This information is detailed in policy N206.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Credentialing Criteria for Facility/Organization Providers policy included criteria and processes for inpatient, outpatient/ambulatory, and residential facilities. Review of records on-site demonstrated that VO/CHP contracted with each of this type of facility.		
Required Actions: None.		
16. The Contractor has documentation that it has assessed contracted behavioral health care (organizational) providers. NCQA CR11—Element C	**Documents Submitted/Location Within Documents:** 1. N206_Credentialing_Criteria_for_Facility_Organizational_Providers-Entire Document **Description of Process:** ValueOptions assesses all providers initially and again within 36 months of the prior credentialing date. All information obtained from these assessments, including application information, verifications, credentialing decisions and correspondence, is entered into our proprietary credentialing software application and electronic file cabinet and NetworkConnect.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: On-site review of organizational provider records demonstrated adequate record keeping of organizational provider assessments.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
17. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR12	**Documents Submitted/Location Within Documents:** 1. Credentialing and Recredentialing Delegation Policy_CHP-Entire Policy 2. DelegationAgree2011_CHP-page 15 *Misc 3. CAP_DelegationCAP_BHO_2011Oct03_COM-Entire Document 4. 3BHOCAPforCODeskAuditToolforVODelegationAgtFinalReport 100212.-Entire Document **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions (refer to Credentialing and Recredentialing Delegation Policy_CHP). In addition, the BHO has delegation procedures that outlines the requirements of the NCQA CR 12 standards as follows: • Retains the right to approve, suspend, and terminate individual practitioners, providers, and sites. Refer to DelegationAgree2011_CHP-page 15 • Audits credentialing files annually against NCQA standards. Refer to DelegationAgree2011_CHP-page 15 and • Performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. • Evaluates regular reports. Refer to DelegationAgree2011_CHP-page 15, Provider Credentialing and Recredentialing Section) • The organization identifies and follows up on opportunities for improvement, if applicable. Refer to DelegationAgree2011_ CHP-page3, Article V – Corrective Action)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
Although VO is a CHP partner, CHP has entered into a delegation agreement between the partnership and VO to document the relationship and activities performed by VO on behalf of the partnership, and to formalize the oversight structure. Oversight was accomplished by regular reporting and an annual delegation audit performed by an external contractor. Reports and audit results were reviewed by the CHP board.

Required Actions:
None.

Standard VIII—Credentialing and Recredentialing

Requirement	Evidence as Submitted by the BHO	Score
18. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the contract) if the delegate does not fulfill its obligations. NCQA CR12—Element A	**Documents Submitted/Location Within Documents:** 1. DelegationAgree2011_CHP-Entire Document *Misc **Description of Process:** Attached are the delegation agreements for the BHO with an Amendment which describes the elements listed.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The delegation agreement described delegated activities and responsibilities for both parties, reporting requirements, and specified how CHP will monitor VO's performance of the credentialing program. The agreement specified several reports required monthly, quarterly, or semiannually, as appropriate. The agreement also provided for remedies if VO's performance is not adequate. The fully executed agreement signed by both parties was reviewed on-site.

Required Actions:

None.

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
19. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR12—Element B	**Documents Submitted/Location Within Documents:** 1. FinalManagementServicesAgreement201July01COM_CHP-Associate Agreement is attached at the end of the document 2. CredentialingandRecredentialingDelegationPolicy_CHP-Entire Policy **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions (refer to Credentialing and Recredentialing Delegation Policy_CHP-Entire Policy). In addition, the BHO has a Management Services Agreement that outlines the requirements of the NCQA CR 12, element B.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Business Associate Agreement, Exhibit C to the Management Services Agreement between CHP and VO, was HIPAA-compliant and included the requirements for safeguarding PHI. During the on-site interview, staff members confirmed that VO's credentialing process did not use member-level data (complaint information used for recredentialing is in aggregate). Staff described HIPAA-compliant security processes to ensure the confidentiality of all materials obtained during credentialing and recredentialing processes.		
Required Actions: None.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
20. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR12—Element C	**Documents Submitted/Location Within Documents:** 1.DelegationAgree2011_CHP- Entire document *Misc **Description of Process:** Attached are the BHO Delegation Agreements that the contractor retains the right to approve suspend or terminate individual practitioners, providers and sites where it has delegation decision making.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
Findings: Although the partnership (CHP) included VO as a member, there was a delegation agreement between the partnership and VO (as required by the Department). The delegation agreement did not include a provision that CHP retains the right to approve, suspend, and terminate individual practitioners and providers. This provision was present in the delegation agreement submitted for the 2010 EQRO site visit, but it had been removed from the most recently signed agreement. In practice CHP's mechanism to exercise the right to approve, suspend, and terminate individual practitioners and providers is accomplished through the VO local credentialing committee (LCC), which included the CHP medical director and local practitioners. The LCC may make recommendations to the VO NCC regarding credentialing, recredentialing or actions related to quality of care.		
Required Actions: CHP must either revise the delegation agreement or use an addendum to include the required provision that CHP retains the right to approve, suspend, and terminate individual practitioners and providers.		
21. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR12—Element D	N/A	☐ Met ☐ Partially Met ☐ Not Met ☒ Not Applicable
Findings: Not Applicable.		
Required Actions:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence as Submitted by the BHO**	**Score**
22. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR12—Element E	**Documents Submitted/Location Within Documents:** 1. DelegationAgree201_CHP-Entire Policy *Misc 2. CAP-DelegationCAP_BHO_2011OCT03.COM-page 15 3. BHOCAPforCODeskAuditToolforVODelegationAgtFinalReport 100212.-Entire Document **Description of Process:** The BHO conducted a delegation audit in 2011 and 2012. Tools and CAPs are attached for review.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: CHP provided annual audit reports (2011 and 2012) completed by an independent contractor on behalf of CHP and two other Colorado BHOs in partnership with VO. The audit evaluated all activities delegated to VO, including credentialing and recredentialing. The audit process included a file review for compliance with NCQA standards.		
Required Actions: None.		
23. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR12—Element F	**Documents Submitted/Location Within Documents:** 1. DelegationAgree2011_CHP-Entire Policy *Misc 2. CODeskaudittoolforVODelegationAgt Final FY2012-Entire Document 3. Delegation Review Summary-Entire Document 4. CAP_DelegationCAP_BHO_2011OCT03_COM-Entire Document **Description of Process:** Delegation Audit was conducted in 2011 With audit results in the Delegation Review Summary and the required CAP in the CAP_DelegationCAP_BHO_2011OCT03_COM documents. The revised 2012 Desk top audit tool is attached called CO Deskaudittoolfor VO Delegaiton Agt. Final FY2012	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: CHP provided annual audit reports (2011 and 2012) completed by an independent contractor on behalf of CHP and two other Colorado BHOs in partnership with VO. The audit evaluated all activities delegated to VO, including credentialing and recredentialing. The audit process included a review of policies and procedures and review for compliance with NCQA standards.		
Required Actions: None.		

<table>
<tr><th colspan="3">Standard VIII—Credentialing and Recredentialing</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the BHO</th><th>Score</th></tr>
<tr><td>24. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually).

NCQA CR12—Element G</td><td>Documents Submitted/Location Within Documents:
1. COPR_ActivityLog_BHO Report_2012_PR-Entire Document
2. CO QRTLY CRED REPORT_VOCO_2012July03_PR-Entire Document
3. CO QRTLY CRED REPORT_VOCO_2012APR06_PR-Entire Document

Description of Process: All reports are submitted as specified in the deliverables to each BHO as evidenced by emails to the BHO.</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
CHP provided examples of quarterly credentialing reports received from VO. On-site, staff reported that the local director of provider network relations and the CHP board of directors reviewed reports, as needed.</td></tr>
<tr><td colspan="3">Required Actions:
None.</td></tr>
<tr><td>25. The Contractor identifies and follows up on opportunities for improvement, if applicable.

NCQA CR12—Element H</td><td>Documents Submitted/Location Within Documents:
1. DelegationAgree2011_CHP-Entire Policy *Misc
2. CAP-DelegationCAP_BHO_2011OCT03.COM-Entire Document
3. 3BHOCAPforCODeskAuditToolforVODelegationAgtFinalReport 100212. -Entire Document

Description of Process: The organization identifies and follows up on opportunities for improvement. Refer to Delegation Agreement (page3, Article V – Corrective Action). Also refer to Delegation CAP.</td><td>☒ Met
☐ Partially Met
☐ Not Met
☐ Not Applicable</td></tr>
<tr><td colspan="3">Findings:
Both the Management Services Agreement and the Delegation Agreement between CHP and VO included the provision to require corrective action for inadequate performance of the delegated activities. CHP provided evidence of having required corrective actions and following up until corrected.</td></tr>
<tr><td colspan="3">Required Actions:
None.</td></tr>
</table>

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	46	X	1.00	=	46
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	2	X	NA	=	NA
Total Applicable		=	47	**Total Score**		=	46

Total Score ÷ Total Applicable	=	98%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. *42CFR438.240(a)* Contract: II.H.1	**Colorado Health Partnerships (CHP) delegates all requirements in Standard X to ValueOptions® as indicated by the "QMDelegationPolicy_CHP.pdf".** **Documents Submitted/Location Within Documents:** 1. QMDelegationPolicy_CHP – Entire Policy 2. FY13QMUMProgramDescription_ CHP – Entire Document **Description of Process:** CHP delegates all quality management functions to ValueOptions® (refer to QMDelegationPolicy_CHP). ValueOptions®, along with the CHP Quality Improvement Steering Committee /Clinical/Utilization Management Committee (QISC/CAUMC) develops an annual program description/paln that details the planned quality improvement activities for the fiscal year. The annual plan is reviewed and approved by CHP's QISC/CAUMC and the Class B Board.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: CHP staff stated that quality management activities are delegated to VO. The QM Delegation policy outlined the CHP responsibilities for oversight of the delegated QM processes including verification that the QM program incorporated practice guidelines, performance improvement projects, performance measurement, member satisfaction, monitoring of over- and underutilization, and resolution of identified quality of care concerns. The 2013 CHP Quality/Clinical/UM Program Description (QI program description) outlined a comprehensive program for monitoring and evaluating quality. The program description stated that structure, processes, and outcomes are evaluated continuously, opportunities for improvement are identified, and interventions and/or performance improvement projects are implemented. The program description outlined the various components of the program in detail.		
Required Actions: None.		
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: II.H.2.n	**Documents Submitted/Location Within Documents:** 1. FY13QMUMProgramDescription_ CHP-Pages 11, 13, 22, 25, and 46 2. 30DayUnderutilizationReport_CHP – Entire Report 3. ECMResultsRptAdultDepr_FY2011CHP – Entire Report 4. Top 20 CHP_CY2012_Q1- Entire Report 5. QMUMAnnualEvaluation_FY12_CHP –page 3 6. CAUMCQISCMeetingMinutes_CHP-page 2,3 7. QuarterlyPerformanceMeasuresDischargeper1000_CHP – Entire Report	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	8. QuarterlyPerformanceMeasuresERVisits_CHP – Entire Report 9. QuarterlyPerformanceMeasuresALOS_CHP – Entire Report **Description of Process:** ValueOptions® ensures mechanisms are in place to detect and evaluate both over- and under-utilization, as noted in the FY13QMUMProgramDescription_ CHP. These mechanisms include the 30 Day Underutilization Report, the ECM Results Report (Adult Depression), the Top 20 CHP Report, and the Quarterly Performance Measures report. The performance measures reports are reviewed in the QISC/CAUMC meeting quarterly. Screenshots of measures from this report are included (items 7-9, above).	
Findings: The QM program description stated that the QISC/CAUMC reviews utilization management issues and indicators, including under- and overutilization. In addition, the Quality of Care Committee (QOCC), a subcommittee of the local Credentialing Committee, reviews under- and overutilization issues. The description stated that data are analyzed to identify utilization patterns and contributing factors and appropriate intervention is implemented. CHP provided several examples of utilization tracking reports. The Quality Management and Utilization Management (QM/UM) program annual evaluation stated that the QOCC meets monthly and activities involve review of over- and underutilization. The annual evaluation included an analysis of data related to trends in hospital discharges, average length of stay, post inpatient follow-up, readmissions, and ER visits, and included contributing factors and potential interventions.		
Required Actions: None.		
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to all members. *42CFR438.240(b)(4)* Contract: II.H.2.m.6	**Documents Submitted/Location Within Documents:** 1. 308CriticalAdverseIncidents_Policy_VOCO – Entire Policy 2. 309QualityofCareIssuesOutlierPracticePatternsPolicy_VOCO – Entire Policy 3. 403PractitionerMedRecordReviewAnalysisandReportingPolicy_VOCO – Pages 1-2, Section III.A 4. FY13QMUMProgramDescription_ CHP –Pages 5-6, 11, 13, 33, 35, 52 5. QMUMAnnualEvauation_FY12_CHP – Page 3,15 **Description of Process:** ValueOptions® uses several mechanisms to assess the quality and appropriateness of care provided to all members. These mechanisms include clinical treatment record audits, adverse incident and quality of care evaluation and investigations,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	as well as the clinical care management review processes used to authorize care for members. The FY13QMUMProgramDescription_ CHP, along with the policies listed above; provide information regarding the mechanisms used to assess quality and appropriateness of care for members.	
Findings: The QI program description stated that the purpose of the QI program, which includes the CHP Work Plans and quarterly meetings of the QISC/CAUMC, is to evaluate quality and appropriateness of care, pursue opportunities to improve patient care, and resolve problems. The program description stated that the care management program monitors members with care patterns that require monitoring of appropriate use of services, levels of care, and community supports. Care management staff provides comprehensive reviews of care and refers cases that appear to be outside best practice guidelines for specialized review. The QISC/CAUMC activities included review of topics such as adverse incidents, appropriate utilization, compliance with quality of care indicators, compliance with access standards, adherence to clinical treatment guidelines, treatment planning, discharge planning, medication management, and other quality of care issues. CHP submitted several policies that outlined the processes by which quality and appropriateness are monitored and addressed, and included review of adverse events, practitioner medical records, and quality of care concerns. The QM/UM annual evaluation report described the roles of the QISC/CAUMC and the QOCC in carrying out these functions. The report summarized the data and described analysis of the data related to numerous types of monitoring related to the quality and appropriateness of care. The QISC/CAUMC minutes documented review and analysis of QI findings and review of the annual evaluation report.		
Required Actions: None.		
4. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual quality report describes: ◆ The Contractor's performance on the standard measures on which it is required to report. ◆ The results of each performance improvement project. ◆ The techniques used by the Contractor to improve its performance, effectiveness, and quality outcomes. ◆ Qualitative and quantitative impact	**Documents Submitted/Location Within Documents:** 1. QMUMAnnualEvaluation_FY12_CHP –pages 1-18 2. FY13QMUMProgramDescription_ CHP –Page 52 3. CAUMCQISCMeetingMinutes_CHP-page 2 **Description of Process:** ValueOptions® and the CHP QISC/CAUMC conduct an annual evaluation of the Quality Management Program that includes evaluating the effectiveness and impact of the program. Results of the evaluation are documented in the annual report and reviewed by QISC and the Class B Board. The QMUMAnnualEvaluation_FY12_CHP displays a highlight and comment that correspond to each bulleted requirement at left.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
the techniques had on quality. ◆ The overall impact and effectiveness of the quality assessment and improvement program. ◆ How past quality assessment and performance improvement activities will be used to target improvement for the next year. ◆ A description and organizational chart for each quality committee. *42CFR438.240€(2)* Contract: II.H.2.s.1 Exhibit R3		

Findings:
The QM/UM annual evaluation report included a committee structure organizational chart and description of each quality committee as well as a discussion of the results of various performance improvement initiatives. The annual report addressed all of the required elements; however, HSAG recommended that the documentation of continued quality of care concerns and recommendations for the subsequent year's QI Work Plan be more clearly identified in the annual QI Evaluation report to clarify ongoing areas for improvement from one year to another. The overall effectiveness of the QM/UM programs was summarized and performance on individual work plan goals were addressed, including committee recommendations for continuation or addition of work plan goals for the succeeding year. QISC/CAUMC, accountable to CHP governance, reviewed and approved the annual QI program description, the QI annual evaluation report, and the QI Work Plan (per QISC/CAUMC minutes). Following review and approval by the QISC/CAUMC, the evaluation and work plan were reviewed and approved by the VO Quality Council, accountable to VO governance.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting health care professionals. ◆ Are reviewed and updated periodically as appropriate. *42CFR438.236(b)* Contract: II.H.2.h	**Documents Submitted/Location Within Documents:** **All of these documents are located in the Evidence folder for Standard X, unless otherwise noted:** 1. 105LDevelopingandUpdatingTreatmentGuidelinesPolicy_VOCO—Entire policy **Description of Process:** "105LDevelopingandUpdatingTreatmentGuidelinesPolicy_VOCO" addresses this contract element. The entire policy is applicable, and the reviewer is specifically directed to Section V, Procedures (pp. 3-4). Clinical guidelines are reviewed at the QI-UM Committee meetings and approved by the BHO Board.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The VO-CO Developing and Updating Treatment Guidelines policy described the role of the CAUMC in developing treatment, diagnostic, and program-based guidelines using information gathered from existing standards, scientific literature, or current principles and processes. The policy stated that locally-developed guidelines are developed and adopted with the involvement of appropriate medical and clinical specialists, having expertise in the area they are reviewing. The committee edits and updates existing guidelines at least every 2 years. The VO (Corporate) Developing and Updating Treatment Guidelines policy stated that VO determines which guidelines to establish or adopt based on analyses of characteristics of the covered population. The QISC/CAUMC meeting minutes verified that clinical practice guidelines were reviewed and approved by the committee.

During the on-site review, HSAG noted that some components of the requirements were found in the corporate policy. When supplemented with the VO Colorado policy, all required elements were present; however, neither policy contained all of the requirements. HSAG suggested that the VO-CO Developing and Updating Treatment Guidelines policy incorporate all of the required elements from the VO corporate policy (of the same name) to ensure that the local policy includes all required elements.

Required Actions:
None.

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Requirement	**Evidence as Submitted by the BHO**	**Score**
6. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. *42CFR438.236(c)* Contract: II.H.2.h.2	**Documents Submitted/Location Within Documents:** 1. 236LDistributionofClinicalLevelofCareGuidelinesPolicy_VOCO 2. EQROProviderManual_2012Sept_PR-Page 28 *Misc 3. ProvideForum_Presentation_BHO_2012APR_PR" slides 26-24 *Misc 4. BHO website—see link below. 5. ClinicalGuidelinesEmailBlast2012_3BHO-Entire Document **Description of Process:** 236LDistributionofClinicalLevelofCareGuidelinesPolicy_VOCO" addresses this requirement. The entire policy is applicable. These guidelines are reviewed annually and revised as necessary. Providers are informed about these guidelines via ProvideForum_Presentation_BHO_2012APR_PR forums and the Provider Handbook for each BHO. "EQROProviderManual_2012Sept_PR" p. 28 and "ProvideForum_Presentation_BHO_2012APR_PR" slides 26-24 *Misc Members, potential member, providers, and the public have access to these guidelines on the BHO website at no cost: http://www.coloradohealthpartnerships.com/provider/prv_clin_gd.htm	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The VO-CO Developing and Updating Treatment Guidelines policy stated that new and revised treatment guidelines are routinely distributed to CHP providers via the provider manual, at provider forums, at individual training sessions, and are available in hard copy or on the CHP Web site. The Distribution of Clinical Level of Care Guidelines policy detailed VO's responsibilities and procedures for distribution of clinical guidelines. CHP presented evidence that it distributed guidelines through the Web site, provider manual, provider forums, and e-mail blasts to providers. Staff stated that members and the public have access to guidelines at no cost through the Web site, which was verified through HSAG's review of the Web site.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: II.H.2.h.3	**Documents Submitted/Location Within Documents:** 1. C107 Developing and Updating Treatment Guidelines-page 3, number 3 2. QMDelegationPolicy_CHP- Entire policy **Description of Process:** "C107 Developing and Updating Treatment Guidelines" notes that relevant utilization management criteria, member education materials, benefit interpretations and practitioner communications are considered by VO when guidelines are developed to help foster consistency to these areas affected by the guidelines. "CHP QM Delegation Policy - Entire policy. CHP delegates all quality management functions to ValueOptions®. As stated above, the BHO Policy and Guideline Committee has initiated the process of reviewing all guidelines across the three Colorado BHO's that ValueOptions® contracts with to assure consistency and gain consensus across the guidelines. Guidelines are reviewed across the three Colorado BHO's that ValueOptions® contracts with to assure consistency and gain consensus across the guidelines; this includes ensuring the areas to which the guidelines apply (utilization management decisions, member education, coverage of services, etc.) are consistent with the guidelines, as specified in Policy C107, and in the CHP Delegation Policy delineating that ValueOptions must comply with Medicaid contract requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:

The VO (Corporate) Developing and Updating Treatment Guidelines policy stated that the Executive Medical Management Committee reviews relevant utilization management criteria, member education materials, benefit interpretations, and practitioner communications to ensure consistency with clinical guidelines.

During the on-site interview, staff explained that providers are trained locally (by CHP staff members) concerning adopted clinical guidelines, and the guidelines are continually available for reference and guidance to all providers via the Web site. Members are informed of how to access clinical guidelines through the annual member letter. The QISC/CAUMC, which reviews and approves guidelines, included membership from local CMHCs, care management staff, and Office of Member and Family Affairs (OMFA) staff. Staff stated that any of these staff members may raise concerns regarding inconsistencies between clinical practice guidelines and other CHP operational decisions or information. Staff also stated that practice guidelines are derived from professional resources that are "mainstream" and generally reflected in other decision-making criteria, such as benefit determinations or utilization authorizations.

Required Actions:

None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: II.H.2.q.2	**Documents Submitted/Location Within Documents:** 1. ITDelegationPolicy_CHP- Entire document 2. HealthInfoSystemFlow_3BHO- Entire document **Description of Process:** CHP delegates the information technology and health information systems processing to ValueOptions® (please refer ITDelegationPolicy_CHP.pdf). ValueOptions® health information systems captures data including, but not limited to: authorizations, claims, eligibility, provider networks, and encounters. This information is synchronized with a Data Warehouse, a machine optimized for reporting and analysis. This information is also used to generate data extracts and create reports to support the BHO's operations.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The CHP Health Information System Delegation policy stated that CHP delegates responsibility for the health information system operations to VO, which must have the ability to collect, analyze, integrate, and report data. The overview of the VO-CO Health Information System policy stated that the health information system collects and integrates eligibility, encounter, claims, care management, and Colorado Client Assessment Record (CCAR) data for users to analyze, evaluate, and produce reports. During the on-site interview, staff provided an automated listing of numerous health information system reports used for monitoring and analysis of quality performance.		
Required Actions: None.		
9. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. *42CFR438.242(a)* Contract: II.H.2.q.2	**Documents Submitted/Location Within Documents:** 1. UtilizationPaidClaimsAnalysis201112_CHP-Entire Document 2. GrievanceAndAppeals_3BHO-Entire Document 3. GrievanceSummaryReport_3BHO- Entire document 4. CombinedDataReportCardJune2012_3BHO- Entire document **Description of Process:** The ValueOptions® health information system is structured to provide data for reporting utilization (see UtilizationPaidClaimsAnalysis201112_CHP.xlsx), grievance, and appeal data (see GrievanceandAppeals_3BHO.xlsx and GrievanceSummaryReport_3BHO.pdf). The ValueOptions® information system has the ability to check the place of service for	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	encounters submitted – for certain locations such as jails or correctional facilities for adults, ValueOptions® is able to identify temporary loss of Medicaid eligibility and prevent those encounters from being submitted to the State (see the following errors in the CombinedDataReportCardJune2012_3BHO.xlsx, Error Summary Tab): • 50: Adult in correctional facility is NOT eligible for Medicaid services. • 57: Place of service not consistent with USCM procedure specification. Information on dis-enrollments for other than loss of Medicaid eligibility is provided by HCPF, such as the date of death report. Please note that the "Date of Death" reports are large in size and contain PHI – they are available upon request, but not submitted as evidence.	

Findings:
The CHP Health Information System Delegation policy stated that the health information system collects member–specific demographic data and produces information on utilization and member grievances and appeals. The QA/UM Program Description stated that CHP uses the CareConnect system for care management and claims data and described numerous data sources used for QI measurement, including claims/encounter data, authorization data, clinical treatment records, member demographic information, satisfaction surveys, and complaints and grievances.

Staff stated that grievance information is maintained in a separate MS Access database and submitted examples of the online entry form for recording and tracking grievances and an automated summary report from this system. CHP also submitted automated reports of dollars used within various levels of service, and encounters held for resolution of member eligibility determination. Staff stated that disenrollment data are received from the Department, loaded into the health information system, and primarily used to verify eligibility for claims and encounters.

During the on-site interview, staff provided an overview of the dashboard displaying quarterly utilization monitoring measures, which showed trends by level of care. These trends in the data are reviewed by the QISC/CAUMC and the Class B (local) Board of Directors (verified by QI/UM and Class B Board minutes). Staff stated that grievance information is analyzed by the Grievance Committee and reported to the QISC/CAUMC.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The Contractor collects data on member and provider characteristics and on services furnished to members. *42CFR438.242(b)(1)* Contract: None.	**Documents Submitted/Location Within Documents:** 1. AuthorizationsDataDictionary_3BHO-Entire Policy 2. ClaimsDataDictionary_3BHO-Entire Policy 3. MembersDataDictionary_3BHO-Entire Policy 4. ProvidersDataDictionary_3BHO-Entire Policy 5. VendorsDataDictionary_3BHO-Entire Policy 6. VOFlatFileLayout20120823_3BHO-Entire Policy 7. PHPGuideForManagedCarePlans_3BHO -Entire Policy-Entire Policy 8. UniformServiceCodingManual20120501_3BHO -Entire Policy 9. FY2012CoreSystemTableRecordCounts_CHP-Entire Policy **Description of Process:** ValueOptions maintains an extensive collection of data which includes member and provider characteristics and services rendered to members. The following ValueOptions® data dictionaries give insight into the extent of the characteristics stored/capable of being stored in our systems: • Data Dictionary to Authorizations (found in evidence file called AuthorizationsDataDictionary_3BHO.htm). • Data Dictionary to Claims (found in evidence file called ClaimsDataDictionary_3BHO.htm). • Data Dictionary to Members (found in evidence file called MembersDataDictionary_3BHO.htm). • Data Dictionary to Providers (found in evidence file called ProvidersDataDictionary_3BHO.htm). • Data Dictionary to Vendors (found in evidence file called VendorsDataDictionary_3BHO.htm). • Data Dictionary to VO Flat File Specification (found in evidence file called VOFlatFileLayout20120823_3BHO.xlsx). • State of Colorado's PHP Interface File Layout (found in evidence file called PHPGuideForManagedCarePlans_3BHO -Entire Policy.docx). • Uniform Service Coding Manual (USCM) Document (found in evidence file called UniformServiceCodingManual20120501_3BHO -Entire Policy.pdf).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	To demonstrate the robustness of the data currently being stored, the FY2012CoreSystemTableRecordCounts_CHP.xls document is provided, which shows the number of records loaded, by table, for the FY2012 time period. The SQL logic used to produce the record counts is provided within the same document, under a different tab.	
Findings: The QA/UM Program Description stated that CHP uses the CareConnect system for care management and claims data. The health information system data sources used to support quality management included claims, encounter data, authorization data, clinical treatment records, member demographic information, adverse incidents, satisfaction surveys, complaints and grievances, provider data, and CCAR data. The Providers Data Dictionary provided evidence of information collected on provider characteristics (e.g., age, gender, specialty, hospital affiliation), and the Member Data Dictionary provided evidence of information collected on member characteristics (e.g., age, gender, marital status, address, insurance information). The Authorization Data Dictionary and Claims Data Dictionary included information on member services including diagnoses, dates of service, service codes, and authorization information.		
Required Actions: None.		
11. The Contractor monitors member perceptions of accessibility and adequacy of services provided. Tools shall include: ◆ Member surveys. ◆ Anecdotal information. ◆ Grievance and appeals data. Contract: II.H.2.m.1	**Documents Submitted/Location Within Documents:** 1. Analysis_StRpt_FINAL_Q4FY12_CHP – Entire Document 2. Complaint Summary QISC FY11-Final – Entire Document 3. FINAL_Grievance and Appeals State Report_Q4FY12_CHP– Entire Document 4. FactFindersOverSat_CHP_Entire Document 5. RecoveryForum_HGHLTDMinutes_CHP_2011JUL28_OMF-pages 1-2 6. RecoveryForum_HGHLTDMinutes_CHP_2011OCT27_OMF-pages 1-2 7. RecoveryForum_HGHLTDMinutes_CHP_2012JAN26_OMF-pages 1-3 8. QISCCAUMC 05May12 FINAL Meeting Minutes-Page 9 **Description of Process:** CHP monitors member perceptions of accessibility and adequacy of services provided through the MHSIP, YSSF (referenced in Requirement 12), and Fact Finders Survey tools (FactFindersOverSat_CHP). Results from these surveys are monitored at least annually by the QISC/CAUMC committee and submitted to the CHP Class B Board. CHP monitors grievances and appeals by type and days to resolution quarterly through the trend report, and annually by reviewing a more detailed analysis report (Complaint Summary QISC FY11-Final), and CHP also submits a quarterly report to	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Health Care Policy and Financing (Final_Grievance and Appeals State Report_CHP). Anecdotal evidence is collected via the CHP OMFA meeting, as well as periodically raised in the QISC/CAUMC meeting.	
Findings: The QI program description stated that quality indicators include routine, urgent, and emergent access times and that the QISC/CAUMC reviews access issues. The program description stated that access and availability is monitored through tracking data, member and provider surveys, GeoAccess analysis, and member complaints. The QA/UM annual evaluation reported the results of member satisfaction surveys, which included access to care. Selected QISC/CAUMC meeting minutes documented that the results of the member surveys were reviewed by this committee. The quarterly Grievance and Appeals Analysis summarized reasons for member grievances related to access and appointment availability including how the grievances were resolved. The annual Complaints and Grievances Summary provided statistical summaries and analysis of all complaint categories, including access and adequacy of service categories. The Grievance & Appeals State Report summarized the data related to reasons for access and availability grievances. During the on-site review, staff stated that grievances are also reviewed by each CMHC for follow-up of both individual cases and any trends identified. In addition, trends in grievances are reviewed by the Member Advocates Committee, the QI/UM Committee, and the Class B Board. Staff stated that, to date, member grievances had been isolated concerns, and no patterns had been identified that would stimulate follow-up. However, staff described a "Talking to your Doctor" guide for members, which was developed as a result of prescriber concerns regarding unsatisfactory communication between providers and members. In addition, staff provided a copy of the Access to Services report, which included FactFinders member survey results, complaints and grievance information, and appointment availability data, which are reported biannually to the QI/UM Committee.		
Required Actions: None.		
12. The Contractor monitors member perceptions of well-being and functional status as well as accessibility and adequacy of services provided by the Contractor by reviewing the results of the statewide Mental Health Statistics Improvement Program (MHSIP), the Youth Services Surveys (YSS), and the Youth Services Surveys for Families (YSS-F). Contract: II.H.2.m.2	**Documents Submitted/Location Within Documents:** 1. MHSIP.YSSFReport2011_2BHO – Entire Document 2. QISCCAUMC 05May12 FINAL Meeting Minutes-Page 9 **Description of Process:** CHP monitors perceptions of well-being and functional status as well as accessibility and adequacy of services through bi annual review of the MHSIP and the YSS-F by the QISC/CAUMC. These reports are reviewed for trends within the BHO as well as comparisons across BHO's.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Mental Health Statistics Improvement Program (MHSIP) and the Youth Services Survey for Families (YSS-F) PowerPoint presented the results of the 2011 surveys of each CMHC population and compared trends in responses over 3 years. The QISC/CAUMC meeting minutes demonstrated that the results were presented to the committee annually, and staff stated that results were also reported to the Class B Board. Staff stated that none of the results applicable to the audit period warranted follow-up action. During the on-site review, staff stated that each CMHC extensively reviews the detailed results of MHSIP and YSS surveys annually. In addition, the QISC/CAUMC reviews performance indicators biannually, which includes results of the FactFinders member satisfaction survey results.		
Required Actions: None.		
13. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported. Contract: II.H.2.m.5	**Documents Submitted/Location Within Documents:** 1. 309QualityofCareIssuesOutlierPracticePatternsPolicy_VOCO – Pages 8- 10, Section V.G.4.b.v and 6.d, I, J.3-4 2. 305MemberSatisfactionSurvey_Policy_VOCO_QM – Page 3, Section V.F-G 3. 303LGrievance_Policy_VOCO_OMFA – Page 13, Section V.D. **Description of Process:** ValueOptions develops corrective action plans when significant levels of dissatisfaction are reported, when a pattern of complaint is detected, or when a serious complaint is reported. Highlights and notations in the policies listed above identify the corrective action plan processes.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: CHP submitted several policies related to grievances, adverse events, member satisfaction surveys, and outlier practice patterns, which documented that clinical grievances or serious adverse events are forwarded to the medical director for investigation and intervention as required, and that patterns of grievances and adverse events are tracked by provider and type of incident, and reviewed. CHP staff reported that provider incidents are reviewed by the QOCC and administrative incidents are reviewed by the QISC/CAUMC. Staff also reported that corrective actions are imposed by the reviewing committee as appropriate. The VO Member Satisfaction Survey policy stated that the CHP quality committees analyzed survey results to identify opportunities for improvement and develop corrective actions as indicated. During the on-site interview, staff provided a sample of a corrective action requested from a provider for an adverse incident, which documented appropriate evaluation of the incident, conclusions regarding problems identified, and follow-up processes initiated to correct concerns.		
Required Actions: None.		

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
14. The Contractor investigates, analyzes, tracks, and trends quality of care (QOC) concerns. Contract: II.H.2.o	**Documents Submitted/Location Within Documents:** 1. 309QualityofCareIssuesOutlierPracticePatternsPolicy_VOCO – Page 7, Section V.G.2-3, Pages 10-11, Sections K-L 2. QOCAgendaIssues_CHP_2012Aug – Entire Document 3. QOCTrendRpt_Jul2010toPresent2012_CHP-Entire Document 4. AdverseIncident_QTR4FY12_ QM _CHP- Entire document **Description of Process:** ValueOptions has a process for investigating, analyzing, tracking and trending quality of care concerns. This is noted in the Quality of Care Issues Policy listed above. Investigations are completed on reported adverse incidents that are classified as major or sentinel events; if a potential quality of care issue is identified during the investigation of an adverse incident, it is documented as a quality of care issue as well. Reported quality of care concerns are investigated and reviewed by the Quality of Care Committee (QOCC) for disposition. The document titled QOCAgendaIssues_CHP provides a summary of each CHP QOC issue and subsequent investigation to date that was included for Committee review in the August 2012 QOCC. An example of a quality of care investigation, and a quality of care trend report (QOCTrendRpt_Jul2010toPresent_CHP2012) are also included for review, as noted above.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Findings:
The VO Quality of Care Issues and Outlier Practice Patterns policy stated that quality of care (QOC) concerns are investigated and monitored through resolution by the QOCC (subcommittee of QISC/CAUMC). Member grievances concerning clinical care and adverse clinical events were processed and reviewed by appropriate committees(s) using the quality management process. The policy outlined the procedures for managing an individual urgent QOC issue and for monitoring and trending patterns of issues for corrective action by the CHP quality committees. QOC concerns were also reviewed during the provider recredentialing process. CHP submitted sample trending reports including adverse incidents by CMHC and by severity, a summary of individual QOC concerns and findings/resolutions, and evidence of QOC issues being reviewed by the QOCC.

During the on-site interview, staff stated that the QOCC reviews individual QOC concerns—including ongoing follow-up through investigation and resolution—according to assigned risk category. Staff stated that individual QOC concerns are investigated, as they are possible indicators of patterns/trends or more global issues that have previously not been reported. In addition, the QOCC reviews the summary of reported QOCs in an effort to identify any apparent trends. A Performance Improvement Committee may be formed to thoroughly evaluate contributing factors and implement alternative approaches for improvement. Staff cited several examples of focused QI projects that resulted from QOC concerns over the years.

Required Actions:
None.

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
15. When a quality of care concern is raised, the Contractor : ◆ Sends an acknowledgement letter to the originator of the concern. ◆ Investigates the QOC issue(s). ◆ Conducts follow-up with the member to determine if the immediate health care needs are being met. ◆ Sends a resolution letter to the originator of the QOC concern, which contains: • Sufficient detail to foster an understanding of the resolution. • Description of how the member's health care needs have been met. • A contact name and telephone number to call for assistance or to express any unresolved concerns. Contract: II.H.2.o	**Documents Submitted/Location Within Documents:** 1. 308CriticalAdverseIncidents_Policy_VOCO – Page 7.V.D. 2. 309QualityofCareIssuesOutlierPracticePatternsPolicy_VOCO-Pages 5-6, Sections V.C-D.1 and V.D.5, and Pages 10-11, Section V.G.1-3 and V.G.4.a.i-iii 3. QOCAgendaIssues_CHP_2012Aug – Entire Document 4. AdverseIncRptQOC_CHP – Entire Document 5. QOCInvestigationDocs_CHP – Entire Document 6. QOCResolutionLtr_CHP – Entire Document 7. QOCAcknowledgementLtr_CHP – Entire Document **Description of Process:** As indicated in the Quality of Care (QOC) Issues Policy, an acknowledgement letter is sent, and an investigation completed. Upon receipt, each QOC issue is evaluated to determine the urgency of the issue and assess immediate follow-up actions to assure well- being of the member. Since adverse incidents may also be quality of care issues, all adverse incidents are evaluated upon receipt to determine whether there are any urgent safety issues to be addressed – noted in the Critical/Adverse Incident Policy listed above. The QOCC reviews the results of the investigation and makes a determination as to whether the investigation has identified a quality of care issue, and provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action, etc. The document titled QOCAgendaIssues_CHP provides a summary of each CHP QOC issue and subsequent investigation to date that was included for Committee review in the August 2012 QOCC. Resolution letters are sent following the completion of a QOC investigation; because some of the QOC issues are reported retrospectively, the health care needs of the member have clearly already been met. However, VOCO does have a procedure included in the Quality of Care and Adverse Incident policy, for responding to the immediate needs of a member. No QOC issues occurred during the review period that required this type of response. In addition, included are three documents related to a quality of care investigation. In this case, a provider reported an adverse incident that occurred in their facility (AdverseIncRptQOC_CHP) which also became a quality of care issue. In this case, since the provider reported their own issue, no acknowledgement letter was sent. A letter initiating the	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	investigation, along with the investigation details are included in the document titled, "QOCInvestigationDocs_CHP." The resolution letter pertaining to the investigation is also included for review (QOCResolutionLtr_CHP). An acknowledgement letter pertaining to a different investigation (QOCAcknowledgementLtr_CHP) is also included for review.	
Findings: The VO Quality of Care Issues and Outlier Practice Patterns policy outlined the process for responding to QOC concerns identified through a member grievance, and included the required processes. Samples of the member acknowledgement letter, member resolution letter, and investigation letter substantiated that CHP followed each of the steps outlined in the policy. During the on-site review, staff clarified that acknowledgement of receipt of a QOC identified by an internal staff member or network provider is acknowledged through e-mail communication rather than letter. HSAG recommended that CHP consider using a formal standardized statement of acknowledgement in the e-mail to minimize confusion and formalize the process.		
Required Actions: None.		
16. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* Contract: II.H.2.q.1	**Documents Submitted/Location Within Documents:** 1. ListOfEditsPerformedAgainstClaimsAndEncounters_3BHO-Entire Document 2. xx201206_LOG_3BHO-Entire Document 3. xx201206_ERR_3BHO-Entire Document 4. xx201206_DUP_3BHO-Entire Document 5. xx201206_MOD_3BHO-Entire Document 6. xx_duplicates_hold_inventory_3BHO-Entire Document 7. xx_eligibility_hold_inventory_3BHO-Entire Document 8. UniformServiceCodingManual20120501_3BHO -Entire Policy 9. VOFlatFileLayout20120823_3BHO-Entire Document 10. CombinedDataReportCardJune2012_3BHO-Entire Document **Description of Process:** The accuracy and completeness of data is assessed at reception/load time and feedback is sent to the submitter (for each submission) in the form of multiple log files: **LOG** : A detailed accounting of each record that had an error (or warning). The end of the LOG file includes a summary, by error type and frequency.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	ERR: A file containing only key elements of failed records; this allows submitters the ability to focus on errors and identify if a trend exists which could be resolved at a procedural level, rather than on a line-by-line basis. **DUP**: A file containing records from the submission that appear to be duplicates. This file shows which previous records where accepted (an in what file) as well as the duplicate record that is being withheld from the current submission. A summary of duplicates detected appears at the end of the report. **MOD**: The selection of procedure modifiers is an important method of conveying to the State the special circumstances under which the service was provided. To help he submitter verify that the procedure modifier selected was the correct one, this file offers a line-by-line accounting of key properties of the record and the selected modifier. **Duplicates_Hold_Inventory**: A complete account of ALL records that have been held from the submitter for being a duplicate. The first part of the report shows which records are held, and the previously-submitted records which rendered it a duplicate. The second part of the report shows a summary of duplicate records, total units and total charges, by submission. The last part of the report show the complete total by count, total units and total charges. **Eligibility_Hold_Inventory**: A complete list of all records that have been held for eligibility reasons. Eligibility is based on the date of service being between the effective and expiration dates of at least one(1) eligibility record received from the State. Records which fail this test are reported back to the submitter here. As this is a historical file, the first part is every record in order of Medicaid ID and Service Date. The second part is an aggregate by member, in descending order by total charges (the ones at the top of the list are worth more if resolved, as they tie up more funds). The last part of the report shows the total number of records, units and charges that are held for failing eligibility. Standardizing the collection of encounter data is addressed by employing the State of Colorado's Uniform Service Coding Manual (USCM), which not only describes the standard layout for submitting encounters (pages 238-249), but also clearly specifies the necessary and required attributed of all encounters submitted to the State, by procedure	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	code (pages 10-180 and 212-215). ValueOptions uses the USCM (entire document) to augment existing edits for claims and encounters, resulting in early detection/reporting and holding of unacceptable records. A list of edits performed on claims and encounters is included as ListOfEditsPerformedAgainstClaimsAndEncounters_3BHO.xls. The accuracy and timeliness of submitted data is best viewed through the use of the monthly Data Report Cards. The tabs in this document show overall error trends in both a chart and a spreadsheet. A reconciliation tab allows for in-depth exploration of the data submitted, its disposition/status and aggregate values. A timeliness tab shows when the submissions were sent to VO-CO, when they were processed, and when data from that file was sent to the State. A color-coding scheme is used to convey early, on-time or late submission. All submitters are using standardized formats; for submitters of encounters, the VO-CO Flat File format is being used. For claim, both UB-04 and CMS-1500 forms are used. These standardized formats allow submitters and VO-CO staff to leverage their knowledge across multiple MHCs and enhancements that are implemented for one can be shared by all.	

Findings:
CHP employed various mechanisms to ensure that data submitted by providers were complete and accurate. CHP submitted evidence of automated edits that are applied to claims/encounters at the time the information is loaded into the system, including screening for eligibility, duplicate submissions, and coding accuracy, and completeness of the required fields of data. Staff reported that detection of errors is reported back to the providers for correction, and claims/encounters are held for correction prior to submission to the State. Staff stated that CHP uses the Uniform Service Coding Standards Manual (USCM) as the guide to requirements for accurate and complete submission of claims/encounter data and that all providers are using standardized formats for submission of data. CHP submitted evidence of detailed and summary reports of errors provided to submitters to allow for detection and correction of patterns of submission errors. A sample Combined Data Report Card documented the monthly analysis of timeliness and data quality of encounters submitted by each CMHC including a summary of error reasons, encounter error trends, dollars held due to ineligibility or duplication, and overall timeliness of submission of CHP encounter data to the State. During the on-site interview, staff stated that CHP submits the data report card to each CMHC for follow-up, correction, and resubmission of erroneous data and correction of any ongoing procedural problems with data accuracy.

Required Actions:
None.

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	16	X	1.00	=	16
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	0
Total Applicable		=	16	**Total Score**		=	16

Total Score ÷ Total Applicable	=	100%

Appendix B. Record Review Tools
for Colorado Health Partnerships, LLC

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
Credentialing Record Review Tool
for Colorado Health Partnerships, LLC

HSAG Reviewer:	Rachel Henrichs and Barbara McConnell	**Review Period:**	October 2009 through September 2012
Participating Plan Staff Member:	Michelle Denman and Cathleen Gilbert	**Date of Review:**	November 27, 2012

SAMPLE	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**	
Provider ID#	016831		035600		124028		131047		602847		612002		655943		659121		683860		684285	
Provider Type (MD, PhD, NP, PA, MSW)	MD		LCSW		LCSW		PhD		LPC		LPC		PhD		LPC		LPC		LCSW	
Application Date	8/17/11		11/3/11		2/22/11		11/28/11		7/23/10		2/10/12		3/5/11		4/2/10		10/10/11		5/31/11	
Specialty	Psychiatrist		Social Worker		Social Worker		Psychologist		Counselor		Counselor		Psychologist		Counselor		Counselor		Social Worker	
Credentialing Date (Committee/Medical Director Approval Date)	2/14/12		1/17/12		4/19/11		4/17/12		1/25/11		5/15/12		4/19/11		6/8/10		1/17/12		8/23/11	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Initial Credentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		NA		NA		NA		NA		NA		NA		NA		NA		NA	
♦ Credentials (i.e., education and training, including board certification if the practitioner states on the application that he or she is board certified)	X		NA		NA		NA		NA		NA		NA		NA		NA		NA	
♦ Work history	X		X		X		X		X		X		X		X		X		X	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's credentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
Applicable Elements	**8**		6		**6**		6		**6**		6		**6**		6		**6**		6	
Point Score	**8**		6		**6**		6		**6**		6		**6**		6		**6**		6	
Percentage Score	**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**		**100%**	

Total Record Review Score					**Total Applicable: 62**	**Total Point Score: 62**	**Total Percentage: 100%**

Notes: CHP routinely checks both OIG and NPDB for all providers to ensure the provider has not been excluded from federal participation.

Appendix B. Colorado Department of Health Care Policy and Financing
Recredentialing Record Review Tool
for Colorado Health Partnerships, LLC

HSAG Reviewer:	Rachel Henrichs and Barbara McConnell	**Review Period:**	October 2009 through September 2012
Participating Plan Staff Member:	Michelle Denman, Cathleen Gilbert	**Date of Review:**	November 27, 2012

SAMPLE	**1**		**2**		**3**		**4**		**5**		**6**		**7**		**8**		**9**		**10**	
Provider ID#	016772		033928		035204		035355		035540		054578		062306		070480		076805		077491	
Provider Type (MD, PhD, NP, PA, MSW)	MD		PhD		LCSW		LCSW		LMFT		PhD		LCSW		MD		PhD		LPC	
Application/Attestation Date	6/11/10		10/24/11		12/5/10		11/11/10		10/6/10		1/5/10		12/2/10		11/23/11		9/26/10		6/2/10	
Specialty	Psychiatrist		Psychology		Social Work		Social Work		Therapist		Psychology		Social Work		Psychiatrist		Psychology		Counselor	
Last Credentialing/Recredentialing Date	10/23/07		3/17/09		4/15/08		3/18/08		2/26/08		4/27/11		3/31/08		4/28/09		2/28/08		10/23/07	
Recredentialing Date (Committee/Medical Director Approval Date)	8/24/10		4/17/12		3/22/11		3/22/11		1/25/11		3/16/10		3/22/11		4/17/12		1/25/11		7/13/10	
Item	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Recredentialing Verification: The contractor, using primary sources, verifies that the following are present:																				
♦ A current, valid license to practice (with verification that no State sanctions exist)	X		X		X		X		X		X		X		X		X		X	
♦ A valid DEA or CDS certificate (if applicable)	X		NA		NA		NA		NA		NA		NA		X		NA		NA	
♦ Credentials (i.e., verified board certification only if the recredentialing application indicates there is new board certification since last credentialing/recredentialing date)	X		NA		NA		NA		NA		NA		NA		Not board certified		NA		NA	
♦ Current malpractice insurance in the required amount (with history of professional liability claims)	X		X		X		X		X		X		X		X		X		X	
♦ Verification that the provider has not been excluded from federal participation	X		X		X		X		X		X		X		X		X		X	
♦ Signed application and attestation	X		X		X		X		X		X		X		X		X		X	
♦ The provider's recredentialing was completed within verification time limits (see specific verification element—180/365 days)	X		X		X		X		X		X		X		X		X		X	
♦ Recredentialing was completed within 36 months of last credentialing/recredentialing date	X			X	X		X		X		X		X		X		X		X	
Applicable Elements	**8**		**6**		**6**		**6**		**6**		**6**		**6**		**7**		**6**		**6**	
Point Score	**8**		**5**		**6**		**6**		**6**		**6**		**6**		**7**		**6**		**6**	
Percentage Score	**100**		**83**		**100**		**100**		**100**		**100**		**100**		**100**		**100**		**100**	
Total Record Review Score									**Total Applicable: 63**				**Total Point Score: 62**				**Total Percentage: 98**			

Notes: File number 2 was not recredentialed within the 36-month time frame; however, HSAG noted documentation that ValueOptions made numerous attempts to gather required information from the provider, beginning 6 months before the required recredentialing date.

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

Table C-1 lists the participants in the FY 2012–2013 site review of **CHP**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Katherine Bartilotta, BSN	Project Manager
Rachel Henrichs	Project Coordinator
CHP Participants	**Title**
Amie Adams	Clinical Director
Erica Arnold-Miller	Vice President, Quality Management
Tami Ballard	Clinical Team Lead
Joyce Cannon	Quality Management Specialist
Steve Coen	Clinical Peer Advisor
Michelle Denman	Director, Provider Relations
Cathleen Gilbert	Vice President, Provider Relations
Haline Grublak	Director, Special Programs/Vice President, Office of Member and Family Affairs
Leslie Moldauer	Medical Director
Arnold Salazar	Chief Executive Officer
Rose Stauffer	Chief Financial Officer, Foothills Behavioral Health Partners and Northeast Behavioral Health Partnership
Stacey Thompson	Quality Director, Northeast Behavioral Health Partnership
Kyle Turnwall	Chief Financial Officer, Colorado Health Partnerships
Jennifer Woodard	Quality Management Specialist
Department Observers	**Title**
Russell Kennedy	Quality/Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2012–2013

for Colorado Health Partnerships, LLC

If applicable, the BHO 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 2012–2013 Corrective Action Plan *for* CHP					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
Standard VIII—Credentialing and Recredentialing ♦ The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement.	The delegation agreement between VO and **CHP** did not include a provision that **CHP** retains the right to approve, suspend, and terminate individual practitioners and providers. **CHP** must either revise the delegation agreement or use an addendum to include the required provision that **CHP** retains the right to approve, suspend, and terminate individual practitioners and providers.				

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 2012–2013 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 BBA Medicaid managed care regulations, NCQA Credentialing and Recredentialing Standards and Guidelines, and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tools, 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 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 BHO's 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.)
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 2012–2013 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions required of the BHO to achieve full compliance with Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2012–2013 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.