Colorado Medicaid
Community Mental Health Services Program

# FY 2013–2014 Site Review Report

*for*

# Colorado Health Partnerships, LLC

May 2014

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

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## Introduction

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 federal health care regulations and managed care contract 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 report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the two standard areas reviewed this year. Section 2 contains graphical representation of results for all 10 standards across two, three-year cycles, as well as trending of required actions. Section 3 describes the background and methodology used for the 2013–2014 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2012–2013 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials 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 plan process the BHO will be required to complete for FY 2013–2014 and the required template for doing so.

## Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any 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 some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal health care regulations.

Table 1-1 presents the scores for **Colorado Health Partnerships, LLC** (**CHP**) for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* 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) |
|---|---|---|---|---|---|---|---|
| I Coverage and Authorization of Services | 31 | 31 | 31 | 0 | 0 | 0 | 100% |
| II Access and Availability | 15 | 15 | 15 | 0 | 0 | 0 | 100% |
| **Totals** | **46** | **46** | **46** | **0** | **0** | **0** | **100%** |

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

**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) |
|---|---|---|---|---|---|---|
| Denials | 150 | 99 | 99 | 0 | 51 | 100% |
| **Totals** | **150** | **99** | **99** | **0** | **51** | **100%** |

## Standard I—Coverage and Authorization of Services

### *Summary of Findings as Evidence of Compliance*

**CHP** delegated utilization management (UM) functions to ValueOptions (VO). The UM program is an integral part of the quality management (QM) program. The QM Program Description and medical necessity policies addressed the structure and goals of the program; described roles and responsibilities of both the clinical care managers (CCMs) and the medical directors/peer advisors; defined medical necessity according to the State definition; addressed application of clinical level-of-care criteria and training for UM staff; and described detailed procedures and time frames for processing emergent, urgent, and routine prior and concurrent authorizations. The QM Program Description stated that the **CHP** Quality Improvement Steering Committee/Clinical Advisory Utilization Management Committee (QISC/CAUMC) both provides oversight for all local program operations and outcomes and reviews UM issues and data indicators of under- and overutilization. **CHP** submitted numerous examples of reports used to track and trend utilization. These included outpatient service mix by community mental health center (CMHC), inpatient census days, inpatient recidivism rates, costs per user, specific underutilization indicators, monthly denials and appeals, and performance measures as compared to other BHOs.

The program description stated that CCMs apply local level-of-care criteria, approved by the QISC/CAUMC, to determine medical necessity and appropriateness of services for authorization requests for intensive levels of care services (23-hour observation, inpatient, acute treatment unit (ATU), sub-acute, partial hospitalization, day treatment, and residential treatment), as well as selected specialized services, such as psychological testing, family services, wrap-around services, and community support services. CCMs also used tools for determining a BHO covered diagnosis according to State defined guidelines. All questions regarding a covered diagnosis or medical necessity were referred to a professional peer advisor or medical director for determination. Prior to finalizing an adverse decision, treating providers were offered an opportunity for peer-to-peer consultation. During on-site interviews, staff members described processes that demonstrated good coordination among claims management, UM, care management, quality management, and communications with providers concerning UM decisions.

Denial record reviews demonstrated that authorization requests were consistently processed within required time frames. VO processed all inpatient authorizations as expedited requests. The CCM verbally interacted real-time with the requesting provider both to obtain applicable clinical information and to communicate the authorization decision. Denial record review results documented the following:

- All cases involved authorization of new services. Of 15 records, 12 were expedited requests and 3 were standard authorizations. No cases included an extension of the decision time frame. No cases were denied due to lack of information.
- All denials were compliant with all required criteria, including determination within required time frames, notice of action sent to member and provider, determination based on criteria, and decision made by qualified clinician. The notice of action included required content and was easy to understand.

VO provided evidence that UM staff at all levels were both appropriately qualified and well trained in UM procedures. Policies, reports, and the CCM training manual stated that all CCMs, peer advisors, and medical directors must participate in training at orientation and annually thereafter. The CCM training manual included detailed information on all aspects of the UM process. All clinical staff participated in an annual interrater reliability audit, which included an established benchmark for corrective action. Clinical rounds were held at least weekly (daily as needed) to review admissions, continuing care, case management, and/or clinically problematic cases. Staff reported that VO also audits UM telephone interactions and documentation to ensure that staff members appropriately apply criteria.

All UM authorization reviews were documented in the Care Connect system, which was demonstrated during the on-site review. The system allowed for documentation of the essential elements of the UM process, including date-stamped receipt of the authorization request and decision dates, type of authorization, communications with providers, decision outcomes, and detailed clinical and reviewer notes. Staff members described that Provider Connect, a Web-based application, allowed providers to enter authorization requests, look up authorization letters, ask questions about eligibility, and obtain customer service online.

Policies and member and provider communications defined emergency and post-authorization services as specified in requirements. The Emergency and Poststabilization policy stated that **CHP**

would cover emergency and poststabilization services provided by contracted or non-contracted providers without prior authorization. Claims review procedures supported that emergency services for a covered diagnosis were paid in all cases. If VO determined retrospectively that emergency care was for a non-covered diagnosis, the notice of action would inform the member that the member was not financially responsible. The notice of action would also inform the member and provider of alternative sources for Medicaid coverage. The notice of action template included this information. The policy stated that poststabilization services, which did not require authorization, ended when the member was discharged from the emergency room to another level of care. Policies described the circumstances in which **CHP** was financially responsible for poststabilization services, as defined in the requirements.

### *Summary of Strengths*

The extensive experience of VO at the national and local BHO levels resulted in well-defined UM systems and processes, well-trained and qualified UM staff, efficient operations, and extensive reporting and oversight of utilization outcomes and UM performance. In addition, on-site interviews demonstrated that leadership staff members were continuously seeking opportunities for improvement in UM processes.

### *Summary of Findings Resulting in Opportunities for Improvement*

Although **CHP** provided numerous examples of data sources and measures used routinely to monitor utilization, there was minimal evidence of planned interventions and/or documentation of conclusions related to the analysis of data. **CHP** should consider documenting staff and committee meeting conclusions related to reviewed utilization data. This will allow for clearly linking data analyses to determinations regarding program performance, direction, and/or plans for follow-up.

The notice of action template included an insert of appeal procedures with all required content; however, **CHP** should consider clarifying in its member communications the following information regarding notices of action:

- The responsibility of the member to pay for requested continued services during an appeal may apply when a denial is upheld by either the State fair hearing *or an internal appeal*. The appeal insert only referenced the State fair hearing.
- The terminology regarding a State fair hearing, used interchangeably with Office of Administrative Courts, did not explain to the member that these were the same entity.

The Care Connect UM software provided a field for the documentation of the specific level-of-care guidelines applied by the CCMs to determine medical necessity. **CHP** did not require CCMs to complete this field, nor was there reference in the member/provider notice of action to the specific level-of-care guideline used to make the medical necessity determination. For reference purposes, **CHP** might consider both documenting in the system the specific criteria used to determine medical necessity and including this information in the member/provider notification.

### Summary of Required Actions

There were no required actions for this standard.

## Standard II—Access and Availability

### Summary of Findings as Evidence of Compliance

**CHP** delegated provider network development and provider relations activities to VO. VO provided administrative and delegated services to three BHOs in Colorado, and conducted data analysis of network sufficiency, developing most network plans across the three combined BHO regions. During on-site interviews, staff confirmed that members may access any provider in any of the three BHO regions, although staff recognized that network development needs vary in each of the BHO geographic regions.

Policies outlined both access requirements for the provider network and mechanisms for measuring compliance with access requirements. These included provider-to-member ratios, geographic distribution, distance between members and provider locations, provider language expertise, appointment availability standards, and the number of single case agreements (SCA). **CHP** submitted numerous reports, including comprehensive quarterly Network Adequacy reports and the Annual Needs Assessment, which demonstrated active staff engagement in evaluating the sufficiency of the provider network. Reports stated that the **CHP** network was adequate to meet member needs for mix (e.g., mental health centers, independent practitioners, essential community providers, variety of licensed professionals) and distribution of providers. In addition, staff reported that VO had entered into 80 new contracts (statewide) to support the integration of substance abuse benefits into the BHOs.

The Network Development Plan (statewide information) identified the following priority provider recruiting criteria: providers practicing in a primary care integrated model, out-of-state psychiatrists, providers with special language or cultural expertise, providers in rural/frontier areas, providers offering a specific clinical specialty, and providers with 10 or more SCAs. **CHP** tracked increases in the number of BHO members by particular State benefit categories, increases in the number of members served, and penetration rates. Staff members stated that demands for providers and services were increasing due to the expanded Medicaid populations, and that resulting demographic shifts within the BHO eligible membership may impact the types of services needed. Staff stated that **CHP** was monitoring utilization carefully to identify increased demand on network providers, but that most members (80 percent) receive care through CMHCs, which have been able to absorb the increased demand to date.

Policies and procedures outlined processes for provision of second opinions and out-of-network services at no cost to the member. SCAs were used to contract with out-of-network providers or to meet unique treatment or cultural needs of members. The provider handbook required providers to maintain 24-hour, 7-day-per-week coverage and communicated all appointment response time requirements. The Measurement of Access and Availability policy addressed monitoring of access standards, as well as giving feedback to providers and taking corrective action as necessary.

CMHCs were monitored quarterly for compliance with access standards, and independent practitioners were monitored periodically using a random sampling method. Staff stated that VO was exploring additional mechanisms for monitoring compliance with access and appointment standards for independent practitioners. QISC/CAUMC meeting minutes confirmed that the committee was actively monitoring both access and availability reports and data reflecting member perceptions of access and availability, such as member surveys and grievances and appeals.

The **CHP** Cultural Competency Plan described **CHP**'s recognition of the influence of a member's culture on that individual's health behaviors, beliefs, and practices. The plan outlined program goals, which included assessment of operations and staff, and training for cultural competency. The plan described the oversight roles of the Cultural Competency Steering Committee and the Office of Member and Family Affairs for the program. Numerous policies and procedures addressed methods of delivering services to meet members' diverse linguistic needs. In addition, staff described mechanisms for identifying unique cultural needs of members and aligning them with specific providers as necessary. **CHP** provided cultural competency education for staff and providers. When **CHP** identified a provider's specialized cultural expertise, the information was included in the provider directory and used by staff to refer members to appropriate providers. The Network Development Plan stated that **CHP** gave recruiting preference to providers who could provide treatment in a foreign language, sign language, and/or who had specific cultural experience. **CHP** also used SCAs as necessary to align members with unique cultural needs with providers that had appropriate cultural experience. Staff members stated that **CHP** was conducting research to identify cultural attributes, beyond linguistic characteristics, of various cultures within the BHO population, and was exploring methods to integrate consideration of those attributes into various programs and the development of the network. **CHP** acknowledged that the changing demographics and characteristics of the Medicaid expansion populations would present new cultural competency challenges.

## *Summary of Strengths*

Due to **CHP**'s long-standing presence as the BHO in the region, **CHP** has secured contracts with the majority of qualified providers in the service area. Therefore, **CHP** has engaged in several initiatives related to expanding the availability of mental health services to members through non-traditional means such as provision of home-based services, telemedicine, and primary care provider (PCP) training programs for medication management of depression.

**CHP** tracked provider specialty areas (e.g., adoption, marital counseling, and anger management) as well as any unique cultural expertise. This information is communicated to members in the provider network directory and/or used by staff to align members with providers to address areas of special need.

## *Summary of Findings Resulting in Opportunities for Improvement*

**CHP** had multiple provider network data sources. **CHP** may want to consolidate various sources of information to facilitate analysis and document conclusions related to network adequacy from

multiple perspectives. In addition, although **CHP** analyzes the network by county, it may want to consider analysis and decision-making related specifically to **CHP** as a whole.

Although policies and operational procedures supported the provision of out-of-network services as stated in the requirements, **CHP** should clarify member and provider communications regarding the ability to access out-of-network services when services are not available in network.

Considering the changing demographics and cultural needs of the BHO population resulting from Medicaid expansion, **CHP** should continue efforts to proactively anticipate and project the impact of those member populations on the need for specific services and integrate conclusions into provider network development plans.

Although **CHP** had some mechanisms in place to identify special cultural needs of individual members and to seek appropriate providers to meet those needs, **CHP** should consider mechanisms to more routinely identify members' cultural needs. Further, **CHP** should proactively identify provider areas of cultural expertise to better match members with providers who understand the beliefs and behaviors of select cultural groups.

### *Summary of Required Actions*

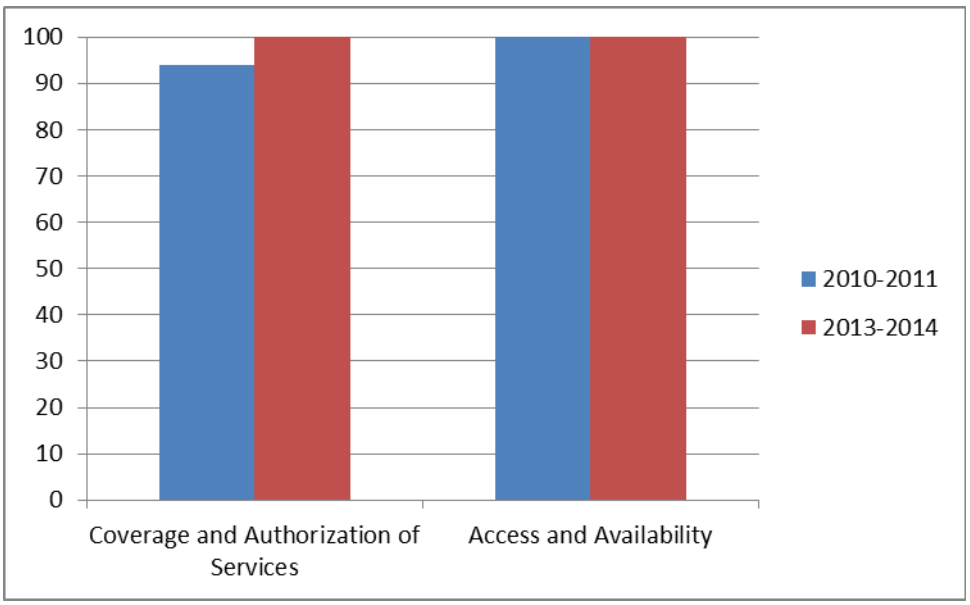
There were no required actions for this standard.

# Comparison of Results

## *Comparison of FY 2010–2011 Results to FY 2013–2014 Results*

Figure 2-1 shows the scores from the FY 2010–2011 site review, when Standard I and Standard II were previously reviewed, compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **CHP**'s contract with the State may have changed, and may have contributed to performance changes.

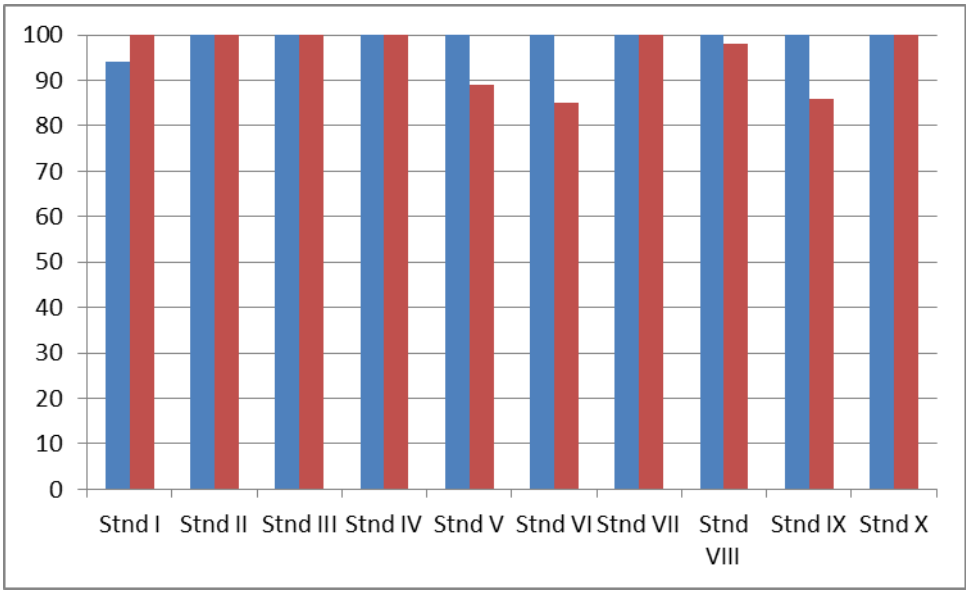
**Figure 2-1—Comparison of FY 2010–2011 Results to FY 2013–2014 Results**



## Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the last two, three-year cycles of compliance monitoring. The figure compares the score for each standard across two review periods and may be an indicator of overall improvement.

**Figure 2-2—CHP's Compliance Scores for All Standards**




Note: The older results are shown in blue. The most recent review results are shown in red.

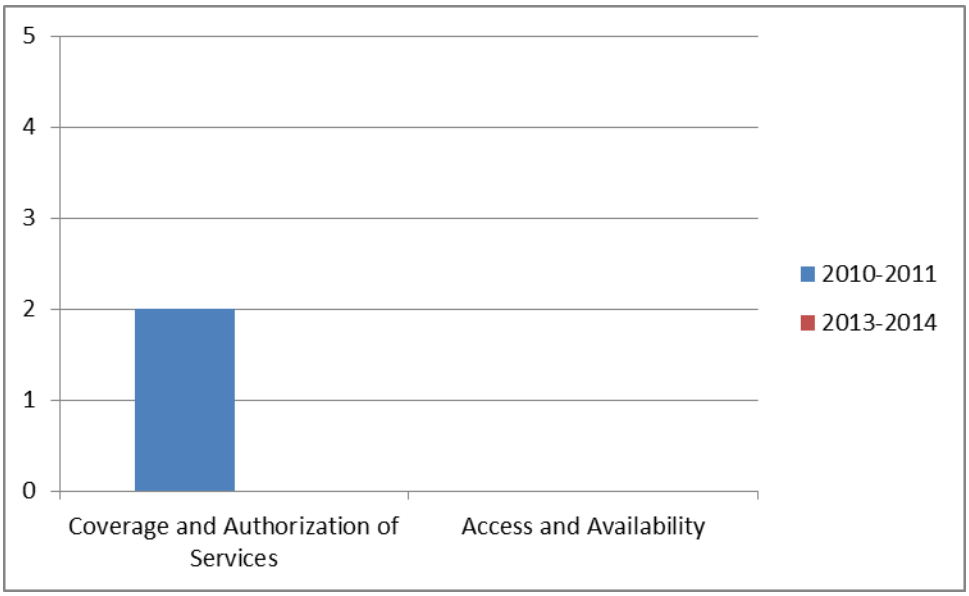
Table 2-1 presents the list of standards by review year.

| Table 2-1—List of Standards by Review Year | | | | | | |
|---|---|---|---|---|---|---|
| **Standard** | **2008–09** | **2009–10** | **2010–11** | **2011–12** | **2012–13** | **2013–14** |
| I—Coverage and Authorization of Services | | | X | | | X |
| II—Access and Availability | | | X | | | X |
| III—Coordination and Continuity of Care | | | X | | X | |
| IV—Member Rights and Protections | | X | | | X | |
| V—Member Information | X | | | X | | |
| VI—Grievance System | | X | | X | | |
| VII—Provider Participation and Program Integrity | | X | | X | | |
| VIII—Credentialing and Recredentialing | | X | | | X | |
| IX—Subcontracts and Delegation | | X | | X | | |
| X—Quality Assessment and Performance Improvement | | X | | | X | |

## Trending the Number of Required Actions

Figure 2-3 shows the number of requirements with required actions from the FY 2010–2011 site review, when Standard I and Standard II were previously reviewed, compared to the results from this year's review. Although the federal requirements did not change for the standards, **CHP**'s contract with the State may have changed, and may have contributed to performance changes.

**Figure 2-3—Number of FY 2010–2011 and FY 2013–2014 Required Actions per Standard**

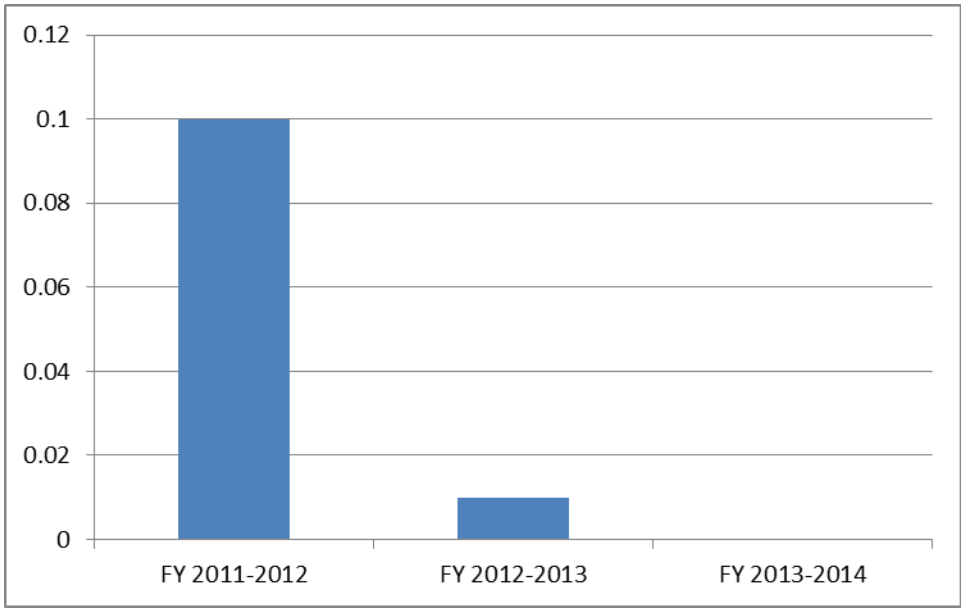



Note: **CHP** did not have any required actions for Access and Availability in FY 2010–2011. **CHP** did not have any required actions for either standard in FY 2013–2014.

## Trending the Percentage of Required Actions

Figure 2-4 shows the percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards.

**Figure 2-4—Percentage of Required Actions—All Standards Reviewed**




Note: **CHP** did not have any required actions for FY 2013–2014.

## Overview of FY 2013–2014 Compliance Monitoring Activities

For the fiscal year (FY) 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

## Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key BHO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to BHO service and claims denials. In addition, HSAG conducted a high-level review of the BHO's authorization processes through a demonstration of the BHO's electronic system used to document and process requests for BHO services.

A sample of the BHO's administrative records related to Medicaid service and claims denials was also reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 15 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. For the record review, the BHO received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2013–2014 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—

Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

## 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 health care regulations and managed care contract requirements in the two 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 recommended to improve the quality of the BHO's services related to the standard areas reviewed.

# 4. Follow-up on Prior Year's Corrective Action Plan

*for* **Colorado Health Partnerships, LLC**

## FY 2012–2013 Corrective Action Methodology

As a follow-up to the FY 2012–2013 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 it successfully completed each of the required actions. HSAG and the Department continued to work with **CHP** until it completed each of the required actions from the FY 2012–2013 compliance monitoring site review.

## Summary of 2012–2013 Required Actions

Because VO is a **CHP** partner, a delegation agreement may not be required. However, 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/or 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/or providers.

## Summary of Corrective Action/Document Review

**CHP** submitted its CAP to HSAG and the Department in February 2013. HSAG and the Department reviewed the plan and determined that, if implemented as written, **CHP** would achieve full compliance with the requirement. **CHP** submitted documents in April 2013 that demonstrated it had successfully completed the required action.

## Summary of Continued Required Actions

**CHP** had no required actions continued from FY 2012–2013.

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

The completed compliance monitoring tool follows this cover page.

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 1. The Contractor established and maintains a comprehensive Utilization Management (UM) Program to monitor the access to, use, consumption, levels and intensity of care, outcomes of, and appropriate utilization of covered services. The Contractor evaluates the medical necessity, appropriateness, efficacy, efficiency of health care services, referrals, procedures, and settings. The Contractor's Utilization Management Policies and Procedures include:<br>◆ Prior authorization for identified intensive levels of care.<br>◆ Description of activities undertaken to specifically identify and address underutilization.<br>◆ Routine trending and analysis of data by level of care (including care not prior-authorized).<br>◆ Routine trending of services by provider.<br><br>Contract:<br>II.I.1.a., II.I.1.s, Exhibit V, IV.A and IV.B | **Documents Submitted/Location within Documents:**<br>1. DelegationAgreement_CHP– Exhibit A, pages pp. 10-11, p. 13, and pp. 16-17 *Misc<br>2. C101 Utilization Management Program Description Policy_3BHO– Entire document<br>3. C101A UM Program Description Outline_3BHO – Entire policy<br>4. C102 Quality Management_Utilization Management Work Plans_3BHOs – Entire policy<br>5. 204LIntakeDataCollectInitialAuthHLOC_3BHO–Entire policy<br>6. 206LDataCollectionContinuedAuthHLOC_ 3BHO–Entire policy<br>7. FY14_QMUMWorkPlanFINAL_2013SEPT27_Quality (3)_CHP- entire document<br>8. 2014_QualityManagementProgramDescriptionFinal_2013SEPT09_SigPage_Quality (3)_CHP – entire document<br>9. 202L Medical Necessity_3BHO–Entire policy<br>10. IV403 Provider Treatment Record Review, Analysis and Reporting_2BHO – Page 1, Section III.A<br>11. FY13_QMUMAnnualEval_FINAL_with_CommOrgCht_2013SEPT09_Quality (3)_CHP-Entire Document<br>12. IP by History_CY13_Q1_CHP-Entire Document<br>13. CMHC Outpatient Service Mix CY12Q2_CY13Q1_CHP-Entire Document<br>14. Avg Cost Per User CY12Q2 to CY13Q1_CHP-Entire Document<br>15. OON Report_CY13_Q1_CHP-Entire Document<br>16. IP Benefit Limit_3BHO- entire document<br>17. IP_Readmit_3BHO-Entire Document<br>18. Weekly Inpatient Census_CHP-Entire Document | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | 19. DailyCensus_2013-0307_3BHO-Entire Document<br>20. 2013-01Census Summary_CHP-Entire Document<br>21. HLOC DecisionSummary_Oct_2013_CHP-Entire Document<br>22. Residential After Care Timeliness_FY2014_Q1_CHP-Entire Document<br>23. Performance Measures FY 2012 2013_3BHO-Entire Document<br>24. AccessToCare_FINAL_Report_Q1FY14_2013OCT30_CHP-Entire Document<br>25. FY2013_MHCContractComp_CMHC_Tool_2013Sept_QM_CHP-Entire Document<br>26. MHSIPYSSFItemLevelReport_report_2013JUL01_QM_2BHO-Entire Document<br><br>**Description of Process:**<br>ValueOptions® is the CHP delegate for all utilization management functions (Delegation Agreement_CHP– Exhibit A; document 1 ). The program is under the oversight of Dr. Peter Brodrick, CHP's Medical Director, and UM activities are reported through the BHO's Quality Improvement and Utilization Management Committee (see UM Program Description and Annual Work Plan; documents 7 and 8). Our policies and procedures describing our comprehensive Program can be found :<br>• C101 Utilization Management Program Description Policy_3BHO (Document 2)<br>• C101A UM Program Description Outline_3BHO – Entire policy (Document 3)<br>• C102 Quality Management_Utilization Management Work Plans_3BHOs –(Document 4) | |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | Additionally, the UM program operates under the BHO's comprehensive medical necessity policy (Policy 202L; document 9). This keystone document provides the operational definition of medical necessity used by the BHO. It is our policy to monitor the appropriateness of care for our members by formally reviewing their documentation of care, as well ( IV403 Provider Treatment Record Review, Analysis and Reporting_2BHO – Page 1, Section III.A- Document 10)<br><br>**Prior authorization for identified intensive levels of care:**<br>Through the authorization process, medical necessity and appropriateness of referrals are evaluated during the initial authorization process. During requests for continued authorization, Care Managers take clinical information which helps them make decisions on medical necessity and determine whether the services provided are effective for the member as they review the treatment plan and member's progress towards discharge goals. Preauthorization is required for higher levels of care, including 23 hour observation, inpatient, ATU, partial hospitalization, day treatment and residential services require prior authorization. The authorization process for initial and concurrent reviews are outlined in the following documents:<br>• 204LIntakeDataCollectInitialAuthHLOC_3BHO (Document 5)<br>• 206LDataCollectionContinuedAuthHLOC_ 3BHO (Document 6).<br>• On a more granular level, treatment progress and the efficacy of treatment are monitored through the concurrent review and authorization processes by the ValueOptions care management team .See | |

| Standard I—Coverage and Authorization of Services | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | (2014_QualityManagementProgramDescriptionFinal_2013SEPT09_SigPage_Quality (3)_CHP (Document 8)<br><br>**Description of activities undertaken to specifically identify and address underutilization:**<br>Under-utilization is monitored on an aggregate basis by looking at the service penetration rate and comparing it to that of the other BHOs in the state. Under-utilization also may be indirectly reflected by performance measures such as inpatient readmission rates or ambulatory follow-up rates (Performance Measures, document 24). An annual evaluation of the UM program is provided to the BHO's QI-UM Committee (FY13_QMUMAnnualEval_FINAL_with_CommOrgCht_2013SEPT09_Quality (3)_CHP), document 11).<br><br>**Routine trending and analysis of data by level of care (including care not prior-authorized).**<br>The BHO routinely reviews the utilization of services through monthly and quarterly reports and UM dashboard data:<br>• .DailyCensus_2013-0307_3BHO-Entire Document (Document 19)<br>• Weekly Inpatient Census_CHP-Entire Document (Document 18)<br>• 2013-01Census Summary_CHP (Document 20)<br>• CMHC Outpatient Service Mix CY12Q2_CY13Q1_CHP-( Document 13)<br>• IP by History_CY13_Q1_CHP-( Document 12)<br><br>Authorization decisions, including denials and appeals are monitored on a regular basis (HLOC DecisionSummary_Oct_2013_CHP-Entire Document document | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | 21)<br>A variety of policies and reports as well as satisfaction surveys provide evidence of the monitoring and evaluation of health care services, access to care, procedures and settings Additionally, each facility is required, per NCQA, to have an accreditation or undergo a facility site visit upon credentialing and recredentialing. The on-site reviewer uses the facility site visit tool(FY2013_MHCContractComp_CMHC_Tool_2013Sept_QM_CHP-Entire Document 25)in order to measure contract compliance. Many other reports are used to evaluate and monitor provision of appropriate services to our members:<br>• **Access:**<br>• AccessToCare_FINAL_Report_Q1FY14_2013OCT30_CHP-(Document 24)<br>• Residential After Care Timeliness_FY2014_Q1_CHP-(Document 22)<br>• Efficiency of Call Center operations indicate members can easily reach us for referrals and call center performance is monitored through various telephone statistics and the timeliness of authorization decisions Timely authorization decisions also contribute to ease of access for our members as our providers are able to proceed with treatment without undue delay (FY13_QMUMAnnualEval_FINAL_with_CommOrgCht_2013SEPT09_Quality (3)_CHP` (Document 11).<br>• OON Report_CY13_Q1_CHP(Document 15) allows for monitoring of services provided out of network by type of service, area and provider<br><br>**Procedures and Settings**: (appropriateness of care)<br>• FY2013_MHCContractComp_CMHC_Tool_2013Sept_Q | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | M_CHP-Entire Document`(Document 25)<br>• MHSIPYSSFItemLevelReport_report_2013JUL01_QM_2 BHO- (Document 26) (Member satisfaction/quality of services)<br>• Avg Cost Per User CY12Q2 to CY13Q1_CHP-Entire Document (intensity of treatment, capturing changes), Document 14<br>• IP_Readmit_3BHO-(Document 17)<br><br>These and similar reports are reviewed and evaluated through Quality and Utilization Management Committees.<br>These documents provide trending by levels of care and by provider. They help us monitor use and consumption and levels of care accessed by our members. One indication of outcomes is seen in our review of members who readmit to inpatient levels of care. (IP_Readmit_3BHO Document 17) The quality and appropriateness of services is monitored on an aggregate basis through key performance indicators, including inpatient discharges per 1,000 members, average length of inpatient stay, and ambulatory follow-up after inpatient discharge (see Performance Measures, document 23). Also, service outliers are reported and investigated to identify any common themes that might represent systemic problems in service quality or access (e.g., IP Benefit Limit_3BHO, document 17). | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 2. The Contractor's Utilization Management Program Description is written so that staff members can understand the program and includes:<br>◆ Program goals.<br>◆ Program structure, scope, processes, and information sources, including the identification of all intensive levels of care.<br>◆ Roles and responsibilities.<br>◆ Evidence of Medical Director leadership in key aspects of the UM Program to include denial decisions and criteria development.<br>◆ A description of how oversight of any delegated UM function will occur.<br>◆ A description of how staff making utilization review decisions are supervised.<br>◆ A statement regarding staff availability at least eight hours a day during normal business hours for inbound calls regarding UM issues.<br>◆ The mechanisms used to ensure that members receive equitable access to care and services across the network.<br>◆ The mechanisms used to ensure that the services authorized are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished.<br>*42CFR438.210(a)(3)(i)*<br><br>Contract:<br>II.I.1.s, Exhibit V, I.A | **Documents Submitted/Location within Documents:**<br>1. 2014_QualityManagementProgramDescriptionFinal_2013SEPT09_SigPage_Quality (3)_CHP-Entire Document<br>2. 202L Medical Necessity_3BHO-entire policy<br>3. 223LTreatmentPlanning_Policy_3BHO – Entire policy<br>4. 236LClinicalLOCGuidelines_Policy_3BHO- entire policy<br>5. 420LContin24HrCMPhoneCoverage_Policy_3BHO-entire policy<br>6. Under-utilization_Summary_FY13_Q2_CHP-Entire Document<br>7. LOC Guideline 3 BHO_23-Hour_Observation- Entire document<br>8. LOC Guideline 3 BHO_Acute Inpatient Treatment- Entire document<br>9. LOC Guideline 3BHO_Acute_Treatment_Unit_Services-Entire document<br>10. LOC Guideline 3BHO_Adult_Residential_Treatment_Services- Entire document<br>11. LOC Guideline 3 BHO_Advocacy_Svcs- Entire document<br>12. LOC Guideline 3 BHO_alternative outpatient services-Entire document<br>13. LOC Guideline 3 BHO_Alternative_Family_Care- Entire document<br>14. LOC Guideline 3 BHO_Case_Management_Services-Entire document<br>15. LOC Guideline 3BHO_Child_Adol_Day_Treatment_Services- Entire document<br>16. LOC Guideline 3 BHO_Community_Support_Programs-Entire document<br>17. LOC Guideline | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | 3BHO_Consumer_Operated_Services_Adult- Entire document<br>18. LOC Guideline 3BHO_Intensive_Outpatient_Programs_Adult- Entire document<br>19. LOC Guideline 3BHO_IOP_ChildAdol_Sex_Disorder_TX- Entire document<br>20. LOC Guideline 3BHO_Outpatient_Crisis_Intervention_Services- Entire document<br>21. LOC Guideline 3 BHO_Outpatient_Services- Entire document<br>22. LOC Guideline 3BHO_Parameters_for_Treating_Children_Under_5- Entire document<br>23. LOC Guideline 3 BHO_Partial_Hospitalization- Entire document<br>24. LOC Guideline 3 BHO_Peer_Support_Services- Entire document<br>25. LOC Guideline 3 BHO_Psychological-Neuropsychological_Testing- Entire document<br>26. LOC Guideline 3BHO_Residential_Treatment_Children-Adolescents- Entire document<br>27. LOC Guideline 3 BHO_Respite_Care_Services- Entire document<br>28. LOC Guideline 3 BHO_Wrap_Around_Services- Entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). The CHP Program Description | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | (2014_QualityManagementProgramDescriptionFinal_2013SEPT09_SigPage_Quality (3)_CHP (Document 1) summarizes processes and policies utilized to ensure appropriate services are authorized to help members achieve positive outcomes. The Program goals can be located in Section XIII (p.44) of the description. Multiple policies and avenues exist for ValueOptions® (VO) to ensure that services provided to CHP's members are reasonably expected to achieve their outcome. These policies are:<br>• 202L Medical Necessity_3BHO-entire policy<br>• 223LTreatmentPlanning_Policy_3BHO – Entire policy<br>• 236LClinicalLOCGuidelines_Policy_3BHO-entire policy<br><br>In addition to following policy and procedures, VO staff reference the Level of Care Guidelines (Documents 7-28) for all levels of care to determine clear admission, continued stay and discharge criteria for use in case reviews. Matching member clinical details with the admission criteria for each LOC is the first step in insuring that members can achieve their outcomes while in treatment. Continued review focuses on the ongoing criteria for the level of care, which provides regular oversight of the service effectiveness. The guidelines are used to insure that services are appropriate for each member's situation and the services are reasonably expected to achieve the outcome for which the service is furnished. ValueOptions®' clinical staff reviews guidelines, formally, at least annually.<br><br>2014_CHPQualityManagementProgramDescriptionFinal_2013SEPT09_SigPage_Quality (3) provides information about each of the required elements:<br>Program structure and scope, including roles and | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | responsibilities and oversight of the program can be located in the Program Description in Section IV, pp. 6-17<br><br>UM processes are described in detail in Section A. 1-18, pp. 22-34, information sources can be found in Section J, p. 17, #7, pp. 26-27 and identification of all intensive levels of care in Section K, p. 17, and in #3, p. 23. Staff roles, including supervisory structure is outlined on pages 14-17<br><br>Oversight of delegated functions is described in Section XII, page 43<br><br>Medical Director leadership in key areas can be found in Section III. A, p.6, D. p. 10-11, Section I.2, p. 14, III. A, 5-6, pp. 25-26 and 11.pp. 29-30<br><br>UM staff are available 24 hours per day, 7 days per week through our toll free access to care/clinical referral line (Section V.A. 1, p. 23) , and management staff (Medical Director, Clinical Peer Advisor, Clinical Director) are available to first level review staff on a 24/7 basis as well (Section VII, p. 41) Also noted in: 420LContin24HrCMPhoneCoverage_Policy_3BHO<br><br>Member access to care monitoring is described in committee structures and oversight (pages 8-11), regular monitoring by Quality staff, page 16, quality improvement projects and outcomes measurement, pages 16-19, and also SectionV.7, pages 20-21 gives more examples of mechanisms providing oversight of access to care. | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | Our Level of Care Guidelines, and insuring that staff apply these consistently is one of the main ways we insure that services are authorized appropriately, and are sufficient to help members achieve their treatment goals. (#5 and 6, pp. 25-26) (Documents 12-28) Close involvement and oversight from the Medical Director/Clinical peer advisor of any case that potentially does not meet medical necessity is another safeguard that appropriate services are being authorized for our members (Section 8, pp.27-28, Section 10-11, pp. 28-30). In addition analysis of the overall program through multiple reports and committees looks at the bigger picture for trends that may show any areas of insufficient services or network status to insure that the program is effective. (#20-24, pp. 35-36) In addition, the program is formally evaluated on all goals each year to insure that services are effective. (Section XIV, p. 44)<br>. | |
| 3. The Contractor's UM Program is conducted under the auspices of a qualified clinician and has:<br>◆ Evidence of formal staff training designed to improve the quality of UR decisions.<br>◆ Policies and procedures to evaluate and improve the consistency with which UR staff apply criteria (e.g. inter-rater reliability) across multiple levels of care.<br>◆ Policies, procedures, and job descriptions to specify the qualifications of personnel responsible for each level of UR decision-making (e.g. review, denial).<br>◆ Policies and procedures to ensure that a practitioner with appropriate clinical expertise in treating the member's condition reviews any potential denial based on medical necessity. | **Documents Submitted/Location within Documents:**<br>1. Brodrick CV- entire document<br>2. C405-Orientation and Training of Clinical Staff-3BHO-Entire Document<br>3. C406 Clinical Rounds_3 BHO-Entire policy<br>4. ROUNDS_MINUTES_SC_2013OCT03_3BHO-entire document<br>5. ROUNDS_MINUTES_SC_2013JUL03_3BHO-entire document<br>6. CCM Training Manual- entire document<br>7. DSM V Training sheet_Aug2013_CL- 3BHO-Entire Document<br>8. Sign in Sheet_DSM5Training_2013Aug-3BHO-Entire Document | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| *42CFR438.210(b)(3)*<br><br>Contract:<br>II.I.1.a, II.I.1.h. Exhibit V, VA | 9. Annual Trainings-National Summary_2013_3BHO-Entire Document<br>10. C409 Interrater Reliability_3BHO-entire policy<br>11. Clinical Care Manager Job Description_3BHO-entire document<br>12. Clinical Director Job Description_3BHO-entire document<br>13. Clinical Supervisor Job Description_3BHO-entire document<br>14. Peer Advisor PhD Job Description_3BHO-entire document<br>15. VP Medical Director Job Description_2BHO-entire document<br>16. 202L Medical Necessity_3BHO-p.5, letter F--entire document<br>17. 303LPeerAdvisorAdverseDeterm_Policy_3BHO-page.2-IV-C and V, pp.3-7<br>18. 408LCareManagementDocAudit_Policy_3BHO-entire document<br>19. C408 Clinical Operations Audits_3BHO-Entire Document<br>20. Dementia Training_13OCT09_3BHO-entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). The Medical Director (Dr. Peter Brodrick) oversees the UM program by providing leadership and being intimately involved in the day to day functioning of the Clinical Department. Dr. Brodrick's qualifications are outlined in "Brodrick CV- entire document" Dr. Brodrick participates in daily rounds meetings with the team, and also is available on site daily for case consults and reviews. When he is off site for a meeting, he is available by cell phone to the team. In addition, to Dr. Brodrick, the team has the management support of our | |

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| | psychologist, Clinical Peer Advisor, Clinical Director and Clinical Services Supervisor are available to staff for immediate consult on difficult cases for support of administrative workflows and UR decision making on a daily basis.<br><br>Formal Staff Training:<br>Clinical Care Managers (CCM) receive both initial and ongoing training in a variety of venues described in "C405-Orientation and Training of Clinical Staff-3BHO."Clinical Care managers begin their employment with an intensive training process that formally goes through our CCM Training manual, which orients them to important policies and procedures, level of care criteria, and resources for decision making as well as important nuances and systemic information for our Colorado Medicaid contract. (CCM Training Manual- entire document_) New CCM receive oversight and 1:1 coaching and training from our Clinical Services Supervisor as they learn our computer system and to take calls. By the 90 day review point, they are able to apply criteria consistently, and they receive feedback from direct observation of cases as well as audits of recorded calls.<br><br>Ongoing training is provided throughout the year in a variety of venues. Clinical staff participates in rounds to discuss individual cases and receive formal training. Scheduled rounds time is important to allow applied training on a day to day basis. C406 Clinical Rounds_3 BHO_Entire policy describes our rounds process. In the fall of 2013, we moved from a weekly rounds time, to a daily rounds time to allow for more training and discussion time for the Medical and Clinical Staff. In this venue, there is both formal training (Dementia Training_3BHO_ 100713, DSM V Training sheet_Aug2013_CL- 3BHO, Sign in Sheet_DSM5Training_2013Aug-3BHO) as well as training | |

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| | tailored to trends or questions that come up (ROUNDS_MINUTES_SC_3BHO_2013JUL03_CL and ROUNDS_MINUTES_SC_2013OCT03_3BHO-entire document). In addition to live training, staff also completes multiple online trainings each year- including required trainings as well as trainings tailored to interests or areas they need to learn more about. "Annual Trainings-National Summary_2013_3BHO" provides an overview of the variety of trainings completed through our National online resources in 2013.<br><br><u>Policies and Procedures to evaluate and improve consistency of decision making:</u><br>Inter-rater reliability is formally tested on an annual basis and compared with VO staff across the country to insure consistent application of guidelines and to identify any needs for improvement by any team or individual not meeting the minimum requirements. C409 Interrater Reliability_3BHO-entire policy describes our IRR testing policy and process. Results are analyzed by geographic region, professional specialty and time with the company to allow for identification of trends and actions to improve the application of criteria.<br><br>In addition, all phone calls are recorded, and staff making UR decisions receive regular audits of their performance (See C408 Clinical Operations Audits_3BHO). Documentation audits are also done based on a customized list of criteria for initial and concurrent reviews and on timeliness of reviews. (408LCareManagementDocAudit_Policy_3BHO-entire document). Both documentation audits and telephone audits provide formal oversight opportunities to insure that staff are making appropriate application of clinical criteria. | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | Policies, Procedures and Job Descriptions/Qualifications for UR decision making:<br>Multiple policies and avenues exist for ValueOptions® (VO) to ensure that staff members are clear on their roles and responsibilities. 202L Medical Necessity_3BHO-p.5, letter F is one example of this role clarification, noting that Clinical Care Managers only have authority to approve care, and that a Peer Advisor must be consulted to make any denial decisions. The CCM training manual also reiterates that CCM may not ever deny care in our section "Levels of Care to Approve/Deny" (CCM Training Manual, p. 16) Our job descriptions also outline the qualifications for Clinical Care Managers, Clinical Service Supervisor, Clinical Director, Clinical Peer Advisor and VP Medical Director in the corresponding documents:<br>• Clinical Care Manager Job Description_3BHO-entire document<br>• Clinical Director Job Description_3BHO-entire document<br>• Clinical Supervisor Job Description_3BHO-entire document<br>• Peer Advisor PhD Job Description_3BHO<br>• VP Medical Director Job Description_2BHO-entire document<br><br>Policies ensuring practitioners with appropriate clinical expertise reviews any potential denial based on medical necessity:<br><br>Training materials, job descriptions and policies and procedures make it clear that care can only be denied by a VO Medical Director or Clinical Peer Advisor. 303LPeerAdvisorAdverseDeterm_Policy_p.2-IV-C, and V, pp.3-7 demonstrates that appropriate clinical staff with expertise in treating the member's condition review any potential denials and | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | make decisions based on medical necessity. In addition, 202L Medical Necessity_3BHO-p.5, letter F--entire document, also reiterates that Clinical Care Managers may not deny care, but potential denials must be reviewed with a Peer Advisor. | |
| 4. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.<br><br>*42CFR438.210(a)(3)(ii)*<br><br>Contract:<br>II.I.1.e. | **Documents Submitted/Location within Documents:**<br>1. LOC Guideline 3 BHO_23-Hour_Observation- Entire document<br>2. LOC Guideline 3 BHO_Acute Inpatient Treatment- Entire document<br>3. LOC Guideline 3BHO_Acute_Treatment_Unit_Services- Entire document<br>4. LOC Guideline 3BHO_Adult_Residential_Treatment_Services- Entire document<br>5. LOC Guideline 3 BHO_Advocacy_Svcs- Entire document<br>6. LOC Guideline 3 BHO_alternative outpatient services- Entire document<br>7. LOC Guideline 3 BHO_Alternative_Family_Care- Entire document<br>8. LOC Guideline 3 BHO_Case_Management_Services- Entire document<br>9. LOC Guideline 3BHO_Child_Adol_Day_Treatment_Services- Entire document<br>10. LOC Guideline 3 BHO_Community_Support_Programs- Entire document<br>11. LOC Guideline 3BHO_Consumer_Operated_Services_Adult- Entire document<br>12. LOC Guideline 3BHO_Intensive_Outpatient_Programs_Adult- Entire document<br>13. LOC Guideline 3BHO_IOP_ChildAdol_Sex_Disorder_TX- | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | Entire document<br>14. LOC Guideline 3BHO_Outpatient_Crisis_Intervention_Services- Entire document<br>15. LOC Guideline 3 BHO_Outpatient_Services- Entire document<br>16. LOC Guideline 3BHO_Parameters_for_Treating_Children_Under_5- Entire document<br>17. LOC Guideline 3 BHO_Partial_Hospitalization- Entire document<br>18. LOC Guideline 3 BHO_Peer_Support_Services- Entire document<br>19. LOC Guideline 3 BHO_Psychological-Neuropsychological_Testing- Entire document<br>20. LOC Guideline 3BHO_Residential_Treatment_Children-Adolescents- Entire document<br>21. LOC Guideline 3 BHO_Respite_Care_Services- Entire document<br>22. LOC Guideline 3 BHO_Wrap_Around_Services- Entire document<br>23. 202L Medical Necessity_3BHO– Pages 4-5, Section V.A-F<br>24. 303L Peer Advisor Adverse Determinations – Entire policy<br>25. Exhibit D_Covered Mental Health Diagnoses_3BHO-Entire Document *Misc<br>26. ROUNDS_MINUTES_SC_2013SEP25_3BHO-entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' staff refers to CHP's medical necessity policy (202L; document 23), the list of covered diagnoses (Exhibit D, document 25) and clinical level of care | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | criteria (documents 1-22) to authorize care, based on individual case review to ensure that care is not arbitrarily reduced or denied based on diagnostic categories or conditions. Care can be denied only by the BHO's Medical Director or the Clinical Peer Advisor (policy 303L; document 24).<br><br>Variables such as the member's situation and other care available are also taken into account in each individual situation as demonstrated by the Clinical Rounds process (document 26). Staff work with providers to review the context of the member's care, and give input into best discharge plans to help members stabilize in the long run, with the member's best interest in mind. ValueOptions®' staff refers cases for possible adverse clinical decisions to the Medical Director/Peer Advisor for review. | |
| 5. If the Contractor places limits on services, it is:<br>◆ On the basis of criteria applied under the State plan (medical necessity).<br>◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.<br><br>*42CFR438.210(a)(3)(iii)*<br><br>Contract:<br>II.I.1.f.1. and II.I.1.f.2. | **Documents Submitted/Location within Documents:**<br>1. 202L Medical Necessity – Page 3, Section IV. A-B<br>2. 272LTrackingCaidBenefitLimits_Policy_3BHO_entire policy<br>3. LOC Guideline 3 BHO_23-Hour_Observation- Entire document<br>4. LOC Guideline 3 BHO_Acute Inpatient Treatment- Entire document<br>5. LOC Guideline 3BHO_Acute_Treatment_Unit_Services- Entire document<br>6. LOC Guideline 3BHO_Adult_Residential_Treatment_Services- Entire document<br>7. LOC Guideline 3 BHO_Advocacy_Svcs- Entire document<br>8. LOC Guideline 3 BHO_alternative outpatient services- Entire document<br>9. LOC Guideline 3 BHO_Alternative_Family_Care- Entire document<br>10. LOC Guideline 3 BHO_Case_Management_Services- Entire | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | document<br>11. LOC Guideline 3BHO_Child_Adol_Day_Treatment_Services- Entire document<br>12. LOC Guideline 3 BHO_Community_Support_Programs- Entire document<br>13. LOC Guideline 3BHO_Consumer_Operated_Services_Adult- Entire document<br>14. LOC Guideline 3BHO_Intensive_Outpatient_Programs_Adult- Entire document<br>15. LOC Guideline 3BHO_IOP_ChildAdol_Sex_Disorder_TX- Entire document<br>16. LOC Guideline 3BHO_Outpatient_Crisis_Intervention_Services- Entire document<br>17. LOC Guideline 3 BHO_Outpatient_Services- Entire document<br>18. LOC Guideline 3BHO_Parameters_for_Treating_Children_Under_5- Entire document<br>19. LOC Guideline 3 BHO_Partial_Hospitalization- Entire document<br>20. LOC Guideline 3 BHO_Peer_Support_Services- Entire document<br>21. LOC Guideline 3 BHO_Psychological-Neuropsychological_Testing- Entire document<br>22. LOC Guideline 3BHO_Residential_Treatment_Children-Adolescents- Entire document<br>23. LOC Guideline 3 BHO_Respite_Care_Services- Entire document<br>24. LOC Guideline 3 BHO_Wrap_Around_Services- Entire document | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | 25. IP Benefit Limit_3BHO-Entire Document<br>26. Exhibit D_Covered Mental Health Diagnoses_3BHO-Entire Document *Misc<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). The Medical Necessity policy uses the State definition (202L Medical Necessity – Page 3, Section IV. A-B). Covered Diagnoses lists are stipulated by contract (Exhibit D_Covered Mental Health Diagnoses_3BHO *Misc folder) and care is limited based on the State benefit limits (272LTrackingCaidBenefitLimits_Policy_3BHO_entire policy and IP Benefit Limit_3BHO-Entire Document). Level of Care Guidelines provide the basis for any other limits placed on services authorized to control utilization and focus it on the members who will benefit from services and achieve their goals. (Documents 1-22). Each Level of Care guideline starts with a clear description of the service, and continues with inclusion and exclusion criteria designed to authorize care for the members who would reasonably be expected to benefit from the service. Criteria are clearly outlined to continue authorization for members who are progressing in treatment or who have treatment plans adjusted by providers to address any lack of progress. Care managers actively work with providers during reviews, based on the LOC criteria to shape treatment so that it will achieve the purposes needed by members. | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 6. The Contractor specifies what constitutes "medically necessary services" in a manner that:<br>◆ Is no more restrictive than that used in the State Medicaid program.<br>◆ Addresses the extent to which the Contractor is responsible for covering services related to the following:<br>• The prevention, diagnosis, and treatment of health impairments.<br>• The ability to achieve age-appropriate growth and development.<br>• The ability to attain, maintain, or regain functional capacity.<br><br>*42CFR438.210(a)(4)*<br><br>Contract:<br>I.A.25. | **Documents Submitted/Location within Documents:**<br>1. 202L Medical Necessity_3BHO –Entire policy, especially Section IV.A<br>2. 223LTreatmentPlanning_Policy_3BHO-Entire Policy<br>3.Exhibit D_Covered Mental Health Diagnoses_3BHO-entire document *Misc<br>4. LOC Guideline 3 BHO_23-Hour_Observation- Entire document<br>5. LOC Guideline 3 BHO_Acute Inpatient Treatment- Entire document<br>6. LOC Guideline 3BHO_Acute_Treatment_Unit_Services- Entire document<br>7. LOC Guideline 3BHO_Adult_Residential_Treatment_Services- Entire document<br>8. LOC Guideline 3 BHO_Advocacy_Svcs- Entire document<br>9. LOC Guideline 3 BHO_alternative outpatient services- Entire document<br>10. LOC Guideline 3 BHO_Alternative_Family_Care- Entire document<br>11. LOC Guideline 3 BHO_Case_Management_Services- Entire document<br>12. LOC Guideline 3BHO_Child_Adol_Day_Treatment_Services- Entire document<br>13. LOC Guideline 3 BHO_Community_Support_Programs- Entire document<br>14. LOC Guideline 3BHO_Consumer_Operated_Services_Adult- Entire document<br>15. LOC Guideline 3BHO_Intensive_Outpatient_Programs_Adult- Entire | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | document<br>16. LOC Guideline 3BHO_IOP_ChildAdol_Sex_Disorder_TX- Entire document<br>17. LOC Guideline 3BHO_Outpatient_Crisis_Intervention_Services- Entire document<br>18. LOC Guideline 3 BHO_Outpatient_Services- Entire document<br>19. LOC Guideline 3BHO_Parameters_for_Treating_Children_Under_5- Entire document<br>20. LOC Guideline 3 BHO_Partial_Hospitalization- Entire document<br>21. LOC Guideline 3 BHO_Peer_Support_Services- Entire document<br>22. LOC Guideline 3 BHO_Psychological-Neuropsychological_Testing- Entire document<br>23. LOC Guideline 3BHO_Residential_Treatment_Children-Adolescents- Entire document<br>24. LOC Guideline 3 BHO_Respite_Care_Services- Entire document<br>25. LOC Guideline 3 BHO_Wrap_Around_Services- Entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). Medically necessary services are needed for the diagnosis or treatment of health impairments and also to prevent deterioration in functioning as a result of a covered mental health disorder (policy 202L, document 1). Our treatment planning policy (223LTreatmentPlanning_Policy_3BHO_) outlines the | |

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| | focus of treatment by starting with an individualized assessment of the member, starting with the DSM diagnosis. This diagnosis includes the 5 axis assessment that includes not only a behavioral health diagnosis, but developmental and personality factors, physical health factors, social and developmental stressors as well as the member's functioning level. The policy notes that treatment goals need to be focused and measurable to address these identified problems.<br><br>CHP's Level of Care guidelines (documents 4-25) apply these principles to specific types of treatment and levels of care. Each LOC guideline is designed to take into account the needs of the member to help them in the recovery process from their behavioral health disorder. For example, for children, academic success is a core focus of age appropriate development and success. Helping children and adolescents in the school setting contributes to their ability to maintain or regain a functional capacity and appropriate participation in the school environment is an age appropriate milestone for our youngest members. Therefore, the LOC guideline for Child and Adolescent Day Treatment Services (Document 12, above) focuses on the current academic impairment in the admission and discharge criteria. Similarly, the LOC guideline for Adult Residential Services (document 7) also provides in the definition, a focus on the attainment of life skills to help members with activities of daily living. These are life tasks that a member needs to accomplish in order to be able to transition to a less restrictive level of care, once they go back to the community. Services are rehabilitative in nature and as such, designed to help members return to or attain a higher level of functioning. (Definition of service I, page 1, Document 12) All of our LOC guidelines are written with these principles in mind. ValueOptions®' policies are based on the State Medicaid | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | Program's definition for medical necessity and the covered diagnoses (Exhibit D, document 3) provides the scope of covered diagnoses that we are responsible to treat. | |
| 7. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services.<br><br>*42CFR438.210(b)*<br><br>Contract:<br>II.I.1.g. | **Documents Submitted/Location within Documents:**<br>1. 203LMedicalNecessityDetermination_3BHO – Section IV, definitions and Section V Pages 4-17<br>2. 204LIntakeDataCollectInitialAuthHLOC_3BHO- entire policy<br>3. 206LDataCollectionContinuedAuthHLOC_ 3BHO- entire policy<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies clearly define and outline the procedures and information needed for each type of authorization- initial and continuing authorizations in policy 203L, 204L and 206L. . | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 8. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure that each staff member is applying criteria consistently, such as inter-rater reliability testing. The contractor takes action to improve consistency where possible.<br><br>*42CFR438.210(b)(2)(i)*<br><br>Contract:<br>II.I.1.q | **Documents Submitted/Location within Documents:**<br>1. C409 Interrater Reliability_3BHO-entire policy<br>2. 236LClinicalLOCGuidelines_Policy_3BHO- section V, A, 2 pages 2-3<br>3. 408LCareManagementDocAudit_Policy_3BHO- entire policy<br>4. VO IRR CAP-individual-3BHO-entire document<br>5. IRR results_3BHO-entire document<br><br>**Description of Process:**<br>The submitted documents demonstrate our written policies/procedures for ensuring consistent application of criteria: C409 Interrater Reliability_3BHO-entire policy and 236LClinicalLOCGuidelines_Policy_3BHO- section V, A, 2 pages 2-3 outlines our policies, procedures and mechanisms to ensure and oversee that staff are consistently applying criteria for | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| | decision making. IRR results_3BHO is the result of our annual Inter Rater Reliability testing. We analyze results by discipline, and length of time with the company to see if there are any general trends or problems in application that need to be followed up for additional training. In addition, VO IRR CAP-individual-3BHO is an example of some of the follow up and re-training that is done with individuals who don't pass the test. We also do quarterly documentation audits to make sure that all required elements are being documented- as elements must be present to be included into decision making appropriately.<br>408LCareManagementDocAudit_Policy_3BHO- entire policy outlines this audit process. Care managers perform these audits on their peers, which allows them to see how others are documenting and also provides a natural reinforcement of items that need to be in each record. These are formal processes to make sure that criteria are being applied consistently.<br>We also have informal mechanisms in place such as our daily rounds meeting where cases are discussed with our Medical Director, and reviews of cases that are denied when the Notice of Action is being sent, to make sure that the letter accurately reflects what took place. During this review process, the work of the individual case managers receives oversight and any issues where criteria were not applied correctly can be identified and followed up. | |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 9. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate.<br><br>*42CFR438.210(b)(2)(ii)*<br><br>Contract:<br>II.I.1.j. | **Documents Submitted/Location within Documents:**<br>1. 202L Medical Necessity_3BHO – Page 4, Section V.D<br>2. 203LMedicalNecessityDetermination_3BHO – Section V., pages 4-24<br>3. 303L Peer Advisor Adverse Determ_3BHO – Page 1, Section III.C<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies direct staff to contact the provider, when necessary, for a review determination (policy 303L, entire policy, document 3). In addition, VO policies outline a formal process which includes consultation with a requesting provider, upon request, for reconsideration when initial or continued authorization is denied (303L Peer Advisor Adverse Determ_3BHO – Page 1, Section III.C). Authorizations or denials of services involve immediate telephonic notification of providers. (203L Medical Necessity Determination_Policy_3BHO – Section V., pages 4-24 )If providers fail to request additional services, VO staff reaches out to coordinate with the provider to determine whether the member has discharged from care. If there is not enough information available to make a determination, the provider is notified along with details about the information needed. (202L Medical Necessity_3BHO– Page 4, Section V.D) Finally, appropriate attempts are made to contact the requesting provider for reconsideration/peer to peer review before finalizing any adverse clinical decisions. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 10. The Contractor has in place and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing).<br><br>*42CFR438.210(c)*<br><br>Contract:<br>II.I.1.j | **Documents Submitted/Location within Documents:**<br>1. 203LMedicalNecessityDetermination_Policy_BHO– Page 8-17, sections V.D-V.G<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy outlines the processes for notifying the requesting provider and involved member of any decision to deny or authorize less care than requested, for all types of requests and levels of care. Specifically,<br>• **Section V.D.5** outlines that for denials/limited authorization or urgent prospective requests, the requesting provider is notified telephonically at the time of determination, and that the member, facility and provider all receive written notice of the determination;<br>• **Section V.E.5** outlines the same notification guidelines indicated above for urgent concurrent reviews;<br>• **Section V.F.5** outlines the same notification guidelines indicated above for routine initial reviews; and<br>• **Section V.G.5** outlines the same notification guidelines indicated above for routine concurrent reviews. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 11. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed:<br>◆ For standard authorization decisions—10 calendar days.<br>◆ For expedited authorization decisions—3 business days. | **Documents Submitted/Location within Documents:**<br>1. 203LMedicalNecessityDetermination_Policy_3BHO – Pages 6 – 16, Section V.C-H<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy specifies the timeframes for each type of authorization and level of care. Specifically,<br>• **Section V.C** outlines all authorization timeframes for | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| *42CFR438.210(d)*<br>Contract:<br>II.F.10, 10CCR2505—10, Sec 8.209.4.A.3.c | decisions. Standard (non-urgent) decisions are made within 10 calendar days and expedited decisions (urgent) are made within 72 hours;<br>• **Section V.D.1** notes 72 hours as timeframe for expedited initial authorizations;<br>• **Section V.E.1** notes 72 hours as the maximum timeframe for concurrent urgent authorizations (expedited);<br>• **Section V.F.1** notes the timeframe for routine initial authorizations is 10 calendar days;<br>• **Section V.G.1** notes the timeframe for routine concurrent authorization is 10 calendar days; | |
| 12. The notices of action must be mailed within the following time frames:<br>◆ For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the time frames specified in 431.211:<br>• The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214).<br>◆ For denial of payment, at the time of any action affecting the claim.<br>◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services.<br>◆ For service authorization decisions not reached within the required time frames on the date time frames expire.<br>◆ For expedited service authorization decisions, as | **Documents Submitted/Location within Documents:**<br>1. 203LMedicalNecessityDetermination_Policy_3BHO-Entire Policy<br><br>**Description of Process:**<br>Policy 203L outlines the timeframes for mailing of Notices of Action:<br>• For termination, suspension or reduction of previously authorized services, notices must be mailed at least 10 days before the date of the intended action (Section I. pages 19-20)<br>• For denial of payment (such as for retro reviews), at the time of the action affecting the claim (Section H.4, pages 18-19)<br>• All authorization decisions are made as expeditiously as the member's health condition requires (Section A.2, pages 4-5)<br>• For standard service authorization decisions that deny or limit services- within 10 calendar days of the receipt of request for service (Sections V.F.5, page 14 and V.G.5, page 17)<br>• For service authorization decisions not reached within the required timeframes, on the date timeframes expire (Section | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services.<br><br>*42CFR438.404(c)*<br>*42CFR438.400(b)(5)*<br><br>Contract:<br>II.F.10, 10CCR2505—10, Sec 8.209.4.A.3.a | A.5, page 5)<br>• For expedited decisions, letters are mailed no later than 3 calendar days from the receipt of request for services (Section V.D.5, page 9 and V.E.5, page 11) | |
| 13. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area).<br><br>*42CFR438.404(a)*<br><br>Contract:<br>II.F.4.e, II.F.10<br>10CCR2505—10, Sec 8.209.4.A.1 | **Documents Submitted/Location within Documents:**<br>1. III306LMemberMaterials_Development_3BHO-III.A-E; IV.B. *Misc<br>2. Notice_of_Action_English_CHP – entire document<br>3. Notice_of_Action_Spanish_CHP – entire document<br>4. Notice of Action Standard Non Covered Diagnosis_CHP – entire document<br>5. Notice of Action Standard- Not Mtg Med Nec Form_CHP – entire document<br>6. Notice of Action Standard Service Not Covered_CHP – entire document<br><br>**Description of Process:**<br>ValueOptions follows our policy on member materials development for any member materials. All member materials are translated into Spanish, which has been deemed as a prevalent language by the state. We recognize that a large proportion of Medicaid enrollees have low health literacy, so we follow guidelines developed by CMS in developing the ValueOptions' member materials policy for low literacy readers. For example, when we present a concept that may be unknown to a low literacy reader, we offer a definition in simple language. The Notice of Action letter is translated into Spanish, and we are prepared to translate it into other languages should a member request this. We | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| | test our materials to ensure they are at or below the 6th grade reading level.<br><br>It's important to note to the reviewers that VO and a subcommittee representing each of the BHO OMFA directors, the CHP Compliance Director and the Clinical Director revised the format of the NOA letters approximately mid- year. We did not make any changes to the language in the letter, we only re-arranged the text to make it easier to read and understand. Specifically, we did away with the text boxes and created a letter template for each of the reasons why we would deny services. Consequently, we are submitting letter several letter templates. Until mid-year, we used Notice_of_Action_English_CHP. After mid-year, we began using templates specific to the denial reason Notice of Action Standard Non Covered Diagnosis_CHP, Notice of Action Standard- Not Mtg Med Nec Form_CHP and Notice of Action Standard Service Not Covered_CHP. | |
| 14. Notices of action must contain:<br>◆ The action the Contractor (or its delegate) has taken or intends to take.<br>◆ The reasons for the action.<br>◆ The member's, the member's authorized representative's, or provider's (on behalf of the member) right to file an appeal and procedures for filing.<br>◆ The date the appeal is due.<br>◆ The member's right to a State fair hearing.<br>◆ The procedures for exercising the right to a State fair hearing.<br>◆ The circumstances under which expedited resolution is available and how to request it.<br>◆ The member's right to have benefits continue | **Documents Submitted/Location within Documents:**<br>1. Notice of Action Standard Non Covered Diagnosis_CHP-Entire Document<br>2. Notice of Action Standard Service Not Covered_CHP-Entire Document<br>3. Notice of Action Standard- Not Mtg Med Nec Form_CHP-Entire Document<br>4. GrievanceAppeal_Guide_CHP-Entire Document<br><br>**Description of Process:**<br>ValueOptions ensures that members receive Notices of Action which contain all of the required elements. We meet on a regular basis to continue refinement of our Notice of Action letters, in a continuous quality improvement process. We look for opportunities to refine the letters to make them easier for our | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| pending resolution of the appeal and how to request that the benefits be continued.<br>◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested).<br>◆ Language clarifying that oral interpretation is available for all languages and how to access it.<br><br>*42CFR438.404(b)*<br>Contract:<br>II.F.4.e, II.F.10, 10CCR2505—10, Sec 8.209.4.A.2 | members to read. This year we changed from one main letter with multiple check boxes for the reasons for any denials to three separate letters which only contain information relevant to the situation of the member receiving the letter. Our goal was to remove information that could confuse our members when it is not relevant to their situation.<br>In our effort to only include elements in the letter which pertain specifically to the member in question, we had moved some information related to the circumstances under which benefits could continue and under which they may have to pay for the cost of benefits into our separate Grievance and Appeal Guide (GrievanceAppeal_Guide_CHP) which we mail with every Notice of Action. Upon review of the NOA requirements, we put this information back into our letter and have been using the revised letter since January 2013. The included letter templates (Notice of Action Standard Non Covered Diagnosis_CHP, Notice of Action Standard Service Not Covered_CHP, and Notice of Action Standard- Not Mtg Med Nec_CHP) include all of the covered elements. | |
| 15. The Contactor may extend the authorization decision time frame if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions:<br>◆ Standard authorization decisions—up to 14 calendar days.<br>◆ Expedited authorization decisions—up to 14 calendar days. | **Documents Submitted/Location within Documents:**<br>1. 203LMedicalNecessityDetermination_Policy_BHO – Pages 7-10, Sections V.D2 and 3 and V.E2 and pages 13-15 Sections V.F.3 and V.E.3<br><br>**Description of Process:**<br>Value Options rarely extends decision timeframes, however when extensions are made, policy 203L provides the guidelines that are followed. For expedited authorizations, due to the urgent nature of the care and to meet URAC requirements, authorization decisions must be made within 72 hours, so extensions are only give due to lack of information to make any decision or if the member requests an extension. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| *42CFR438.210(d)*<br>Contract:<br>II.F.10, 10CCR2505—10, Sec 8.209.4.A.3 | • **Section V.D.2** outlines the timeframe for possible extension, when requested by the member, is up to 14 calendar days for an urgent (expedited) case for an initial authorization decision.<br>• **Section V.D.3** outlines the timeframe for possible extension when there is a lack of information to make **any** authorization decision is up to 14 calendar days.<br>• **Section V.E.2** outlines the timeframe for possible extension is up to 14 calendar days for an urgent (expedited case) for a concurrent authorization decision.<br><br>For standard (routine) authorizations:<br>• **Section V.F.3 and V.G.3** notes a 14 calendar day extension is available if there is a lack of information to make an authorization decision, or if the member requests an extension for initial or concurrent authorization decisions.<br>• **Section V.F.3** notes a 14 day extension is available if there are circumstances beyond the control of ValueOptions®. | |
| 16. If the Contractor extends the time frame for making a service authorization decision, it:<br>◆ Provides the member written notice of the reason for the decision to extend the time frame.<br>◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame.<br>◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.<br><br>*42CFR438.404(c)(4) and 438.210(d)(2)(ii)*<br>Contract:<br>II.F.10, 10CCR2505—10, Section 8.209.4.A.3.c | **Documents Submitted/Location within Documents:**<br>**1.** 203LMedicalNecessityDetermination_Policy_3BHO – Pages 8-15- Sections V.D.3.a , V.E.3.a, V.F.2-3 and V.G.2-3<br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy details the requirements to send written notification to the member and to carry out the determination as expeditiously as the member's health condition requires. Written notification requirements can be found in VO Colorado 203L Medical Necessity Determination in the following locations:<br>• V.D.3.a, page 8<br>• V.E.3.a, pag3 10<br>• V.F.2, page 12 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| | • V.F.3, page 13<br>• V.G.2, pages 14-15<br>• V.G.3, page 15<br>The policy also outlines the fact that authorization decisions are made as required by the member's health condition, and no later than the date the extension expires:<br>• V.D.1, page 7<br>• V.E.1, pages 9-10<br>• V.F.1, page 12<br>• V.G.1, pages 14-15 | |
| 17. The Contractor has in place and follows written policies and procedures that provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member.<br>*42CFR438.210(e)*<br>Contract:<br>II.I.1.c. | **Documents Submitted/Location within Documents:**<br>1. C421 Objectivity in Clinical Decision-Making-3BHO -entire policy<br>2. VOCO Annual Attestation_3BHO-entireDocument<br>3. Annual Attestation-Code of conduct-certificates-example-3BHO-Entire Document<br>4. Code of Conduct Annual Training-3BHO-entire document<br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® has policies in place that define conflict of interest and specifically state that employees are not provided incentives, nor permitted to accept gifts in relation to any UM activities. ValueOptions®' staff annually receives training regarding conflict of interest and employee code of conduct, including signing an annual attestation (VOCO Annual Attestation_3BHO) agreeing with policies that they are not given incentives to deny or limit care for members. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 18. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:<br>◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.<br>◆ Serious impairment to bodily functions.<br>◆ Serious dysfunction of any bodily organ or part.<br>*42CFR438.114(a)*<br>Contract:<br>I.A.12 | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices_Policy_3BHO – Page 4, Section IV.A defines Emergency Medical Condition.<br>2. Provider Handbook_3BHO– Section 4- Utilization Management Procedures, page 13-22 *Misc<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L PostStabilization Services policy defines emergency medical conditions. Members receive information in the member handbook about what defines an emergency or crisis and how to obtain emergency services. ValueOptions®' staff assists members and directs them to the nearest facility/ER when there is any question of an emergency medical condition. The provider handbook defines emergency medical condition for providers. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 19. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition.<br>*42CFR438.114(a)*<br>Contract:<br>II.A.13 | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices_Policy_3BHO – Page 4, Section IV.C.<br>2. Provider Handbook_BHO– Section 4- Utilization Management Procedures, page 13-22.*Misc<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L PostStabilization Services policy provides this exact definition of Emergency Services This definition is also given to providers in the Provider Handbook. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 20. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.<br><br>*42CFR438.114(c)(1)(i)*<br>Contract:<br>II.D.6.a.1 | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices_Policy_3BHO – Page 1, Section III.A.<br>2. Colorado Reference Guide _3BHO- #22, page 12<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' Colorado ER claims procedures indicates members can access these services without prior authorization. This procedure document states that claims for emergency services are accepted and paid for any provider, regardless of network status. Claims processors are instructed to consider claims from In or Out of network providers. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 21. The Contractor does not require prior authorization for emergency services.<br><br>*42CFR438.10(f)(6)(viii)(B)*<br>Contract:<br>II.I.1.p.1. | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices_Policy_3BHO – Page 1, Section III.A. and Section III, F.<br>2. 203LMedicalNecessityDetermination_Policy_3BHO- page 6, Section B<br>3. Member Handbook_CHP – Page 11 *Misc<br>4. Provider Handbook_3BHO– Section 4- Utilization Management Procedures, pages 13-22 *Misc<br>5. Colorado Reference Guide _3BHO- #22, page 12 | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 22. The Contractor may not deny payment for treatment obtained under the following circumstances:<br>◆ A member had an emergency medical condition, and the absence of immediate medical attention would ***have*** had the following outcomes:<br>• Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.<br>• Serious impairment to bodily functions.<br>• Serious dysfunction of any bodily organ or part. | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices – Policy_3BHO-Pages 1-2, Section III.B.1-3<br>2. Colorado Reference Guide _3BHO-entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L PostStabilization Services policy clearly outlines that payment may not be denied | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| ◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes:<br>• Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.<br>• Serious impairment to bodily functions.<br>• Serious dysfunction of any bodily organ or part.<br>◆ A representative of the Contractor's organization instructed the member to seek emergency services.<br>*42CFR438.114(c)(1)(ii)*<br>Contract:<br>II.D.6.a.2. | under either of these circumstances. There is no authorization requirement at all for emergency services. These services are not denied when billed as emergency services, regardless of the actual outcome. Providers are also informed of this requirement through the provider handbook. | |
| 23. The Contractor does not:<br>◆ Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms.<br>◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services.<br>*42CFR438.114(d)(1)*<br>Contract:<br>II.D.6.b. | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices_Policy_3BHO –Page 2, Section III.C.1-2<br>2. Colorado Reference Guide _3BHO-entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L PostStabilization Services policy does not limit what constitutes an emergency medical condition based on diagnoses, symptoms or refuse to cover emergency services based on the provider, hospital or fiscal agent not notifying the primary care providers within 10 days of presentation for services. During claims processing, ValueOptions®' staff pays these claims, without the need for an authorization. Providers are not required to notify Value Options of ER services or request authorizations to obtain reimbursement. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 24. The Contractor will be responsible for Emergency Services when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis.<br><br>Contract:<br>II.D.6.i.2. | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices – Policy_3BHO- Page 1, Section III.A.3<br>2. Colorado Reference Guide _3BHO- #22, page 12<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L PostStabilization Services policy indicates that ValueOptions is responsible to pay for ER services when the primary diagnosis is psychiatric in nature, even if the ER services also included some procedures to treat a secondary medical diagnosis. During claims processing, ValueOptions®' staff pays these claims , without the need for an authorization. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 25. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.<br><br>*42CFR438.114(d)(2)*<br><br>Contract:<br>II.D.6.c. | **Documents Submitted/Location within Documents:**<br>1. DelegationAgreement_CHP - Entire policy *Misc<br>2. 270L PostStabilizationServices – Policy_3BHO -Page 3, Section III.D.<br>3. Member Handbook_CHP –Page 11 &14 *****Misc<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L PostStabilization Services policy releases the member from liability for payment for any subsequent screening and treatment needed to stabilize an emergency medical condition. Members are informed via the member handbook that the member is not responsible to pay for services covered by the Medicaid plan. Members are instructed to call the Behavioral Health Organization if the member receives a bill for services. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 26. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.<br><br>*42CFR438.114(d)(3)*<br><br>Contract:<br>II.D.6.d. | **Documents Submitted/Location within Documents:**<br>1. DelegationAgreement_CHP - Entire policy *Misc<br>2. 270L PostStabilizationServices –Policy_3BHO-Page 3, Section III.E<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L PostStabilization Services policy states the attending physician/facility makes decisions independent of any contact with the Behavioral Health Organization regarding stabilization, as there is no preauthorization required for emergency services, and no authorization needs to be on file for the claim to be paid. The provider makes treatment decisions and submits the bill after services have been rendered. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 27. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition.<br><br>*42CFR438.114(a)*<br><br>Contract:<br>II.A.32. | **Documents Submitted/Location within Documents:**<br>1. DelegationAgreement_CHP - Entire policy *Misc<br>2. 270L PostStabilizationServices –Policy_3BHO-Page 5, Section IV.D.<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' 270L PostStabilization Services policy clearly defines post stabilization care. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 28. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative.<br><br>*42CFR438.114(e)* | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices –Policy_3BHO-Page 3, Section III.G. 1<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| *42CFR422.113(c)*<br><br>Contract:<br>II.D.6.e. | Partnerships (CHP). ValueOptions®' is financially responsible for post stabilization care services obtained within or outside the network that have been pre-approved by a plan provider or other organization representative. Policy 270 L Section III. G.1. clearly states this financial responsibility. | |
| 29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances:<br>◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services.<br>◆ The Contractor does not respond to a request for pre-approval within 1 hour.<br>◆ The Contractor cannot be contacted.<br>◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it *has not* pre-approved ends.<br><br>*42CFR438.114(e)*<br>*42CFR422.113(c)*<br><br>Contract:<br>II.D.6.f.1–3. | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices –Policy_3BHO-Page 3-4, Section III.G2-3<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' is financially responsible for post stabilization care services obtained within or outside the network that have NOT been pre-approved by a plan provider or other organization representative but are administered to stabilize the member's condition in several circumstances. Policy 270 L Section III, G.2-3. clearly states this financial responsibility. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard I—Coverage and Authorization of Services | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 30. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when:<br>◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care.<br>◆ A plan physician assumes responsibility for the member's care through transfer.<br>◆ A plan representative and the treating physician reach an agreement concerning the member's care.<br>◆ The member is discharged.<br>*42CFR438.114(e)*<br>*42CFR422.113(c)*<br>Contract:<br>II.D.6.g. | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices –Policy_3BHO-Page 4-5, Section III.-3-c:1-4<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy details the additional circumstances by which ValueOptions® maintains financial responsibility for provided services and details when this responsibility ends. . Policy 270 L, Section III.G.3.c1-4 outline when the financial responsibility for VO ends. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 31. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor.<br>*42CFR438.114(e)*<br>*42CFR422.113(c)*<br>Contract:<br>II.D.6.f.4. | **Documents Submitted/Location within Documents:**<br>1. 270L PostStabilizationServices –Policy_3BHO-Page 3, Section III. D. Members are not charged for these services regardless of whether they go through VO CO or not.<br>2. Member Handbook_CHP-Page 11*Misc<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policy details the additional circumstances by which ValueOptions® maintains financial responsibility for provided services. Policy 270 L states that members are not charged for these services regardless of whether the services are obtained through Value Options or not. The member handbook also lets members know that they are not responsible to pay for any Medicaid covered services. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 100% |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements: | | |
| 1. The Contractor maintains a comprehensive provider network capable of serving the behavioral health needs of all members in the Medicaid Program, including any new populations.<br><br>*42CFR438.206(b)(1)*<br><br>Contract:<br>II.E.1.c.1. | **Documents Submitted/Location within Documents:**<br>1. III306 Measurement of Access and Availability_3BHO – Entire policy<br>2. PR302 NetworkDesignAndAccessStandards_3BHO Entire document<br>3. ERAccessIPN_Q1FY14_CHP – Entire document<br>4. ATCReport _Q1FY14_CHP– Entire document<br>5. NetworkAdequacyReport_Q4FY13_3BHO-entire document<br>6. 2013AnnualNeedsAssessment_3BHO-entire document<br>7. ProviderDirectory_3BHO-Entire Document *Misc<br>8. NetworkAdeq_Policy_3BHO- entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® has several policies that describe the activities involved to assess and maintain a comprehensive provider network to serve the needs of eligible Medicaid members as noted in the ValueOptions local (NetworkAdeq_Policy_3BHO and III306 Measurement of Access and Availability_3BHO) and national policy (PR302 NetworkDesignAndAccessStandards_3BHO). In addition to policies, ValueOptions® conducts a variety of provider monitoring activities to assure providers are meeting the needs of BHO Medicaid members. These activities include monitoring of accessibility and availability (ATCReport _Q1FY14_CHP and ERAccessIPN_Q1FY14). The BHO maintains other network reports that monitor the number and mix of the providers included in network to serve member needs based on expected utilization | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | and expansion populations (NetworkAdequacyReport_Q4FY13_3BHO, 2013AnnualNeedsAssessment_3BHO and ProviderDirectory_3BHO). | |
| 2. In establishing and maintaining the network, the Contractor considers:<br>◆ The anticipated Medicaid enrollment.<br>◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area.<br><br>*42CFR438.206(b)(1)(i) through (v)*<br><br>Contract:<br>II.E.1.c.1. | **Documents Submitted/Location within Documents:**<br>1. PR302 NetworkDesignAndAccessStandards_3BHO –entire document<br>2. 2013AnnualNeedsAssessment_3BHO–entire document<br>3. ProviderDirectory_3BHO- entire document *Misc<br>4. NetworkAdequacyReport_Q4FY13_3BHO entire document<br>5. Provider Handbook_3BHO – Page 23, Section V, *Member Choice of Providers*, Page 89, Section XVI, *Transportation* *Misc<br>6. NetworkAdeq_Policy_3BHO- entire document<br>7. NetDevPlan_FY2014 _3BHO-entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® reviews the network adequacy for CHP regularly as per our local (NetworkAdeq_Policy_3BHO) and national (PR302 NetworkDesignAndAccessStandards_3BHO) policies to ensure Medicaid members have a range of providers that are available to serve their needs. Our Network Development Plan (NetDevPlan_FY2014 _3BHO) gives details on the specific needs CHP has in provider recruitment. Review of the network includes the number of providers, specialties, languages, locations, and accessibility. As noted in our Network Reports (2013AnnualNeedsAssessment_3BHO and NetworkAdequacyReport_Q4FY13_3BHO), ValueOptions monitors the availability of providers quarterly and annually. The monitoring completed by the ValueOptions includes an | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | assessment of member needs and expected utilization.<br><br>Members are provided choice in providers across the CHP region (Provider Handbook_3BHO and ProviderDirectory_3BHO) which includes an array of providers who can serve member needs based on specialty, licensure level, or level of care that is found to be medically necessary. Information is provided of member's ability to choose providers that are available in the network, or the right to request a provider be added to the network in our member materials (Provider Handbook_3BHO). | |
| 3. The Contractor has a network plan and it, at a minimum, addresses the following:<br>◆ The numbers, types, and specialties of providers required to furnish the contracted Medicaid services, including care coordination.<br>◆ The number of network providers accepting/not accepting new Medicaid members.<br>◆ The geographic location of providers in relationship to where Medicaid members live.<br>◆ The potential physical barriers to accessing providers' locations.<br>◆ The cultural and language expertise of providers.<br>◆ Provider-to-member ratios for behavioral health care services.<br><br>*42CFR438.206(b)(1)(i) through (v)*<br>Contract:<br>II.E.1.c.1.i–vi. | **Documents Submitted/Location within Documents:**<br>1. PR302 NetworkDesignAndAccessStandards_3BHO (page a. 5, Section D, #2)<br>2. 2013AnnualNeedsAssessment_3BHO–entire document<br>3. ProviderDirectory_3BHO- entire document *Misc<br>4. NetworkAdequacyReport_Q4FY13_3BHO entire document<br>5. Provider Handbook_3BHO– Page 23, Section V, *Member Choice of Providers*, Page 89, Section XVI, *Transportation* *Misc<br>6. NetDevPlan_FY2014 _3BHO-entire document<br>7. NetworkAdeq_Policy_3BHO- entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® reviews the network adequacy for CHP as per ValueOptions local (NetworkAdeq_Policy_3BHO) and national (PR302 NetworkDesignAndAccessStandards_3BHO ) policies regularly to ensure Medicaid members have a range of providers that are able to serve their needs (ProviderDirectory_3BHO). The review includes, but is not limited to, the number of providers, specialties, languages, locations, and accessibility. ValueOptions maintains a | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | Network Development Plan (NetDevPlan_FY2014 _3BHO) to address all needs of the BHO network and fill any disparity found.<br><br>Monitoring of the network is completed through reviews quarterly and annually (AdequacyReportQ1FY14_3BHO and 2013AnnualNeedsAssessment_3BHO). Providers are given information through the provider manual on how members can access transportation (Provider Handbook_3BHO) for members who may have difficulties access services or experience barriers with access care. | |
| 4. The Contractor ensures that its members have access to a provider within 30 miles or 30 minutes travel time, whichever is larger, to the extent such services are available.<br><br>Contract:<br>II.E.1.a.8. | **Documents Submitted/Location within Documents:**<br>1. AdequacyReport_Q1FY14_3BHO- entire document<br>2. 2013AnnualNeedsAssessment_3BHO- entire document<br>3. NetworkAdeq_Policy_3BHO- entire document<br>4. GeoAccessReport_2013OCT_3BHO – entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® reviews network adequacy for CHP regularly as per our local policy (NetworkAdeq_Policy_3BHO ) to ensure Medicaid members have access to providers within 30 minutes or 30 miles whenever possible. This review is completed quarterly through our network adequacy reports (AdequacyReport_Q1FY14_3BHO and GeoAccessReport_2013OCT_3BHO) and then annually with the BHO annual needs assessment (2013AnnualNeedsAssessment_3BHO). | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 5. The contractor offers to contract with essential community providers located in the Contractor's geographic service area, as defined in Section 25.5-5-404(2) C.R.S. The Contractor's network shall include both essential community providers and other private/non-profit providers, thus allowing members choice and facilitating continuity of care.<br><br>Contract:<br>II.E.1.c.2. | **Documents Submitted/Location within Documents:**<br>1. ProviderDirectory_3BHO-entire document *Misc<br>2. ECP_ContractRequests1_3BHO-entire document<br>3. Essential_Community_Providers_Application_Log-entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). All essential community providers are offered contracts in the CHP (ECP_ContractRequests1_3BHO) area including school based providers, FQHCs, RHC, and other community based providers as noted on the state essential community provider listing (Essential_Community_Providers_Application_Log). Those accepting contracts are listed in the provider directory (ProviderDirectory_3BHO). In addition to essential community providers, the BHO also includes a number of private providers in the BHO network. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |
| 6. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.<br><br>*42CFR438.206(b)(3)*<br><br>Contract:<br>II.E.1.a.12. | **Documents Submitted/Location within Documents:**<br>1. 257LRequestforSecondOpinion_Policy_3BHO– Pages 1-2, Sections III.A and V.A.1-2<br>2. SecondOpinionworkflow_3BHO– Entire document<br>3. Provider Handbook_3BHO – Pages 20 Section VI, *Second Opinion *Misc*<br>4. Member Handbook_CHP– Page 14, Paragraphs 3 and 4 **Misc*<br>5. ProvideForum_Presentation_BHOMEMBERS RIGHTS_3BHO- slide 7 and 12<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® has mechanisms for members to request and obtain a second opinion at no cost to | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | members. Workflow documents demonstrate that ValueOptions® staff can assist members in getting a second opinion through either the Clinical Department or the Office of Member and Family Affairs. ValueOptions® clinical staff and OMFA staff receives training on the process for members to obtain a second opinion. Included in the training is a review of the policy *257LRequestforSecondOpinion_Policy_3BHO*. Members learn about their rights to a second opinion through the member handbook which includes the member rights and responsibilities statements. Providers are informed of the second opinion process and that there is no cost to the member through the provider handbook. | |
| 7. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network at no cost to the member for as long as the Contractor is unable to provide them.<br><br>*42CFR438.206(b)(4)*<br>Contract:<br>II.E.1.c.3. and II.E.1.d.1. | **Documents Submitted/Location within Documents:**<br>1. 274LProvisionSvcsOutOfNetworkProvider_Policy_3BHO – Entire policy, especially Page 3, Section IV.A.7<br>2. SCALetter_Practioner_with cover_3BHO-entire document<br>3. SCALetter_Facilities_with cover_3BHO-entire document<br>4. Provider Handbook_3BHO – Page 20, Section V, Member Choice of Providers*Misc<br>5. Member Handbook_CHP – Page 6 and 16*Misc<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies (274LProvisionSvcsOutOfNetworkProvider_Policy_3BHO) describe services not available through an in-network provider may be accessible to members through an out-of-network provider at no cost to the member and that all timeframes for authorization decisions must be upheld. Policies outline the approval process and situations in which Single Case Agreements are approved for member services outside of the provider network. Providers are | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | sent individual contracts (SCALetter_Practioner_with cover_3BHO and SCALetter_Facilities_with cover_3BHO) which indicate that the BHO Provider Manual must be references in regard to Medicaid members in treatment. The Provider Handbook (Provider Handbook_3BHO) notes that members cannot be billed for behavioral health services. In the member handbook (Member Handbook_CHP), members are informed that they can ask to see a provider who may not be listed in the provider directory. The provider handbook outlines the member's rights regarding choice of providers. | |
| 8. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network.<br><br>*42CFR438.206(b)(5)*<br>Contract:<br>II.E.1.d.2. | **Documents Submitted/Location within Documents:**<br>1. SCALetter_Practioner_with cover_3BHO-entire document<br>2. SCALetter_Facilities_with cover_3BHO-entire document<br>3. Provider Handbook_CHP-page 44, pp 3 *Misc<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP) (DelegationAgreement2013_CHP). Single Case Agreements require that out-of-network providers coordinate with ValueOptions® with respect to payment (SCALetter_Facilities_with cover_3BHO and SCALetter_ Practitioner_with cover_3BHO). Referenced in these individual single case contracts is reference to the provider manual (Provider Manual_CHP) which also indicates that members cannot be billed for behavioral health services. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 9. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary.<br>*42CFR438.206(c)(1)(iii)*<br>Contract:<br>II.E.1.a.5. | **Documents Submitted/Location within Documents:**<br>1. 420L Continuous 24hr Care Management Phone Coverage_ 3BHO – Entire policy<br>2. 210LMemberRequestRoutine_3BHO-Page 1 Section III.A<br>3. 211LMemberRequestUrgent_ 3BHO -Page 1 Section III. A-C<br>4. FY2013 Contract Compliance_CHP – Items 6-7<br>5. ATCReport Q1FY14_CHP- ATC Data tab- Rows 27-39<br>6. Template Call Log Qtr1FY2014_3BHO-Entire Document<br>7. Provider Handbook_3BHO– Page 5, Section III, *Provider* Assistance & Referrals*Misc.<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® ensures that crisis services are available throughout the CHP service areas 24 hours a day, 7 days a week (420L Continuous 24hr Care Management Phone Coverage_ 3BHO, 210LMemberRequestRoutine_3BHO-Page 1 Section III.A and 211LMemberRequestUrgent_ 3BHO -Page 1 Section III. A-C<br><br>These services can be provided by contracted providers or, in the case of emergent services that are medically necessary, through non-contracted, out of network providers. Crisis evaluations are conducted in person primarily onsite at inpatient facilities, which offer services 24 hours a day, 7 days a week. The availability of crisis services are monitored through access to care data, (ATCReport Q1FY14_CHP- ATC Data tab- Rows 27-39) and reported to HCPF quarterly, as well as through mental health center annual contract compliance audits. (FY2013 Contract Compliance_CHP – Items 6-7) In addition, services are available through other facilities such as ATUs and residential treatment centers, which also offer service 24 hours a day, 7 days a week. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | The ValueOptions® Colorado Call Center has a policy and procedure to ensure clinical staff is available 24/7 to facilitate care for members, and to ensure services are coordinated in emergent situations. Telephone statistics are monitored to ensure timely responses to telephone-based emergency service requests. As seen in Template Call Log Qtr1FY2014_3BHO-Entire Document | |
| 10. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members.<br><br>*42CFR438.206(c)(1)(ii)*<br><br>Contract:<br>II.E.1.a.4. | **Documents Submitted/Location within Documents:**<br>1. III306 Measurement of Access and Availability Policy _3BHO Page 1, Section III.A<br>2. FY2013 Contract Compliance_CHP – Items 6-7<br>3. Member Handbook_CHP –Page 1 & 4 *Misc<br>4. Provider Handbook_3BHO– Page 8, Provider Availability for Member Access to Care *Misc<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies (III306 Measurement of Access and Availability Policy _3BHO) describe provider availability and members' access to care requirements. The provider handbook (Provider Handbook_3BHO ) is incorporated into each provider's contract as a participating ValueOptions®/BHO provider. Providers are required to offer hours of operation that are not less than that offered to any other client/member that has other coverage including self-pay. Contract compliance audits are conducted to evaluate several elements including access standards (FY2013 Contract Compliance_CHP). Grievances or survey results may also be used for monitoring as applicable. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 11. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services:<br>◆ Emergency services are available:<br>• By phone, including TTY accessibility, within 15 minutes of initial contact.<br>• In person within one hour of contact in urban and suburban areas.<br>• In person within two hours of contact in rural and frontier areas.<br>◆ Urgently needed services are provided within 24 hours from the initial identification of need.<br>◆ Routine services are available upon initial request within 7 business days. (Routine services include but are not limited to an initial individual intake and assessment appointment. Placing members on waiting lists for initial routine service requests is not acceptable.)<br>◆ Outpatient follow-up appointments within 7 business days of an inpatient psychiatric hospitalization or residential facility.<br><br>*42CFR438.206(c)(1)(i)*<br><br>Contract:<br>II.E.1.a.6 and 7 | **Documents Submitted/Location within Documents:**<br>1. III306 Measurement of Access and Availability Policy 3BHO – Entire policy<br>2. ERAccessIPN Q2fy13_CHP – Entire document<br>3. ATCReport Q1FY14_CHP- Entire document<br>4. FY2013 Contract Compliance _CHP– Items 6-9<br>5. Perf Meas Amb FU 7 day_3 BHO – Entire document<br>6. Residential After Care Timeliness Q1FY2014_CHP –Entire document<br>7. AdequacyReport_Q1FY14_3BHO-Entire Document<br>8. ProviderTrainingPlanFY13_3BH O-training schedule tab row 38 and curriculum tab rows 15-17<br>9. FY13ProvideForum_Presentation_3BHO-Slides 100 and 101<br>10. Provider Handbook_3BHO– Pages 7-8**Misc*.<br>11. Member Handbook_CHP– 5 and 10**Misc*.<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®' policies describe provider availability and members' access to care requirements. The provider handbook specifies access requirements and is incorporated into each provider's contract as a participating ValueOptions®/BHO provider. Further information regarding access standards is included in provider forums. Access and availability standards are tracked and monitored throughout the year for emergent call response and access to emergent, urgent and routine care as well as follow-up visits completed post hospitalization and follow-up post residential treatment and acute treatment unit discharge. Members are made aware of their right to access services in the member handbook. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| 12. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access.<br><br>*42CFR438.206(c)(1)(iv) through (vi)*<br><br>Contract:<br>II.E.1.a.9–11 | **Documents Submitted/Location within Documents:**<br>1. III306 Measurement of Access and Availability Policy_ 3BHO-Entire Policy<br>2. FY2013 Contract Compliance_CHP – Items 6-9<br>3. QISCCAUMC Meeting Minutes_Sept2013-CHP-page 2 Access to Care<br>4. ERAccessIPN Q1fy14_CHP–Entire document<br>5. ATCReport Q1FY14_CHP- Entire document<br>6. Perf Meas Amb FU 7 day_3 BHO – Entire document<br>7. Fact Finders Survey Access to Care Comparison_BYCMHC_ CY2011-2013_CHP – Entire document<br>8. Access_Questions_All_Sources_2013_CHP-Entire Document<br>9. Residential After Care Timeliness Q1FY2014_CHP –Entire document<br>10. Colorado Letter First Time 15 min_CHP – Entire document<br>11. Colorado Provider CAP Emergent Response_CHP – Entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions®. Policy III306 Measurement of Access and Availability Policy_ 3BHO establishes the access to care standards and outlines monitoring of access and availability of services. A variety of mechanisms exist to monitor provider access and availability to determine compliance. IPN providers are contact4ed quarterly (ERAccessIPN Q2fy13_CHP) in order to access emergency response times. Providers whose standards are not in compliance are notified and must submit corrective action plans per Colorado Letter First Time 15 min_CHP and Colorado Provider CAP Emergent Response_CHP.<br><br>Along with various mechanisms for all levels of access | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | monitoring, grievances regarding access are investigated through the Quality of Care process, and member survey results are evaluated. Annually, ValueOptions® conducts contract compliance audits (FY2013 Contract Compliance_CHP – Items 6-9) and monitors access trends based on satisfaction survey data through quality committees and minutes. | |
| 13. The Contractor has developed policies and procedures for monitoring the performance of providers on an ongoing basis related to the timeliness of services, and has monitored providers annually to determine compliance.<br><br>Contract:<br>II.G.10.a.3, II.G.10.a.4, Exhibit S, IV.A | **Documents Submitted/Location within Documents:**<br>1. ProviderHandbook_3BHO– Page 8, *Provider Availability for Member Access to Care**Misc<br>2. ERAccessIPN Q1fy14_CHP–Entire document<br>3. QISCCAUMC Meeting Minutes_Sept2013-CHP FY2013<br>4. FY2013 Contract Compliance_CHP– Items 6-9<br>5. III306 Measurement of Access and Availability Policy-_3BHO-Page 4 Section B 1-5<br>6. 303LGrievancePolicy_3BHO -Entire Policy<br>7. 304L Rights and Responsibilities_3BHO -Section III A. 11 and page 11 Section H.1<br>8. ChrtAudResultsLtr_CCQCAudits_3BHO- entire document<br>9. 403ProviderTreatmentRecordReviewAnalysisandReportingAttachmentA_Policy_3BHO- entire document<br>10. 403ProviderTreatmentRecordReviewAnalysisandReporting_3BHO -Entire Policy- entire document<br>11. FY14Q2CMHC_EmergencyAccessToCare_CHP-Entire Document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). ValueOptions® policies and procedures establish the standards for monitoring the performance of providers in relation to timeliness of services access to care. (III306 Measurement of Access and Availability Policy_3BHO, 303LGrievancePolicy_3BHO and 304L Rights and | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | Responsibilities_3BHO.)<br><br>In order to determine compliance providers are monitored on regular basis through a variety of means. Providers are monitored annually through contract compliance audits. Mental Health centers crisis lines are also monitored for emergency procedures. (Contract Compliance_CHP and ERAccessIPN Q2fy13_CHP and FY14Q2CMHC_EmergencyAccessToCare_CHP.)<br><br>In order to determine compliance ValueOptions® has written policies which require mental health centers will submit quarterly reports on routine and urgent access. (ChrtAudResultsLtr_CCQCAudits_3BHO 403ProviderTreatmentRecordReviewAnalysisandReporting_3BHO)<br><br>Also, access requirements are monitored for the independent provider network as well. Monitoring s also conducted through annual contract compliance audits. (Contract Compliance_CHP – Items 6-9) | |
| 14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by:<br>◆ Developing, implementing, and promoting a written strategic Cultural Competency Plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.<br>◆ Maintaining policies that support the provision of | **Documents Submitted/Location within Documents:**<br>1. 310LNonDiscrimination_Policy_3BHO-Entire Document<br>2. 304L Rights and Responsibilities_3BHO- III.A.3,4,13,15,20<br>3. PolulationAnalysisWorksheet-3BHO-data2012tab<br>4. Cultural Competence Plan 2013_CHP– Pages 8, 10-11<br>5. cultural_competence_training_CHP – entire document<br>6. M205PP_Handling_Calls_with_Limited_English_Speaking_Members_2013nov19_CHP– Entire policy<br>7. 238LServiceforDeafHardHearing_Policy_3BHO – I.A., III.A, V A-D<br>8. III306LMemberMaterials_Development_3BHO- III.A, C-E; V.D *Misc. | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| health care services that respect individual health care attitudes, beliefs, customs and practices of members related to cultural affiliation.<br>◆ Having sufficient cultural competency staff to implement and oversee compliance with the Contractor's Cultural Competency Plan, policies, and contract requirements and to oversee compliance with all cultural competency requirements and limited English proficiency needs.<br>◆ Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include:<br>• Inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls.<br>• Being served by participating providers.<br>• Improving access to health care through community outreach and Contractor publications.<br>◆ Developing and/or providing cultural competency training programs, as needed, to the network providers and Contractor staff regarding:<br>• Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services.<br>• The medical risks associated with the client population's racial, ethnic, and socioeconomic conditions.<br>◆ Making a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse, and culturally competent clinical providers that represent the racial and ethnic | 9. voianceworkfloworalinterpretations_3BHO – entire document<br>10. VoianceLanguageLineWorkflow_standard_3BHO – entire document<br>11. 2014_CHPQualityManagementProgramDescriptionFinal_2013SEPT09_SigPage_CHP – pages 47-51<br>12. MHSIP_YSS-F_item-level report_2BHO – pages 2 & 5<br>13. Achievesolutions_screenshot_CC_training_CHP – entire document<br>14. FY2013 Contract Compliance_CHP – row 9<br>15. Referral_Connect_Screen_Shot_CHP<br>16. Provider Handbook_3BHO – Page 79, paragraph two and bullets 4 and 5, Page 80-Cultural Competence, Section;, Section 17, page 85 , *Medical Record Documentation Standards* *Misc.<br>17. Manual de Miembro_CHP – CHP Member Handbook in Spanish - entire document – *Misc.<br>18. Member Handbook_CHP – Pages 12, 18 & 21 **Misc.*<br>19. notice_of_privacy_practices_2013_CHP -Entire Document - translated into Spanish<br>20. ProviderDirectory3BHO-Entire Document **Misc*<br>21. ProvideForum_Presentation_BHOMEMBERS RIGHTS_3BHO-Slides 7&11<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). CHP and ValueOptions do not discriminate against any members in the provision of services based on race, religion, gender, disability, or ethnicity. ValueOptions® conducts a demographic analysis for CHP using census data to determine the ethnic, linguistic, educational and economic characteristics of its membership. This is used to assess changes in demographics as well as demographic composition of the regions we serve. This | |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| communities being served.<br>◆ Providing access to interpretive services by a qualified interpreter for deaf or hard of hearing members in such a way that it promotes accessibility and availability of covered services.<br>◆ Providing to members in their preferred language verbal offers and written notices, upon request, informing them of their rights to receive language assistance services.<br>◆ Materials, including member handbook, correspondence, and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area.<br>◆ Providing language assistance services, including bilingual staff and interpreter services, at no cost to any member with limited English proficiency at all points of contact, in a timely manner during all hours of operation.<br>◆ Ensuring the competence of language assistance provided to limited English proficient members by interpreters and bilingual staff. Family and friend should not be used to provide interpretation services (except on request by the member).<br>◆ Making available easily understood member-related materials and posting signage in the languages of the commonly encountered groups and/or groups represented in the service area.<br>◆ Developing policies and procedures, as needed, on how the contractor responds to requests from participating providers for interpreter services by a | analysis is used in the development of our Cultural Competency plan. Please note that this data was accessed on the U.S. Census website in October, 2013, and there is about a 1 year lag; however, this contains the most recent data available to the public. Member satisfaction survey results (Access_Questions_All_Sources_2013_CHP) are also used to assist in the evaluation of the availability of culturally competent services. This information is considered in the development of a provider network that includes providers who speak languages other than English and/or have expertise in the cultural needs of Medicaid members.<br><br>CHP has several policies that address cultural competency and provide direction to staff and providers about what is necessary in providing culturally competent services. Providers are required to uphold member rights and provide culturally competent services; treatment record documentation audits evaluate cultural factors relevant to member treatment. Providers are required to include cultural and social factors when doing their initial assessment, per Section 17 in the provider handbook. We have policies that guide us in handling calls from members who are deaf, have low English literacy or other communication disabilities; 306L is a policy that guides us in developing culturally relevant member material for our diverse membership This policy, III306L, requires that we use person first language, that materials are written for a low literacy level readers and that we provide materials in the most prevalent non-English language, and in alternative formats for persons with disabilities, or low reading level members. A population analysis for CHP is included as part of the QM/UM Program Description. This population analysis also includes risk factors of members residing in our region. This analysis is used to develop the BHO's cultural competence plans and plan for member material | |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| qualified interpreter.<br>◆ Ensuring that when providing or arranging for the provision of all medically necessary covered behavioral health services that they are linguistically and culturally accessible to all members, including racially and ethnically diverse communities, the disability community, and deaf and hard of hearing members.<br>◆ Addressing the language and cultural expertise of providers in the network plan.<br>◆ Evaluating members' cultural and linguistic needs in the individual needs assessment and using information gathered (regarding cultural and linguistic needs) in the service plan.<br><br>*42CFR438.206(c)(2)*<br>Contract:<br>II.E.1.c.1.v; II.F.4.j.3.iv; II.F.7.d.1; II.F.7.d.8; and II.F.9.a; II.I.9; Exhibit N, I.A.4 | distribution. Spanish is the most prevalent non-English language spoken by CHP's membership and member materials are available in both English and Spanish.<br><br>CHP monitors access to culturally relevant services through its FactFinders survey as well as through the MHSIP and YSSF surveys, all of which ask a question related to the member's perception of access to culturally competent services. We also monitor member perceptions of culturally competent services through the grievance process. Although there isn't a specific category related to culturally competency in the grievance data base, we review grievances for rights violations and discrimination. Both of these categories can give us information about member's perception of cultural competence.<br><br>ValueOptions' hiring practices provide a premium or salary increase for staff that are bi-lingual. We also actively recruit providers who have a cultural specialty or who are bi-lingual or bi-cultural. Providers who have a cultural specialty or who are bi-lingual are given preference for inclusion into the network, as long as they meet all of the other credentialing requirements.<br><br>Members are made aware of their right to get culturally competent care through the member rights statement within the member handbook. Members who contact the ValueOptions® Colorado Call Center and speak a language other than English are assisted using the language line. During the call, members are asked a series of questions to assess their cultural needs which are documented in our electronic clinical systems.<br><br>CHP has developed a cultural competency training that has been offered as a provider webinar training, as well as a training for | |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | service center staff. Additionally, ValueOptions' AchieveSolutions® website developed an on-line interactive training for all employees. We are promoting this training to staff at the Colorado service center and our providers. The training can be found at https://www.achievesolutions.net/achievesolutions/en/chp/Content.do?contentId=34540<br><br>CHP provides access to interpreter services free of charge. Members are informed of this right in the member handbook and providers are made aware of this in the provider handbook. All required materials are available in English and Spanish. When distributing information through the mail, we identify members who speak Spanish, as noted on their eligibility application form, and send them information in Spanish so that they don't have to call to request the information. When telephonic oral interpretation is requested by a member who speaks a language other than English or Spanish, we use the Voiance® language line. If a provider is needed in a face to face interaction, we select interpreters from professional language service providers, or use the interpreters authorized to provider interpretation for the court system. ASL and sign language interpreters we use are certified. We do not use family or friends, unless a member requests we do.<br><br>All member materials are written at a 6th grade reading level and are available in English or Spanish. Materials are tested using internet available tools such as the Fleisch-Kinkaid test. Materials are also submitted to the Department for approval prior to distribution. Policy III306LMemberMaterials_Policy_CHP and explains the cultural factors that should be considered when developing member materials. Culturally specific information that should be considered includes language (limited English | |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | proficiency) and disability (visual or auditory impairments, disabilities that impact communication). An example of materials in Spanish includes the member handbook as well as the Notice of Privacy Practices.<br><br>The provider directory includes languages spoken by each of the providers listed. ReferralConnect, which is available on our website, can be used to find providers with language or cultural expertise. The user can select a provider using several fields in the data base, including languages spoken or specialty.<br><br>Assessing cultural factors is a component of the clinical assessment and is incorporated into the service plan when appropriate. The provider handbook explains the requirements for medical record documentation (pages 85-87). As part of the initial assessment, providers should assess social and cultural factors that may be important to the member/family. | |
| 15. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor uses tools including member surveys, anecdotal information, and grievance and appeals data.<br><br>Contract:<br>II.H.2.m.1 | **Documents Submitted/Location within Documents:**<br>1. Grievance and Appeals State_Report_Final_Q1FY14_CHP-Row 25-40<br>2. Complaint Summary QISC FY13_CHP-page 1,2,9.<br>3. Analysis_StRpt_DRAFT_Q1FY14_2_CHP—page 1<br>4. MemberHandbook_CHP – Page 18-19**Misc*<br>5. 303LGrievancePolicy_3BHO-V. C & D, page 12-13<br>6. III306 Measurement of Access and Availability Policy_3BHO- Page 5 Section C D-E<br>7. Fact Finders Survey Access to Care Comparison_BYCMHC_ CY2011-2013_CHP – page 5 of seven – comparison between 2011-2013<br>8. Access_Questions_All_Sources_2013_CHP-Entire Document<br>9. MHSIP_YSS-F_item-level report_2BHO_page 1 & 5,<br>10. MHSIP_YSS-F_Domain-level report_2BHO- Pages 8, 9, 10, | ☒ Met<br>☐ Partially Met<br>☐ Not Met<br>☐ N/A |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | 11, 20, 21, 26, 27<br>11. Grievance_Database_Screenshot_2013dec27_CHP-entire document<br><br>**Description of Process:**<br>This element is delegated to ValueOptions® by Colorado Health Partnerships (CHP). VO CO monitors perceptions of access through a variety of mechanisms, including a very important element, grievance data. Grievances are listed by category so that we can monitor trends, access, customer service, and several other categories. Placing grievances into categories allows us to implement interventions if we denote a trend in a functional area (i.e. access) or specific geographic area. All grievances are loaded into the grievance data base. This includes both grievances received at the service center and through the advocates at the mental health centers. The grievance is assigned a category. As seen in the grievance data base screenshot document, Grievance_Database_Screenshot_2013dec27_CHP. There are 14 categories for access and availability. Included in the categories is the "other" category. This is used when a member requests a different provider. Although the member doesn't always present as a grievance, we track this information because a good match between client and provider is an element of access. Grievance reports are presented to the OMFA committee (Advocates) at the mental health centers, who meet bi-monthly), the Recovery Forum (client advisory committee) the QISC/CAUMC committee and the Class B Board for review and recommendations. We also submit a quarterly report to the Department .In addition the quarterly reports to the Department, we put together an annual summary of grievances. The Complaint Summary QISC FY13_FINAL breaks grievances down by several factors, including access. This report is presented to the QISC/CAUMC and the OMFA committee as | |

| Standard II—Access and Availability | | |
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| **Requirement** | **Evidence as Submitted by the BHO** | **Score** |
| | well as the B Board. The report allows us to monitor compliance with requirements as well as community and organizational trends. Also included is the quarterly grievance report that is sent to the Department for Q1FY14. The report consists of the excel spreadsheet and the analysis, Analysis_ StRpt_DRAFT_Q1FY14_2_CHP and Grievance and Appeals State Report_Final_Q1FY14_CHP.<br><br>Member perception of access is also monitored through the FactFinders, the MHSSIP, and the YSSF survey tools. These surveys offer different member perspectives because grievances are filed when the member has had a negative experience. The survey tools give us member perceptions that may be positive, neutral or negative. The results are monitored by the QISC/CAUMC, the OMFA committee and the class B Board. | |

| Results for Standard II—Access and Availability | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 15 | X | 1.00 | = | 15 |
| | Partially Met | = | 0 | X | .00 | = | 0 |
| | Not Met | = | 0 | X | .00 | = | 0 |
| | Not Applicable | = | 0 | X | NA | = | 0 |
| **Total Applicable** | | = | 15 | **Total Score** | | = | 15 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | 100% |

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

The completed record review tool follows this cover page.

# *Appendix B.* Colorado Department of Health Care Policy and Financing
# FY 2013–2014 Denials Record Review Tool
# *for* Colorado Health Partnerships, LLC

| | |
|---|---|
| **Review Period:** | January 1, 2013–December 31, 2013 |
| **Date of Review:** | March 4, 2014 |
| **Reviewer:** | Katherine Bartilotta |
| **Participating Plan Staff Member:** | Amy Adams |

| Requirement | File 1 | File 2 | File 3 | File 4 | File 5 |
|---|---|---|---|---|---|
| 1. Member ID | ****** | ****** | ****** | ****** | ****** |
| 2. Date of initial request | 9/6/13 | 12/13/13 | 7/27/13 | 6/3/13 | 10/21/13 |
| 3. What type of denial? (termination [T], new request [NR], or claim [CL]) | NR | NR | NR | NR | NR |
| 4. Standard (S) or Expedited (E) | E | S | E | E | E |
| 5. Date notice of action sent | 9/9/13 | 12/19/13 | 7/29/13 | 6/4/13 | 10/23/13 |
| 6. Notice sent to provider and member? (C or NC) | C | C | C | C | C |
| 7. Number of days for decision/notice | 3 | 6 | 2 | 1 | 2 |
| 8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before) | C | C | C | C | C |
| 9. Was authorization decision timeline extended? (Y or N) | N | N | N | N | N |
| a. If extended, extension notification sent to member? (C or NC, or NA) | NA | NA | NA | NA | NA |
| b. If extended, extension notification includes required content? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 10. Notice of Action includes required content? (C or NC) | C | C | C | C | C |
| 11. Authorization decision made by qualified clinician? (C or NC, or NA) | C | C | C | C | C |
| 12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA) | C | NA | C | C | NA |
| 14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC) | C | C | C | C | C |
| 15. Was correspondence with the member easy to understand? (C or NC) | C | C | C | C | C |
| **Total Applicable Elements** | 7 | 6 | 7 | 7 | 6 |
| **Total Compliant Elements** | 7 | 6 | 7 | 7 | 6 |
| **Score (Number Compliant / Number Applicable) = %** | 100% | 100% | 100% | 100% | 100% |

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

| Requirement | File 6 | File 7 | File 8 | File 9 | File 10 |
|---|---|---|---|---|---|
| 1. Member ID | ****** | ****** | ****** | ****** | ****** |
| 2. Date of initial request | 3/11/13 | 1/10/13 | 6/11/13 | 1/22/13 | 9/24/13 |
| 3. What type of denial? (termination [T], new request [NR], or claim [CL]) | NR | NR | NR | NR | NR |
| 4. Standard (S) or Expedited (E) | E | E | E | S | E |
| 5. Date notice of action sent | 3/12/13 | 1/11/13 | 6/13/13 | 1/30/13 | 9/25/13 |
| 6. Notice sent to provider and member? (C or NC) | C | C | C | C | C |
| 7. Number of days for decision/notice | 1 | 1 | 2 | 8 | 1 |
| 8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before) | C | C | C | C | C |
| 9. Was authorization decision timeline extended? (Y or N) | N | N | N | N | N |
| a. If extended, extension notification sent to member? (C or NC, or NA) | NA | NA | NA | NA | NA |
| b. If extended, extension notification includes required content? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 10. Notice of Action includes required content? (C or NC) | C | C | C | C | C |
| 11. Authorization decision made by qualified clinician? (C or NC, or NA) | C | C | C | C | C |
| 12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA) | C | NA | C | NA | C |
| 14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC) | C | C | C | C | C |
| 15. Was correspondence with the member easy to understand? (C or NC) | C | C | C | C | C |
| **Total Applicable Elements** | 7 | 6 | 7 | 6 | 7 |
| **Total Compliant Elements** | 7 | 6 | 7 | 6 | 7 |
| **Score (Number Compliant / Number Applicable = %)** | 100% | 100% | 100% | 100% | 100% |

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

| Requirement | File 11 | File 12 | File 13 | File 14 | File 15 |
|---|---|---|---|---|---|
| 1. Member ID | ****** | ****** | ****** | ****** | ****** |
| 2. Date of initial request | 12/11/13 | 10/3/13 | 2/5/13 | 8/19/13 | 6/25/13 |
| 3. What type of denial? (termination [T], new request [NR], or claim [CL]) | NR | NR | NR | NR | NR |
| 4. Standard (S) or Expedited (E) | E | E | E | E | S |
| 5. Date notice of action sent | 12/11/13 | 10/4/13 | 2/5/13 | 8/20/13 | 7/3/13 |
| 6. Notice sent to provider and member? (C or NC) | C | C | C | C | C |
| 7. Number of days for decision/notice | 1 | 1 | 1 | 1 | 9 |
| 8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before) | C | C | C | C | C |
| 9. Was authorization decision timeline extended? (Y or N) | N | N | N | N | N |
| a. If extended, extension notification sent to member? (C or NC, or NA) | NA | NA | NA | NA | NA |
| b. If extended, extension notification includes required content? (C or NC, or NA) | NA | NA | NA | NA | NA |
| 10. Notice of Action includes required content? (C or NC) | C | C | C | C | C |
| 11. Authorization decision made by qualified clinician? (C or NC, or NA) | C | C | C | C | C |
| 12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA) | NA | NA | NA | NA | C |
| 13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA) | NA | NA | C | C | NA |
| 14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC) | C | C | C | C | C |
| 15. Was correspondence with the member easy to understand? (C or NC) | C | C | C | C | C |
| **Total Applicable Elements** | 6 | 6 | 7 | 7 | 7 |
| **Total Compliant Elements** | 6 | 6 | 7 | 7 | 7 |
| **Score (Number Compliant / Number Applicable = %)** | 100% | 100% | 100% | 100% | 100% |
| Comments: | | | | | |

| Total Record Review Score | Total Applicable Elements: 99 | Total Compliant Elements: 99 | Total Score: 100% |
|---|---|---|---|

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

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

Table C-1 lists the participants in the FY 2013–2014 site review of **CHP**.

| Table C-1—HSAG Reviewers and BHO Participants | |
|---|---|
| **HSAG Review Team** | **Title** |
| Katherine Bartilotta, BSN | Project Manager |
| Rachel Henrichs | Project Coordinator |
| **CHP Participants** | **Title** |
| Amie Adams | Clinical Director |
| Erica Arnold-Miller | Quality Director |
| Tami Ballard | Clinical Services Supervisor |
| Peter Brodrick | Chief Medical Officer |
| Steve Coen | Clinical Peer Advisor |
| Michelle Denman | Director of Provider Relations |
| Kat Fitzgerald | Quality Auditor |
| Haline Grublak | Member Services Director |
| Tina McCrory | Chief Operating Officer |
| Jeremy White | Quality Manager |
| **Department Observers** | **Title** |
| Russell Kennedy | Quality and Health Improvement Unit |

# Appendix D. Corrective Action Plan Template for FY 2013–2014

*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 compliance site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification to HSAG and the Department. The BHO must submit the CAP using the template provided.<br><br>For each element 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:<br><br>◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan.<br>◆ 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.<br><br>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 health care regulations and managed care contract requirements. |

The template for the CAP follows.

| Table D-2—FY 2013–2014 Corrective Action Plan *for* CHP | | |
|---|---|---|
| **Standard I—Coverage and Authorization of Services** | | |
| **Requirement** | **Findings** | **Required Action** |
| | | |

**CHP** did not have any required actions.

# Appendix E. Compliance Monitoring Review Protocol 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' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

**Table E-1—Compliance Monitoring Review Activities Performed**

| For this step, | HSAG completed the following activities: |
|---|---|
| **Activity 1:** | **Establish Compliance Thresholds** |
| | Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements:<br>◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies.<br>◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates.<br>◆ HSAG submitted all materials to the Department for review and approval.<br>◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans. |
| **Activity 2:** | **Perform Preliminary Review** |
| | ◆ HSAG attended the Department's Behavioral Health Quality Improvement Committee (BQuIC) meetings and provided group technical assistance and training, as needed.<br>◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the request for desk review documents 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 two standards and on-site activities. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested.<br>◆ Documents submitted for the desk review and on-site 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. The BHOs also submitted a list of all Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. HSAG used a random sampling technique to select records for review during the site visit.<br>◆ 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 3:** | **Conduct Site Visit** |
| | ◆ 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.<br>◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO service and claims denials and notices of action. |

| Table E-1—Compliance Monitoring Review Activities Performed | |
|---|---|
| **For this step,** | **HSAG completed the following activities:** |
| | ◆ Also while on-site, 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 confidential or proprietary, or were requested as a result of the pre-on-site document review.)<br>◆ At the close of the on-site portion of the site review, HSAG met with BHO staff and Department personnel to provide an overview of preliminary findings. |
| **Activity 4:** | **Compile and Analyze Findings** |
| | ◆ HSAG used the FY 2013–2014 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities.<br>◆ HSAG analyzed the findings.<br>◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings. |
| **Activity 5:** | **Report Results to the State** |
| | ◆ HSAG populated the report template.<br>◆ HSAG submitted the site review report to the BHO and the Department for review and comment.<br>◆ HSAG incorporated the BHO's and Department's comments, as applicable and finalized the report.<br>◆ HSAG distributed the final report to the BHO and the Department. |