FY 2015–2016 Site Review Report

for

Colorado Health Partnerships, LLC

March 2016

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

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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 healthcare regulations and managed care contract requirements. The Department of Health Care Policy & 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 fiscal year (FY) 2015–2016 site review activities for the review period of January 1, 2015, through December 31, 2015. 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 four 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 2015–2016 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2014–2015 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 credentialing and recredentialing record reviews. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the BHO will be required to complete for FY 2015–2016 and the required template for doing so. Appendix E contains a detailed description of HSAG's site review activities consistent with the Centers for Medicare & Medicaid Services (CMS) final protocol.

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 documented findings and 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 healthcare regulations. At the request of the Department, HSAG designated select contract requirements within the Coordination and Continuity of Care standard as *Information Only* elements. These requirements were not scored. HSAG gathered information during on-site interviews regarding the BHO's implementation of these requirements. Detailed findings for each of these elements were outlined in the Compliance Monitoring Tool and are summarized below in Standard III—Coordination and Continuity of Care.

Table 1-1 presents the scores for **Colorado Health Partnerships, LLC** (**CHP**) for each of the standards. Findings for all requirements 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)
III Coordination and Continuity of Care	10	10	9	1	0	0	90%
IV Member Rights and Protections	6	6	6	0	0	0	100%
VIII Credentialing and Recredentialing	46	45	39	4	2	1	87%
X Quality Assessment and Performance Improvement	14	14	14	0	0	0	100%
Totals	**76**	**75**	**68**	**5**	**2**	**1**	**91%**

Table 1-2 presents the scores for **CHP** for the credentialing and recredentialing 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)
Credentialing	90	83	83	0	7	100%
Recredentialing	90	73	69	4	17	95%
Totals	**180**	**156**	**152**	**4**	**24**	**97%**

Standard III—Coordination and Continuity of Care

Summary of Strengths and Findings as Evidence of Compliance

CHP delivers behavioral health services through community health centers (CMHCs) and an independent provider network (IPN) to members residing in a 43-county geographic region in west and southwest Colorado. ValueOptions/Beacon Health Options, Inc. (VO/Beacon) provides administrative support resources for **CHP**. **CHP** had policies, procedures, and resources in place to address coordination and continuity of care for members, including all State and federal requirements. Behavioral health providers and **CHP** staff were jointly responsible for coordination of care for members—basic care coordination is the responsibility of the primary behavioral health team; complex care coordination for members with intensive care coordination needs or for special populations is provided through **CHP**. **CHP** has established specialized programs and dedicated care coordination positions (e.g., long-term support services [LTSS] coordinator, transitions coordinator, and criminal justice systems coordinator) to address special populations. **CHP** communicated the basic care coordination responsibilities of the primary behavioral health provider, which included obtaining a release of information (ROI) from the member to communicate with medical professionals, coordinating care with medical providers, and exchanging relevant healthcare information with other providers and agencies such as single entry points (SEPs) and departments of human services (DHS). Members with complex needs were assigned a care coordinator such as a CMHC or **CHP** intensive care coordinator.

The provider manual and provider trainings addressed the specific requirements for conducting and documenting the required components of a member needs assessment and treatment plan. **CHP** conducted clinical audits of providers to determine compliance with medical records documentation and other contract requirements. **CHP** assisted members with obtaining a primary behavioral healthcare provider through multiple outreach communications including welcome letters, the member handbook, customer services, and handouts to community organizations that may provide services to members. Members were also referred to BHO providers through county DHS and crisis centers. **CHP** offered a multispecialty network of primary and specialist providers, and members could directly access any network provider without authorization for outpatient services. **CHP** frequently arranged access to out-of-network providers through single case agreements. CMHCs were actively involved with provision of services to members in long-term care (LTC) facilities and had an established, well-functioning alliance with LTCs across the region. CMHCs also had assigned liaisons to work with State mental health institutes and other hospitals to transition members being discharged from inpatient care.

During on-site review, **CHP** provided case presentations which demonstrated:

- **CHP** LTSS coordinator assistance with coordination of services for a member with very complex needs—including transition from an out-of-state medical facility, securing a long-term care facility for a difficult placement, arranging for one-on-one care-sitter services, arranging for home and community-based services (HCBS), arranging for medical support services

through the Regional Care Collaborative Organization (RCCO), arranging for mental health services in the nursing facility, and researching residential care and payment through DHS.

- **CHP** intensive case manager assistance over many months of working with the member, family, and DHS case worker to coordinate services for a child displaced from his home and including inpatient and residential facilities, special community programs, the CMHC, and multiple specialist providers.

Other information provided during on-site interviews applicable to *Information Only* elements included:

- The **CHP** BHO region geographically overlaps with the regions of three RCCOs and shares offices and administrative processes with Integrated Community Health Partners (Region 4), enabling convenient development of integrated care programs with physical health providers. Providers were responsible for collaborating with the RCCO care coordinator to ensure that the care coordination plan for members with complex needs addressed both physical and behavioral health needs. When the RCCO had a care coordinator assigned to the case, the RCCO coordinator was considered the lead coordinator. Staff stated that further integration with the RCCO will enable identification of members in the broader Medicaid population who may be within one-year postpartum, such that the RCCO and BHO care coordinators can target these members to develop a postpartum service plan. HSAG will further explore integration between the RCCOs and BHOs during 2015– 2016 RCCO on-site reviews.
- **CHP** coordinated with SEPs and waiver service providers at multiple levels: behavioral health practitioners, CMHC care coordinators, and **CHP** care coordinators. **CHP** has established an LTSS coordinator position to assist in coordinating care for members with complex long-term care needs. The LTSS coordinator also conducted team meetings with CMHC providers and SEP staff at least monthly to improve care coordination among the organizations.
- CMHCs and/or the **CHP** intensive case managers coordinated individual member needs with the DHS in counties across the region. In addition, the CMHCs had regular meetings with their aligned county DHS to maintain working relationships and improve access and referrals for members in the child welfare system. Staff also cited ongoing initiatives between AspenPointe and the El Paso county DHS to develop alternative programs for members.
- **CHP** has designated a criminal justice systems coordinator to oversee all activities related to integration with the criminal justice system and to serve as the single point of contact for correctional facilities. **CHP** was participating in collaborative processes with the statewide BHOs and Colorado Department of Corrections (DOC) to develop uniform processes for identifying Medicaid-enrolled prison parolees that reside in each BHO catchment area. **CHP** has also established collaborative processes with select county jails to implement and test the VO/Beacon *Justice Connect* software, which will identify members in jails who were previously engaged in receiving services through the BHO, provide information to the jails regarding the member's mental health needs, and generate a list for CMHCs to contact the member and arrange for post-release services. Staff stated that procedures and the infrastructure for implementing coordination with the corrections system were still evolving and being tested and that any successful initiatives may be transferred to other counties in the region. Despite barriers, **CHP** staff felt confident that significant progress was being made to align the BHO with corrections facilities.

- CMHCs were responsible for providing services to members in nursing facilities and assisted living residences (ALRs). Each CMHC was aligned with the long-term care facilities in a defined catchment area. Services were provided by behavioral health professionals either at the nursing facility or at the CMHC. The **CHP** LTSS coordinator serves as an expert point of contact for facilitating problem resolution, assisting with the coordination of services for members with complex needs, and developing LTSS-related programs. **CHP** provided an on-site case presentation which demonstrated **CHP**'s support for LTC members with complex needs and commitment to target specialized resources for LTSS.
- **CHP** described care coordination relationships with numerous external agencies including the DOC, DHS, SEPs, and Community Centered Boards (CCBs). **CHP** staff also participated in trainings and collaborative programs with organizations that specialize in services for members with developmental disabilities, traumatic brain injury, or autism. Staff acknowledged that members with the most complex care coordination needs are often those with both covered and noncovered behavioral health diagnoses. **CHP** has designated intensive care managers to maintain relationships with community agencies necessary to align members with other systems of care and integrate behavioral health and other services. **CHP** provided a case presentation which demonstrated care coordination for a member with brain injury (due to a medical emergency incident) who required extensive physical and mental health services and transition into an acceptable long-term living arrangement.
- Each CMHC had a defined liaison that served as the point person for members being discharged from inpatient care and mental health institutes. A member's transition from inpatient care was executed through collaboration of the inpatient discharge coordinators, CMHC liaisons, and **CHP** support staff. **CHP** has communicated to hospitals the expectations regarding discharge planning and has developed protocols with the institutes for arranging necessary services prior to member discharge. **CHP** has designated a transition coordinator position to assist with the transition of members with complex needs.
- The Department requested that HSAG have an on-site discussion with each BHO regarding the plan's application of the expanded definition of medical necessity for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services. **CHP** stated no authorization requirements for outpatient services are covered by the BHO and that authorization of any higher level of care considers information gathered from physical health providers, including results of EPSDT screenings. If a service is needed for a diagnosis not covered by the BHO (e.g., developmental disabilities or autism), the member may be referred to **CHP** care coordinators who have expertise in collaborating with DHS, CCBs, SEPs, and other organizations that provide long-term support services. In addition, the provider manual informs providers of the role of family health coordinators to assist members with access to EPSDT-related services.

Summary of Findings Resulting in Opportunities for Improvement

- **CHP** submitted several VO/Beacon policies that included regulatory language in the policy statement but no procedures or accountabilities for implementing the policies. Policy statements without procedures provided little insight or guidance regarding mechanisms to ensure that policies are implemented. HSAG recommends that **CHP** enhance numerous policies to more explicitly describe mechanisms for implementation. (Policy examples include but are not

limited to Care Coordination, Services for Members With Special Needs, Advancing Healthcare Integration, Alignment of Systems, and Coordination with Correctional System.)

- Mechanisms for implementing a specialized treatment plan for members who are one-year postpartum were poorly defined. HSAG recommends that **CHP** more clearly communicate to providers the necessity of developing a treatment plan for members who are within one-year postpartum, describing the elements of such a plan, and including mechanisms for coordinating with the RCCO or physical health provider regarding an integrated service plan.
- The Care Coordination policy and procedure was very broadly defined and referred to a number of different options for performing care coordination—the primary therapist, CMHC care coordinator, **CHP** care coordinator, and the RCCO. The policy did not detail the specific roles of the various care coordinators in the system. HSAG recommends that **CHP** enhance the policy to better define the roles of the various levels of care coordination, describe the mechanism for determining which coordinator is accountable for which functions, and describe how the member is referred from one coordinator to another to ensure that a person/entity is formally assigned responsibility for care coordination.
- HSAG recommends that provider communications (e.g., provider manual or provider training materials) related to care coordination be enhanced to better inform providers of the expanded expectations for care coordination (as defined in the current BHO contract) and how to perform care coordination, including an expanded description of the different levels of care coordination—practitioner level, CMHC level, **CHP** level programs and services; how to interface with external agencies; a description of **CHP** specialized care coordination support resources (e.g., intensive care managers, transition coordinator, LTSS service coordinator, criminal justice system coordinator) and how to access those services; and how to assist members with referrals for services (such as to Healthy Communities) as a follow-up to EPSDT screenings.
- During on-site interviews, staff adequately described the processes for allowing members to directly access behavioral health specialists as needed through provision of a provider network with a variety of specialties, access without authorization to any outpatient provider in the network, and use of single case agreements with out-of-network specialists when needed. However, neither policies and procedures, the provider manual, nor the member handbook addressed either the member's right to directly access a behavioral health specialist or the mechanisms for doing so. HSAG recommends that policies and/or member and provider communications clearly communicate that members are allowed to directly access a specialist.
- The **CHP** service area overlaps with three different RCCO geographic areas. During on-site interviews, staff stated that some CMHCs remain unfamiliar with the RCCO in their area. HSAG recommends that **CHP** develop procedures and CMHC education focused on the role of the RCCO and how CMHCs may integrate with the RCCO in their respective area.

Summary of Required Actions

The EPSDT policy, provider manual, and clinical audit tool included information related to EPSDT services. Information focused primarily on the behavioral health provider responsibility to coordinate with the member's primary care provider (PCP) to ensure the provision of EPSDT screenings for eligible members and to provide necessary behavioral health covered services

determined through EPSDT screenings. However, none of these documents addressed the responsibility of the BHO provider to provide referral assistance to members who need services not covered by the BHO but found to be needed as a result of conditions disclosed during screening and diagnosis, including coordinating with State agencies appropriate to the member's needs or assisting with appointments or transportation when needed. **CHP** must enhance its policies and procedures and provider communications to more specifically address the responsibility of the provider and/or BHO to provide referral assistance to members who need services not covered by the BHO but found to be needed as a result of EPSDT screening and diagnosis, and the processes for doing so.

Standard IV—Member Rights and Protections

Summary of Strengths and Findings as Evidence of Compliance

CHP had several written policies and procedures that addressed member rights. These policies delineated member rights and described the processes and mechanisms used by **CHP** to educate members about their rights, how to exercise them, and the availability of assistance through the Office of Member and Family Affairs (OMFA). Upon enrollment, **CHP** mailed new members a welcome letter and member handbook. While the handbook included more detailed information, both documents informed members of their rights and that they could contact OMFA with questions, concerns, or to request assistance.

In its contracts and provider manual, **CHP** told providers about member rights and **CHP**'s expectation that rights be taken into consideration when furnishing services. **CHP** required that its providers give members a copy of their rights during intake and keep a signed acknowledgement form in the member's record or post member rights in the office. The **CHP** provider audit tool included a section that confirmed distribution and/or posting of member rights.

CHP and VO/Beacon required its employees to participate in member rights training at the time of hire and again annually. **CHP** strongly encouraged its providers to participate in periodic face-to-face training forums covering topics such as member rights, compliance, cultural competency, and understanding the Colorado Medicaid program and also posted these presentations on its website. HSAG reviewed several presentations available on the **CHP** website. While few were wholly dedicated to member rights, many included at least one to two slides that touched on member rights and where to find more information.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no opportunities for improvement related to member rights and protections.

Summary of Required Actions

HSAG required no corrective actions for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Strengths and Findings as Evidence of Compliance

CHP delegated credentialing and recredentialing of independent practitioners to VO/Beacon, a National Committee for Quality Assurance (NCQA)-accredited credentialing verification organization (CVO). The signed delegation agreement contained most requirements, including those associated with the use of protected health information (PHI). VO/Beacon had policies and procedures that addressed all aspects of the credentialing and recredentialing process—including the types of practitioners subject to credentialing and recredentialing, criteria used for each type of practitioner, primary verification sources, and the process for notifying applicants of their rights. Policies also delineated the process for ongoing monitoring of sanctions, complaints, and adverse events; the range of actions available to **CHP** if a provider fails to meet minimum standards of quality; and the appeal process available to providers against whom **CHP** has taken action.

VO/Beacon also had policies and procedures to address the credentialing and recredentialing process for contracted organizations. The policies set standards for physical accessibility and appearance, adequacy of space, and appropriate record-keeping and described the process for instituting actions to improve offices that do not meet the minimum standards.

VO/Beacon also had policies that described the roles and responsibilities of the local credentialing committee (LCC) and the national credentialing committee (NCC).

Summary of Findings Resulting in Opportunities for Improvement

VO/Beacon provided HSAG with 26 policies and procedures to demonstrate its compliance with the credentialing and recredentialing requirements. Overall, HSAG found that policies and procedures were well-written and comprehensive; however, the sheer number of policies made the program difficult to understand. Additionally, the policies that addressed the roles and responsibilities of the NCC and LCC did not clearly describe the role of each committee; nor did they accurately describe the relationship between the two committees. HSAG suggested that VO/Beacon might improve the strength of its credentialing and recredentialing program by reducing the overall number of policies governing the credentialing and recredentialing program and by more clearly describing the roles and responsibilities of the NCC and LCC and how the two committees work together to achieve the goals of the program.

Summary of Required Actions

Policies repeatedly stated VO/Beacon's commitment to and outlined procedures for ensuring that credentialing and recredentialing decisions are made in a nondiscriminatory manner. However, during the on-site interview, staff members clarified that one role of the LCC is to review requests from providers desiring participation in the **CHP** network to determine which are allowed to submit credentialing applications. VO/Beacon had no written documents that described this preliminary process or the criteria used to make decisions. If VO/Beacon chooses to use a preliminary process

for determining which providers are allowed to submit credentialing applications, it must document the process. Documentation must include the criteria used to make determinations, any appeal rights available to providers denied applications, and the mechanisms used to ensure nondiscriminatory practices.

VO/Beacon's policies and procedures required that all providers and organizations be recredentialed every 36 months; however, three of 10 provider and two of five organizational recredentialing files reviewed on-site were approved by the NCC more than 36 months after the prior approval date. **CHP** must ensure that providers are recredentialed at least every 36 months.

VO/Beacon's Facility Organization Site Visit policy stated that a CMS or State review could be accepted in lieu of a site visit provided the results were current (the review occurred within the date range covered by the operating certificate). The policy did not specify that VO/Beacon would confirm that the review criteria used by CMS or the State meet its own quality assessment criteria or standards. On-site record review demonstrated that VO/Beacon exercised this right with one of the five organizations in the sample. The file included a letter from the Office of Behavioral Health (OBH) that summarized the results of the review and listed the corrective actions required as a result of the review. The file did not include a copy of the assessment criteria used by OBH. The file also did not include any follow-up documentation to demonstrate that the organization completed the corrective actions. If and when VO/Beacon elects to substitute a CMS or State review in lieu of a site visit, it must confirm that the criteria used by CMS or the State encompasses all criteria used in its own assessment. Additionally, VO/Beacon must follow through to ensure that the organization sufficiently addresses all corrective actions required as a result of the CMS or State review.

During the on-site interview, staff stated that **CHP** performs oversight of the delegated credentialing functions through participation on the LCC. Additionally, **CHP**'s Class B board is responsible for reviewing credentialing and recredentialing reports submitted by VO/Beacon. However, staff members could not produce evidence that the Class B board reviewed any credentialing or recredentialing reports submitted by VO/Beacon during the review period. **CHP** must document that it evaluates (at least semiannually) credentialing and recredentialing reports submitted by its delegate.

The July 1, 2014, delegation agreement between **CHP** and VO/Beacon does not specify that **CHP** retains the right to approve, suspend, or terminate contracts with individual practitioners, providers, or sites. **CHP** must specify in its delegation agreement with VO/Beacon that it retains the right to approve, suspend, or terminate contracts with individual practitioners, providers, or sites.

Standard X—Quality Assessment and Performance Improvement

Summary of Strengths and Findings as Evidence of Compliance

The **CHP** Quality Assessment and Performance Improvement (QAPI) program is a partnership model between VO/Beacon and **CHP**. **CHP** delegated all quality management functions to VO/Beacon. The **CHP** Quality Improvement Steering Committee/Clinical Advisory Utilization Management Committee (QISC/CAUMC) meets monthly to monitor outcomes and progress toward

quality work plan goals. The QISC/CAUMC and **CHP's** Class B board approved the annual Quality Assessment/Utilization Management (QA/UM) program description, work plan, and annual evaluation report. The QA/UM program description was comprehensive and incorporated all required components. The annual evaluation report included detailed results and analysis of ongoing monitoring of quality and appropriateness of care, utilization, performance measures, performance improvement projects, member satisfaction surveys, clinical guideline development, access to care, quality of care concerns, and other quality improvement activities. **CHP** submitted examples of numerous reports used for ongoing monitoring of member care and services. **CHP** monitored the CMHCs and IPN ongoing and periodically through clinical documentation audits, performance indicators, and annual contract compliance audits. Quality of Care (QOC) concerns were thoroughly investigated and tracked. VO/Beacon's health information systems collected and integrated data from a variety of sources into a central data repository for reporting. **CHP** applied a comprehensive set of edits and provided detailed provider training to verify and ensure accuracy and completeness of encounter data. Staff members described that **CHP** is in the process of developing and testing an online dashboard report that will integrate a variety of quality performance indicators into a provider report card and will be accessible to all providers.

Summary of Findings Resulting in Opportunities for Improvement

While **CHP** website documentation confirmed that numerous clinical treatment (best practice) guidelines had been adopted and were accessible to providers and members, audit desk review document submission and on-site discussion indicated that **CHP** is oriented toward UM level of care (LOC) guidelines as representative of clinical practice guideline requirements. HSAG recommends that **CHP** more clearly delineate between UM/LOC guidelines and quality treatment guidelines and more clearly address the intended application of each type of guideline in the QAPI program. Similarly, policies stated that clinical guidelines are developed by a national corporate VO/Beacon committee, which ensured consistency of the treatment guidelines with UM procedures, member education, and coverage of services. However, no procedures were defined for this process; and **CHP** staff described that clinical treatment guidelines were applied "incidentally" to local operational or quality review activities. HSAG recommends that **CHP** define local accountabilities and/or more formal processes for ensuring that adopted treatment guidelines are consistent with UM decisions, member education materials, and other quality review activities.

While **CHP** demonstrated that it applies a variety of mechanisms to ensure that encounter data are accurate and complete, **CHP** did not have a policy and procedure that described these processes. HSAG recommends that **CHP** consider developing an umbrella policy and/or procedure to describe the combined mechanisms used to ensure accuracy and completeness of data received from providers.

HSAG also encouraged **CHP** to expedite the development and implementation of the proposed dashboard quality report card as a mechanism to stimulate providers to actively participate in ongoing quality improvement.

Summary of Required Actions

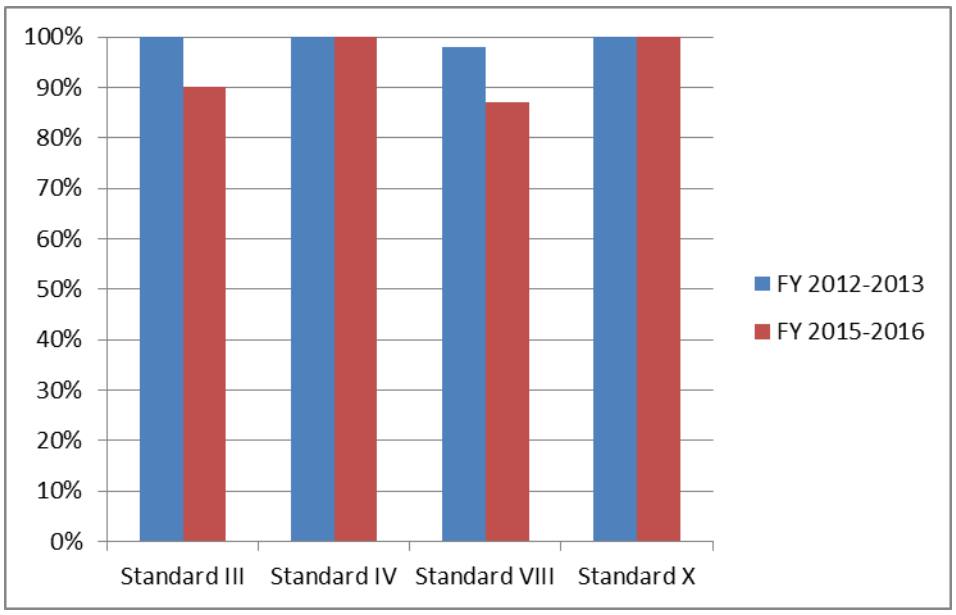
HSAG required no corrective actions for this standard.

Comparison of Results

Comparison of FY 2012–2013 Results to FY 2015–2016 Results

Figure 2-1 shows the scores from the FY 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X 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.

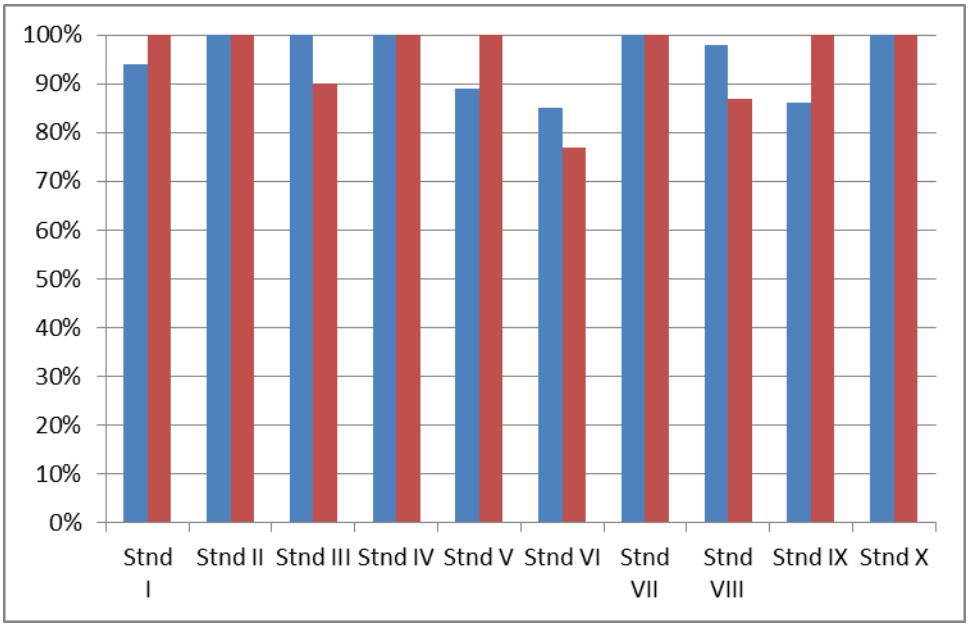
Figure 2-1—Comparison of FY 2012–2013 Results to FY 2015–2016 Results



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. Table 2-1 shows which standards were reviewed each year. 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: Results shown in blue are from FY 2010–2011, FY 2011–2012, and FY 2012–2013. Results shown in red are from FY 2013–2014, FY 2014–2015, and FY 2015–2016.

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

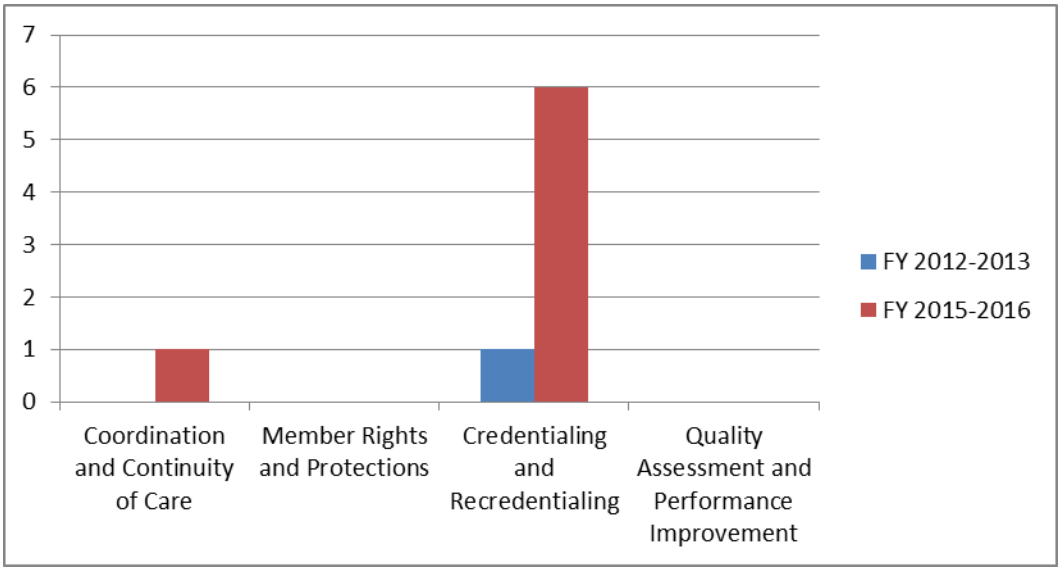
Table 2-1—List of Standards by Review Year

Standard	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
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 2012–2013 site review (when Standard III, Standard IV, Standard VIII, and Standard X 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 2012–2013 and FY 2015–2016 Required Actions per Standard

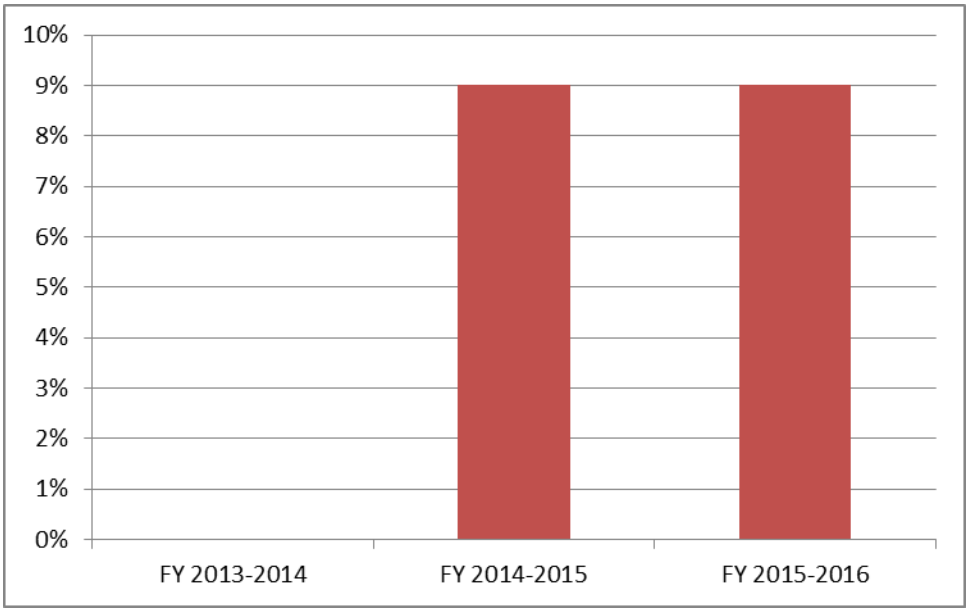


Note: **CHP** had no required actions for Coordination and Continuity of Care, Member Rights and Protections, or Quality Assessment and Performance Improvement resulting from the FY 2012–2013 site review. **CHP** also had no required actions for Member Rights and Protections or Quality Assessment and Performance Improvement resulting from the FY 2015–2016 site review.

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, as indicated in Table 2-1 above.

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



Note: **CHP** had no required actions resulting from the FY 2013–2014 review.

Overview of FY 2015–2016 Compliance Monitoring Activities

For the fiscal year (FY) 2015–2016 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the performance areas chosen. The standards chosen were Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, and Standard X—Quality Assessment and Performance Improvement. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the four standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the four standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities; a review of 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 credentialing and recredentialing. HSAG documented detailed findings in the Compliance Monitoring tool for any requirement receiving a score *Partially Met* or *Not Met*.

A sample of the BHO's administrative records related to Medicaid credentialing and recredentialing were also reviewed to evaluate implementation of federal healthcare regulations and compliance with National Committee for Quality Assurance (NCQA) requirements, effective July 2015. HSAG used standardized monitoring tools to review records and document findings. Using a random sampling technique, HSAG selected a sample of 10 records with an oversample of five records from all of the BHO's credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG reviewed a sample of 10 credentialing records and 10 recredentialing records, to the extent possible. For the record review, the health plan received a score of *M* (met), *N* (not met), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the review of applicable requirements in Standard VIII—Credentialing and Recredentialing. HSAG also separately calculated a credentialing record review score, a recredentialing record review score, and 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. The four standards chosen for the FY 2015–2016 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in

subsequent years: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

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 healthcare regulations and managed care contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal healthcare 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 2014–2015 Corrective Action Methodology

As a follow-up to the FY 2014–2015 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 2014–2015 compliance monitoring site review.

Summary of 2014–2015 Required Actions

Based on the FY 2014–2015 site review, **CHP** was required to address six *Partially Met* elements related to the grievance system. While **CHP**'s policies and procedures accurately addressed most of the required time frames, on-site record reviews indicated that **CHP** was not consistently meeting those time frames. Additionally, **CHP**'s policies misrepresented some time frames related to the continuation of benefits during an appeal and/or State fair hearing. **CHP** was required to correct its written policies and to develop a mechanism to ensure that its practices complied with written policies.

Summary of Corrective Action/Document Review

CHP submitted its CAP to HSAG and the Department in April 2015 and began submitting documents that demonstrated implementation of its plan in May. HSAG and the Department worked closely with **CHP** to ensure that the BHO fully addressed and implemented all aspects of the required actions. HSAG and the Department determined in November 2015 that **CHP** had addressed all required actions.

Summary of Continued Required Actions

CHP had no required actions continued from FY 2014–2015.

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

The completed compliance monitoring tool follows this cover page.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has written policies and procedures that address the timely coordination of the provision of covered services to its members, service accessibility, attention to individual needs, and continuity of care to promote maintenance of health and maximize independent living. Contract: Exhibit A—2.4.2.1.1.1.–2.4.2.1.1.4	**Documents Submitted:** 1. MedicalNecessityPolicy_202L_2BHO—Entire Policy 2. MedicalNecessityDeterminationLackofInformationandNotificationTimelinesPolicy_203L_2BHO—Entire Policy 3. CareCoordinationPolicy_262L_2BHO—Entire policy 4. ProvisionofServicesbyanOutofNetworkProviderPolicy_274L_2BHO — page 2, Section IV, A3 **Description of Process:** "MedicalNecessityPolicy_202L_2BHO" provides a standard definition for medical necessity (Section II.A) which takes into account that services are provided at the most appropriate and least restrictive level of care and is intended to best maintain the member's health. It describes the sources of information that are used in making medical necessity determinations (Section II.B). This policy also describes the procedures for review by Clinical Care Managers (Sections IV.A-G.).The focus of reviews for medical necessity is on individual needs of the member and determining the level of service appropriate to meet these needs. "MedicalNecessityDeterminationLackofInformationandNotificationTimelinesPolicy_203L_2BHO" is a key document, which describes the Contractor's procedures for making medical necessity determinations, the timeframes for these determinations, and the notifications to members. This policy is applicable in its entirety, yet the reviewer should particularly note the sections related to decision timeframes (Section IV.C) and the definitions for urgent, routine and emergency services (Section IV all). Timelines and monitoring of these timelines insure the accessibility of services to our members "CareCoordinationPolicy_262L_2BHO" defines the provider's responsibility for coordinating care for Medicaid beneficiaries. This entire policy is applicable to this requirement and to the other	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	coordination of care requirements in this Standard. "ProvisionofServicesbyanOutofNetworkProviderPolicy_274L" describes how continuity of care is maintained for Medicaid members. Section IV, A, 3 describes how a new Medicaid member's existing treatment can be continued through Medicaid coverage. Value Options/Beacon Health Options Clinical Care managers work to facilitate timely communication to promote continuity of care when multiple providers are involved in care or a member is transitioning to different levels of care, and this is outlined in CareCoordinationPolicy_262L_2BHO.	
2. The Contractor has policies and procedures that address, and the Contractor provides for, the coordination and provision of covered services in conjunction with: ◆ Any other MCO or PIHP. ◆ Other behavioral healthcare providers. ◆ Physical healthcare providers. ◆ Long-term care providers. ◆ Waiver services providers. ◆ Pharmacists. ◆ County and State agencies. ◆ Public health agencies. ◆ Organizations that provide wraparound services. *42CFR438.208(b)(2)* Contract: Exhibit A—2.4.2.1.1.5; 2.4.2.2.1.3	**Documents Submitted:** 1. CareCoordinationPolicy_262L_2BHO—Entire document, especially I.H 2. ClinicalAuditTool_2BHO—Section F **Description of Process:** All CHP behavioral health professionals are expected to provide basic care coordination services including collaboration, with Member consent, with primary care. If complex care management is indicated, the behavioral health professional is required to communicate with other care coordinators or care managers who are assigned through other programs, particularly the RCCO, the Single Entry Points, and the child welfare system. The function of this communication shall be to designate and document the lead care manager for each Member and to ensure that the care coordination plan is an integrated plan that is inclusive of behavioral health needs. "CareCoordinationPolicy_262L_2BHO" defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. The specific entities are listed in Section I.H. Providers are monitored on compliance with this policy through existing audit procedures. Please see "ClinicalAuditTool_2BHO", Section F.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
2.A. The Contractor develops specialized treatment and service plans for female members for one year postpartum to ensure that the behavioral and physical needs of the mother and child are being met. Contract: Exhibit A—2.4.2.4.2.6.1	**Documents Submitted:** 1. CareCoordinationPolicy_262L_2BHO—Entire document 2. ServicesforMembersWithSpecialNeeds_285L_2BHO—Section IV.A-C. **Description of Process:** "ServicesforMembersWithSpecialNeeds_285L_CHP—Section IV.A-C" identifies this post-partum population as a member sub-group with special needs, and it indicates the requirement for specialized service plans. "CareCoordinationPolicy_262L_2BHO" provides details about who is responsible for care coordination and how it is performed.	Information Only
Findings: The Services for Members With Special Needs policy included a statement exactly as defined in the requirement, but did not include a description of procedures or accountabilities for achieving this requirement. The Care Coordination policy described the responsibility of the therapist to communicate with medical professionals to obtain information regarding the member's medical condition (not specific to postpartum members). The provider manual did not include information related to this requirement. During on-site interviews, staff stated that if the member self-identifies to the BHO as being less than one-year postpartum, the member may be linked with a care coordinator for needed services. Staff also stated that further integration with the RCCO will enable identification of members in the broader Medicaid population who may be within one-year postpartum, so that the RCCO and BHO care coordinators can target these members to develop specialized service plans.		
2.B. The Contractor coordinates with the member's medical health providers to facilitate the delivery of health services, and makes reasonable efforts to assist individuals to obtain necessary medical treatment. If a member is unable to arrange for supportive services necessary to obtain medical care due to her/his behavioral health disorders, the Contractor will arrange for supportive services whenever possible. Contract: Exhibit A—2.4.2.2.2	**Documents Submitted:** 1. AdvancingHealthcareIntegration_283L_CHP—Entire document 2. CareCoordinationPolicy_262L_2BHO—Entire document 3. ClinicalAuditTool_2BHO—Section F. **Description of Process:** It is CHP's policy to coordinate with the Member's medical health provider(s) to assist the Member with accessing necessary medical treatment and to facilitate the delivery of health services in an integrated	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	fashion. This function is fully detailed in the two policies listed above. Compliance with this policy is monitored through the retrospective audit process. See ClinicalAuditTool_2BHO—Section F.	
Findings: CHP policies—Care Coordination and Advancing Healthcare Integration—adequately addressed the responsibility of the primary behavioral health provider to obtain an ROI from the member to communicate with medical professionals delivering services to members, provide medication information to the PCP and obtain information from the PCP regarding medical conditions, and share behavioral health treatment information with physical health providers. The provider manual further stated that the primary behavioral health provider must ensure coordination of services and exchange of relevant healthcare information with the PCP or other providers and is responsible for collaborating with the RCCO care coordinator and referring the member to the appropriate agency/entity for complex care coordination needs. The clinical audit tool included monitoring for an ROI in the record and documentation that the provider sent a Coordination of Care letter annually to the PCP.		
2.C. The Contractor provides for care coordination and continuity of care for special populations and complex members, including those who are involved in multiple systems and those who have multiple needs, such as: ◆ Members residing in long-term care/nursing facilities. ◆ Dually or multiply eligible members. ◆ Dually or multi-diagnosed members. ◆ Members involved with the correctional system. ◆ Child/Youth members in out-of-home placements, foster care, and subsidized adoptions. ◆ Members transitioning from Colorado Mental Health Institutes (Ft. Logan and Pueblo) and hospitals. ◆ Members receiving wraparound services under an HCBS waiver. Contract: Exhibit A—2.4.2.4.1; 2.4.2.4.2; 2.4.2.2.1.1	**Documents Submitted:** 1. AdvancingHealthcareIntegration_283L_CHP—Entire document 2. CareCoordinationPolicy_262L_2BHO—Entire document 3. ClinicalAuditTool_2BHO—Section F **Description of Process:** It is CHP's policy to coordinate with the Member's medical health provider(s) to assist the Member with accessing necessary medical treatment and to facilitate the delivery of health services in an integrated fashion. This function is fully detailed in the two policies listed above. Compliance with this policy is monitored through the retrospective audit process. See ClinicalAuditTool_2BHO—Section F.	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: CHP policies—Care Coordination and Advancing Healthcare Integration—addressed the expectation that members with complex needs such those involved with multiple healthcare providers and service delivery organizations be assigned a care coordinator. The provider manual stated that the provider is responsible for collaborating with the RCCO care coordinator, as appropriate, and for referring the member with complex care coordination needs to the community mental health center (CMHC)-based integrated care coordinator or the ValueOptions/Beacon Health Options (VO/Beacon) intensive case manager for assistance in collaborating with appropriate agencies. Neither these documents nor the provider training regarding care coordination specifically referenced care coordination for members of special populations as outlined in the requirement. However, detailed information pertaining to care coordination for each of these populations is outlined below.		
2.D. The Contractor ensures that providers (primarily Community Mental Health Centers) communicate with and coordinate services with the Single Entry Point (SEP) care manager for each member who participates in the Waiver for Persons with Mental Illness (HCBS-MI) or Waiver for the Elderly, Blind, or Disabled (HCBS-EBD). The Contractor also coordinates with assisted living residences (ALRs) or other supported community living arrangements in which HCBS waiver recipients live. Contract: Exhibit A— 2.4.2.2.1.2	**Documents Submitted:** 1. CareCoordinationPolicy_262L_2BHO—Entire policy, especially Section I.H. 2. ServicesforResidentsOfNursingFac_275L_2BHO—Entire policy **Description of Process:** All CHP behavioral health professionals are expected to provide basic care coordination services including collaboration, with Member consent, with other care coordinators or treatment providers who are assigned through other programs including the Single Entry Point agencies or Medicaid waiver programs. The function of this communication shall be to designate and document the lead care manager for each Member and to ensure that the care coordination plan is an integrated plan that is inclusive of behavioral health needs. "CareCoordinationPolicy_262L_2BHO", Section I.H specifically notes that coordination is required with Single Entry Point and waiver service providers. "ServicesforResidentsOfNursingFac_275L_2BHO" policy specifically identifies the requirement to coordinate services for Members in Assisted Living Residences (ALRs) and other supported community living settings.	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Team meetings are held with BHO's LTSS Coordinator, CMHC providers and SEP staff at least monthly to enhance quality of care and improve care coordination. This coordination typically involves identification of treatment needs, barriers, goals, assessment/diagnosis findings and implementation of treatment plans. Team meetings can be scheduled more often, when clinically indicated. CMHCs initiate care coordination with ALRs and ACFs for the purpose of organizing and supervising the delivery of services to persons who require comprehensive and coordinated care. This is done on a monthly basis (at minimum) or more often, if needed.	
Findings: CHP provided documentation that described the responsibility to coordinate with SEPs and waiver service providers at multiple levels: the behavioral health provider, the CMHC care coordinator, or the VO/Beacon care coordinator for members requiring home- and community-based services (HCBS) waiver services. This is especially applicable to members residing in nursing facilities or ALRs as defined in the Services for Residents of Nursing Facilities policy. The provider manual also described that clinical care managers (utilization management) will prompt providers to involve all appropriate organizations (including waiver providers) in the delivery of integrated care and will assist with connecting the member to the appropriate agency, including CCBs, SEPs, and transportation providers. Staff also stated that CHP established a long-term services and supports (LTSS) coordinator position to assist with coordinating care for members with complex long-term care needs. Team meetings with the LTSS coordinator, CMHC providers, and SEP staff are held at least monthly to improve coordination among the organizations. During on-site interviews, staff provided a case presentation that demonstrated coordination of services for an individual member with complex long-term care needs.		
2.E. The Contractor coordinates with county departments of human/social services in regard to children and youth in out-of-home placements (including kinship care, foster care, and subsidized adoptions) to: ◆ Ensure that children who have had a positive screen for trauma receive a formal follow-up trauma assessment and trauma-informed covered services (if indicated). ◆ Coordinate behavioral health referrals and services with county case workers, and initiate/maintain contact with case workers on an ongoing basis regarding	**Documents submitted:** 1. CareCoordinationPolicy_262L_2BHO—Entire document 2. ProviderManual_CHP—Section 8 *Misc. 3. ServicesforMembersWithSpecialNeeds_285L_CHP—Section IV.D-F. 4. Q1 FY16 NW Adequacy Report _2BHO-Entire Document **Description of Process:** "CareCoordinationPolicy_262L_2BHO" provides a general overview of the purposes of care coordination and the specific responsibilities for	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
child/adolescent members as well as adult members who have child welfare-involved children in their care. ◆ Ensure that therapists and case managers coordinate with county case workers regarding significant events which include, but are not limited to, discharge from treatment, significant clinical decompensation, and no-shows. The provider network includes clinical staff who are familiar with the unique needs of child welfare members, are able to provide psycho-educational as well as practical therapeutic interventions, and know of and refer families to community resources. The Contractor identifies a person within its organization who can serve as a main point of contact for the county departments of human/social services. Contract: Exhibit A—2.5.11.5; 2.4.2.4.2.7.1	CHP providers. These expectations are also explained in the ProviderManual_2BHO. "ServicesforMembersWithSpecialNeeds_285L_CHP—Section IV.D-F" identifies this post-partum population as a member sub-group with special needs, and it indicates the requirement for specialized service plans. All CHP behavioral health professionals are expected to provide basic care coordination services including collaboration with primary care, as long as there is member consent. If complex care management is indicated, the behavioral health professional is required to communicate with other care coordinators or care managers, who are assigned through other programs, particularly the RCCO, the Single Entry Points, and the child welfare system. The function of this communication shall be to designate and document the lead care manager for each Member and to ensure that the care coordination plan is an integrated plan that is inclusive of behavioral health needs. CHP has actively sought out providers who have specific expertise in the provision of trauma-informed and trauma-specific care practices, including eye movement desensitization and reprocessing, Trauma-Focused Cognitive Behavioral Therapy, and other evidence-based individual and group modalities that share a trauma-informed care perspective. Area of clinical specialty is a searchable field in our provider network database. See Q1 FY16 NW Adequacy Report _2BHO. The CHP Engagement Center has an Intensive Case Management (ICM) service that will assist primary care physicians, child welfare case workers, long term care facilities, and other agencies with care coordination when Members are involved with multiple systems or have	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	specialized health care needs. This ICM program operates under the supervision of the CHP Clinical Director, who serves as the main point of contact for the county departments of human/social services.	
Findings: The CHP Services for Members with Special Needs policy stated that the BHO must perform each of the elements in the requirement but included no defined procedures or processes for doing so. The Care Coordination policy generally described the role of the care coordinator to coordinate behavioral health services with other healthcare and human service agencies. During on-site interviews, staff stated that coordination of individual member services with the county DHS is performed by the CMHCs and/or the VO/Beacon intensive case management coordinators. In addition, the CMHCs meet regularly with their aligned DHS to maintain working relationships and improve access and referrals for members. Staff cited ongoing endeavors between AspenPointe and El Paso DHS to develop alternative programs for members. Staff stated that when best practice approaches are identified, CHP seeks to integrate those approaches and procedures into other counties and mental health facilities. Staff stated that CHP actively seeks providers with expertise in trauma-related therapies and the child welfare system for participation in the network. Staff stated that CHP's clinical director serves as the ongoing primary point of contact for program or policy issues with every county DHS. During on-site interviews, the VO/Beacon intensive case manager provided a case presentation that demonstrated many months of coordinating services with inpatient and residential facilities, special community programs, the CMHC and multiple specialist providers, and the member and family—including numerous contacts with the county DHS case worker for a child displaced from his home.		
2.F. The Contractor collaborates with agencies responsible for the administration of jails, prisons, and juvenile detention facilities to coordinate the discharge and transition of incarcerated adult and child/youth members. The Contractor: ◆ Ensures members receive medically necessary initial services after release from correctional facilities and provides the continuation of medication management and other behavioral healthcare services prior to community reentry and continually thereafter. ◆ Designates a staff person as the single point of contact for working with correctional facilities that may release incarcerated or detained members into the Contractor's	**Documents submitted:** 1. CoordinationwithCorrectionalSystem_287L_CHP—Entire document **Description of Process:** CHP recognizes the challenges faced by our Members released from correctional facilities and has programs in place in all regions to ensure successful transitions to healthcare services upon their release. We have developed a centralized telephone number for all correctional facilities to reach our Criminal Justice Systems Coordinator. CHP also has implemented a ValueOptions/Beacon Health Options program called Justice Connect, an enhanced identification and referral system that is fully integrated into our care management information	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
service area. ◆ Collaborates with correctional facilities to obtain medical records or information for members who are released into the region, as necessary for treatment of behavioral health conditions. ◆ Works with the Department on initiatives, including Medicaid eligibility issues, related to members involved or previously involved with the State correctional system. ◆ Proposes (to the Department) innovative strategies, such as the use of technology, communication protocols, and coordination techniques with the courts, parole officers, police officers, correctional facilities, and other individuals needed to meet these requirements. Contract: Exhibit A—2.4.2.4.2.5	system. This system facilitates the monitoring and tracking of behavioral health appointments for BHO members released from correctional facilities, helping to ensure that these members receive uninterrupted behavioral health services. CHP has a dedicated Criminal Justice Systems Coordinator that oversees all functions related to this requirement and acts as the single point of contact for correctional facilities in the CHP service area. **MHC Program Highlights:** Aspen Pointe Mental Health Center's Jail Diversion Program is intended to develop community based services to reduce recidivism for individuals with mental illness involved in the criminal justice system. This service occurs at the El Paso County jail and at the Adult and Rural Office. Each program has dedicated clinicians to assist individuals moving from incarceration to the community. Axis Health System's Jail Based Behavioral Health Services Program (JBBS) provides screening for co-occurring disorders, post-traumatic stress disorders and traumatic brain injuries to all individuals who enter the jail. All inmates are initially screened by jail medical staff within the first 48 hours of incarceration and referred to the JBBS team for further assessment and treatment. Once identified, individual and group therapy are initiated, as well as case management for linkage to healthcare following release from the La Plata County Jail. Axis Health staff are co-located within the jail environment.	

Findings:
The CHP Coordination with Correctional System policy included a policy statement with all elements defined in the requirement; however, the policy had no procedures for implementation. Staff stated that procedures and the infrastructure for coordinating with the corrections system are still evolving and being tested through collaborative processes in the region and that procedures will be better defined over time based on the outcome of these processes. CHP designated a criminal justice system coordinator to oversee all activities related to integration with the criminal justice system and to serve as the single point of contact for correctional facilities. During on-site interviews, staff described collaborative processes with the State's BHOs and the DOC to develop uniform

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
procedures for identifying prison parolees enrolled in Medicaid who are residing in each BHO catchment area. Staff stated that implementation of programs for members in the DOC were postponed after Treatment Accountability for Safer Communities' (TASC) contract with the DOC was awarded to a different organization. CHP is collaborating with jails in three of the largest counties in its region to implement and test the VO/Beacon *Justice Connect* software, which will match BHO claims to real-time justice booking records in order to identify persons in jails who were previously engaged in receiving services through the BHO and to provide information to the jails regarding the members' mental health needs, diagnoses, and medications. CHP will send the CMHCs a list of jailed members so they can contact the member to arrange for services upon release. CHP was attempting to contact sheriffs in all of its counties to engage them in the *Justice Connect* system and also participated in the 2015 Sheriff's Conference. Staff cited barriers to implementation as being primarily related to building the communication infrastructure, including establishing a business associate agreement (BAA) with each county's correctional facility and working with the Appriss data vendor to integrate the booking database into *Justice Connect* so it can send lists of Medicaid-enrolled incarcerated persons to the CMHCs. In addition, the turnover of elected county officials, including sheriffs, hinders communication and completion of agreements with individual counties. CHP also cited specific projects of AspenPointe and El Paso County Jail and Axis Health Systems and La Plata County Jail as examples of improving access to behavioral health services for incarcerated persons. Staff stated that any project considered successful may be transferrable to other counties in the region. Staff stated that, despite barriers, they feel confident that significant progress is being made in aligning with corrections facilities for coordinating services for members being transitioned out of the corrections system.		
2.G. The Contractor provides outreach, a delivery system, and support to nursing facilities and assisted living residences in its service area, including: ◆ Provision of medically necessary, covered behavioral health services on-site in nursing facilities and assisted living residences for members who cannot reasonably travel to a service delivery site. (Residents able to travel may be required to receive their behavioral health services at a delivery site.) The Contractor will work collaboratively with the facilities to determine whichf residents are and are not able to travel. ◆ Monthly outreach and coordination for the provision of mental health and substance use disorder services for members in nursing facilities and assisted living residences.	**Documents submitted:** 1. ServicesforResidentsOfNursingFac_275L_2BHO—Entire policy 2. LTSSProcessSummary_CHP—Entire Document **Description of Process:** Please see "ServicesforResidentsOfNursingFac_275L_2BHO—Entire policy" for a description of CHP's policy and procedures related to delivery of services and coordination of care for individuals who reside in nursing facilities and assisted living residences. Currently, CHP has contracted behavioral health professionals providing more than 700 hours in assisted living facilities and nursing homes. Problems related to referrals or access to care are investigated and resolved by CHP's Director of Long-Term Services Support (LTSS).	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ Assigning a primary contact from the BHO to each nursing facility and assisted living residence, who will ensure members are receiving necessary behavioral health services and help problem solve any related member issues. ◆ Establishing an ongoing quarterly meeting with all nursing facilities and assisted living residences to address outstanding issues. ◆ Providing Preadmission Screening and Resident Review (PASRR) Level II requirements and services to members entering nursing facilities, and providing any specialized behavioral health services identified on the assessment. Contract: Exhibit A—2.4.2.4.2.1	Please see "LTSSProcessSummary_CHP—Entire Document" for a detailed description of the processes related to this requirement.	

Findings:

The CHP Services for Residents in Nursing Facilities policy and the LTSS Process Summary described the responsibilities of the CMHCs to provide services to members in nursing facilities and ALRs and the role of CHP's LTSS coordinator in developing LTSS-related programs and assisting with the coordination of services for members with complex needs. Both documents addressed all elements of the requirement. During on-site interviews, staff stated that all CMHCs are aligned with the long-term care facilities in a defined catchment area, including all facilities in which the majority of Medicaid members with mental health needs reside. Services, including transportation arrangements, are provided by behavioral health professionals either at the nursing facility or at the CMHC. The CHP LTSS coordinator sends monthly educational updates to all nursing facilities/ALRs and hosts a quarterly meeting (regarding program improvements) with all nursing facilities in the BHO region.

During on-site review, the LTSS coordinator provided a case presentation that demonstrated the role of the LTSS coordinator in assisting with coordination of services for a member with very complex needs. Services included transferring the member from an out-of-state medical facility; securing admission to a long-term care facility that would provide care to a member with a history of mental health issues and delirium and agitation due to a medical condition (89 facilities refused to accept the member); arranging for a one-on-one care sitter, HCBS waiver services, medical support services through the RCCO, and mental health services to be provided in the nursing facility; and completing all paperwork for the member related to these services. As demonstrated, the LTSS coordinator position serves as an expert point of contact for facilitating problem resolution, complex care, and program issues related to LTSS.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
2.H. The Contractor works closely and collaboratively with the Regional Care Collaborative Organizations (RCCOs) on care coordination activities. Contract: Exhibit A— 2.4.2.2.3	**Documents Submitted:** 1. CareCoordinationPolicy_262L_2BHO—Entire document 2. AdvancingHealthcareIntegration_283L_CHP—Entire document **Description of Process:** CHP's current service area, the South/West Service Area, encompasses three different RCCO regions, Regions 1, 4, and 7. CHP has adapted its own care coordination efforts to align with the plans of each RCCO. CHP has established relationships with each RCCO in the service area and with specialty providers in order to coordinate and provide care for our most complex Members who are often those with both covered and non-covered behavioral health conditions. These relationships encompass the Department's goal of achieving the triple aim to ensure that the Member's experience of care is a coordinated effort among all the providers involved with the Member. Please see both of these policies in their entirety for additional details about how CHP implements this coordination of care requirement: 1. CareCoordinationPolicy_262L_2BHO—Entire document 2. AdvancingHealthcareIntegration_283L_CHP—Entire document	Information Only

Findings:
The CHP Care Coordination and Advancing Healthcare Integration policies specified that the behavioral healthcare coordinator would collaborate with the regional RCCO care coordinator to ensure that care coordination plans for members with complex needs address both physical and behavioral health needs. When the RCCO has assigned a care coordinator to the case, the RCCO coordinator is considered the lead coordinator. However, policies did not define procedures or processes for implementing collaboration with the RCCO. The CHP BHO region is associated with three different RCCO regions: Region 1, Region 4, and Region 7. Staff stated that, in some cases, CMHC staff members were still unfamiliar with the identity and role of the RCCO in their area. Staff also stated that both the BHO and RCCOs contract with many federally qualified health centers (FQHCs) located in the service area, which provide a major resource for integrated behavioral and physical health services for members. CHP currently co-locates behavioral health providers in several FQHC locations. (HSAG will further explore the integration of the BHO and the RCCOs in the FY 2015–2016 RCCO site reviews.)

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
3. The Contractor has a mechanism to ensure that each member has an ongoing source of primary (behavioral health) care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating covered services furnished to the member. *42CFR438.208(b)(1)* Contract: Exhibit A— 2.5.1; 2.5.5.3; 2.5.5.4	**Documents Submitted:** 1. CareCoordinationPolicy_262L_2BHO 2. ClinicalAuditTool_2BHO-Section F 3. ProviderManual_CHP -Sections 4 and 9 *Misc. **Description of Process:** "CareCoordinationPolicy_262L_2BHO" addresses this requirement specifically. The entire policy is applicable. It identifies that the primary therapist is responsible for coordinating with the Member's medical treatment team and any other behavioral health providers involved in the Member's care. A Member's individual needs are taken into account in referrals to care, making sure the care is appropriate to his or her specific needs. The Provider Handbook (Section 9—all) provides additional detail to providers about this expectation. Providers are monitored on compliance with this requirement through existing audit procedures. See ClinicalAuditTool_2BHO—Section F. Additionally, Value Options/Beacon Health Options care management team also conducts coordination of care activities in the following situations (See Provider Manual, Section 4): • When the TeleConnect/IVR system or ProviderConnect directs the provider-user to call the CCM. • When a provider contacts the CCM for initial or continuing authorization. • When there is a need to change the level of care being provided. • When quality data related to any aspect of member care indicates the need for provider involvement to clarify or take action on identified patterns/trends. • When clinical information provided causes concern regarding quality of care, inactive/non-efficient treatment, or any safety concerns for the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	• When a member has had multiple admissions to higher levels of care. • When members/guardians, community agencies or providers request involvement or review of the care provided.	
4. The Contractor ensures that each member accessing services receives an individual intake and assessment for the level of care needed, performed by a qualified clinician. The intake and assessment process addresses: ◆ Developmental needs. ◆ Cultural and linguistic needs. ◆ Screening for mental illness, substance use, and trauma disorders. *42CFR438.208(c)(2)* Contract: Exhibit A—2.5.10.1	**Documents Submitted:** 1. ClinicalAuditTool_2BHO—Section B 2. ProviderManual_CHP- Section 17 *Misc. 3. TreatmentPlanning_223L_2BHO—Sections I.A and IV.A. **Description of Process:** 1. The Provider Audit Tool, "ClinicalAuditTool_2BHO—Section B" addresses this requirement for an individual mental health assessment. Treatment planning for our members must be done after an individualized assessment for each member, as outlined in "TreatmentPlanning_223L_2BHO"—Sections I.A and IV.A. Providers also are required to follow the requirements of the ProviderManual_CHP (Section 17), which outlines that these elements of assessment are required parts of the treatment record for each member: 1. Each record includes an individual bio-psychosocial assessment (e.g., presenting problems; medical history, physical health status, and relevant medical conditions. current medications, allergies, retardation or organic brain disorders; identified strengths; relevant psychological, emotional, behavioral, vocational, cultural and social conditions affecting the member and family; past or present history of abuse and/or trauma; legal involvement; psychiatric history; relevant family information; past and present use of alcohol and other substances). 2. For children and adolescents, the assessment includes a	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	developmental history (e.g., physical, psychological, social, intellectual and academic). 3. For older adults, the assessment includes issues specific to that population, such as hearing and/or vision loss, strength, mobility and aging issues. 4. Each record includes a mental status examination documenting the member's presentation/appearance, affect and mood, speech, cognitive/intellectual functioning, thought content/process, judgment, insight, attention/concentration, memory, impulse control, and danger to self and others. 5. Each record includes a clinical formulation describing the reasoning and justification for the diagnosis, and a current Diagnostic and Statistical Manual (DSM) diagnosis based on psychiatric, psychological, substance use or medical condition. The formulation includes sufficient description of the criteria per the current DSM to support the diagnosis. Any subsequent changes in diagnosis must be similarly documented and explained. 6. The documented diagnosis is consistent with the presenting problems, history, mental status examination and/or other assessment data in the record.	
5. The Contractor shares with all health plans, RCCOs, and providers serving each member with special healthcare needs the results of its identification and assessment of the member's needs to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: Exhibit A—2.4.2.4.2.4.1	**Documents Submitted:** 1. CareCoordinationPolicy_262L_2BHO—Entire document 2. ServicesforMembersWithSpecialNeeds_285L_2BHO-Entire document, especially IV.A. **Description of Process:** "CareCoordinationPolicy_262L_2BHO" defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. The second policy named above, "ServicesforMembersWithSpecialNeeds_285L_2BHO" provides	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	specific direction on coordination of care for special populations, such as child welfare clients or post-partum women, to avoid duplication of services or gaps in care.	
6. The Contractor utilizes the information gathered in the member's intake and assessment to build an individualized, culturally sensitive comprehensive service plan that includes: ◆ Measurable goals. ◆ Strategies to achieve the stated goals. ◆ A mechanism for monitoring and revising the service plan as appropriate. The service plan is developed by the member, the member's designated client representative (DCR), and the provider/treatment team, and is signed by the member and the reviewing professional. (If a member chooses not to sign his/her service plan, documentation shall be provided in the member's medical record stating the member's reason for not signing the plan.) Service planning shall take place annually or if there is a change in the member's level of functioning and care needs. *42CFR438.208(c)(3)* Contract: Exhibit A—2.5.11.1–2.5.11.4	**Documents Submitted:** 1. TreatmentPlanning_223L_2BHO —Entire policy 2. ClinicalAuditTool_2BHO—Section C 3. Member Handbook_CHP*Misc.-Page 7 (What is a Service Plan) 4. ProviderManual_CHP-Section 17 *Misc. **Description of Process:** "TreatmentPlanning_223L_2BHO" addresses this requirement and is applicable in its entirety. Providers are monitored on compliance with this policy through existing audit procedures. Please see ClinicalAuditTool_2BHO—Section C. Members are educated about their role in treatment planning through our Member Handbook. [Member Handbook_CHP*Misc.—page 7 (What is a Service Plan?)]. Specific requirements for documentation of treatment planning is outlined in the ProviderManual_CHP (Section 17) : <u>Service/Treatment Plan</u>: • Each record includes an individualized treatment/service plan containing behaviorally measurable goals and objectives, the desired discharge criteria, the provider's intended therapeutic interventions, frequencies and modalities, and estimated timelines for goal attainment/problem resolution. • The treatment/service plan is consistent with the member's diagnosis and needs as identified in the assessment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	• There is documented evidence in a progress note that the member (and parent/guardian, if applicable) participates in the development of, understands, and agrees with the treatment/service plan and any significant revisions/updates. • The treatment/service plan must include specific criteria for discharging the member from treatment that are agreed upon by the member and provider. Discharge criteria may be modified as a member's circumstances change; modifications will be documented in the member's treatment plan. • The treatment plan addresses coordination of care with other relevant providers. • The treatment/service plan is reviewed by the client and provider at least every 6 months or when a major change in the member's condition or service needs occurs. The plan is revised as necessary. For members involuntarily receiving services pursuant to Section 27-65- 101 et seq., CRS, the plan must be reviewed monthly. • The treatment plan for substance use diagnoses is completed every 45 days in accordance with OBH standards. • The member or guardian must sign the treatment plan. If they refuse, this fact must be documented clearly in a progress note.	
7. The Contractor must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or approved number of visits) as appropriate for the member's condition. *42CFR438.208(c)(4)*	**Documents Submitted:** 1. ProviderManual_CHP *Misc. Section 4 **Description of Process:** For this question, "specialist" is construed as a behavioral health provider, as the BHO is responsible only for authorizing behavioral health care. 1. Members can directly access any network provider for an initial intake evaluation without prior authorization. 2. Providers complete an initial evaluation then obtain authorization for outpatient care via Provider Connect or Tele Connect (IVR) no later than 30 calendar days after the initial evaluation. Initial evaluations do not require authorization for contracted providers and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	can be billed with a deferred diagnosis or no diagnosis code, if needed. 3. Network providers do not need to obtain prior authorization of evaluation or individual or family therapy sessions. However, other services typically require prior approval. 4. For contracted prescribers, medication management services do not require authorization. 5. Emergency services do not require prior authorization. Emergency care is defined as a medical condition manifested by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Documentation must accompany claims for emergency services in order to support covered diagnosis. This documentation will be reviewed on a retrospective basis, after the member has received care.	
8. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor shall adequately and timely provide the covered services out of network at no cost to the member. *42CFR206.(b)(4)* Contract: Exhibit A—2.5.9.5	**Documents Submitted:** 1. ProvisionofServicesbyanOutofNetworkProviderPolicy_274L_2BHO—Entire Document **Description of Process:** CHP has a well-defined process for establishing and implementing Single Case Agreements (SCAs), allowing Members to obtain services from an out-of-network provider, when necessary. Please see the policy referenced above for a full description of this process, which can be initiated by an individual Member, parent or guardian, provider or facility. Single case agreements are frequently approved by CHP for the following reasons (though this list is not exclusive): 1. Geographic access; 2. Cultural or linguistic needs or preferences of the Member; 3. Continuity of care for Members transitioning to Medicaid from	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	another health plan; 4. Clinical specialty of the provider needed by the member	
9. The Contractor must arrange for the provision of all *medically necessary services** identified under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, 42 CFR Sections 441.50 to 441.62, including: ◆ Referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. (Referral assistance must include giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.) ▪ At a minimum, the Contractor must assure that the medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. ◆ Making appropriate use of State health agencies, State vocational rehabilitation agencies, Title V grantees (Maternal and Child Health/Crippled Children's Services), and other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC). ◆ Offering the family or beneficiary necessary assistance with transportation and necessary assistance with scheduling appointments for EPSDT services. *Medical necessity for EPSDT—	**Documents Submitted:** 1. EPSDT_248L_2BHO-Entire Policy 2. Provider Manual_CHP—EPSDT-Section 7 3. ClinicalAuditTool_2BHO—Section F Questions F1 and F2 **Description of Process:** Please see the policy listed above for a full description of the procedures related to service provision to Members under the EPSDT program. Other information related to coordination of care with State programs may be found in the response to Question 11. The CHP Provider Manual gives additional clarification about offering the family or beneficiary assistance with appointment scheduling or transportation services. The EPSDT section notes: "Under the EPSDT program, case management services are the responsibility of the Department of Health Care Policy and Financing and are subcontracted to local agencies. Family Health Coordinators have the responsibility to facilitate the EPSDT screening process, help families select a PCP if requested, give transportation options, complete follow-up on screening appointments and arrange for diagnostic and treatment services. In most cases, the Family Health Coordinators do not provide the services but rather refer to those who are able to provide health care and other needed services within the community." It is worth noting that CHP increasingly provides outpatient services in the context of an integrated care philosophy. We recognize that behavioral health is only one aspect of total health care, and our providers are aware that services are optimally effective when they are delivered in the context of overall Member wellness. Several of our	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
The term "medical necessity" means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it: ◆ Is found to be an equally effective treatment among other less conservative or more costly treatment options, and ◆ Meets at least one of the following criteria: ▪ The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability. ▪ The service will, or is reasonably expected to cure, correct, reduce, or ameliorate the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. ▪ The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury, or disability. ▪ The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living. Medical necessity may also be a course of treatment that includes mere observation or no treatment at all. *42 CFR 441.61 (a) and (b);* *42 CFR 441.62* Contract: Amendment 3— 6.A.2.2.1 10 CCR 2505-10—8.280.8.C and D.5 10 CCR 2505-10—8.280.1	largest providers, including partner CBHCs as well as integrated primary care practices, are offering outpatient behavioral health services in integrated care settings. One of our CBHC partners, Axis Health Systems, is establishing a national reputation for their integrated care model. Several of our other partners, including Aspen Pointe in the Pikes Peak region and San Luis Valley Mental Health Center in the Arkansas River valley, are working closely with large primary care practices to deliver behavioral health services in primary care settings. Compliance with this requirement is monitored through existing audit procedures. Please see ClinicalAuditTool_2BHO—Section F1-F2.	

Standard III—Coordination and Continuity of Care

Requirement	Evidence as Submitted by BHO	Score
Findings: The EPSDT policy stated that the BHO provider will contact the PCP to determine if an EPSDT screening has been conducted and to request that the PCP conduct the screening, if necessary. If the member does not have a PCP, the mental health provider will assist the member in obtaining a PCP through the enrollment broker. The policy also stated that CHP will provide mental health services needed as a result of EPSDT screening. The provider manual explained EPSDT services and stated that the BHO provider should contact the PCP to request results of EPSDT screenings. The provider manual also described the role of family health coordinators as the case managers for EPSDT services. CHP's clinical audit tool included an element to assess whether the record has a note asking the member about a well-child visit in the past year and referring the member to a PCP, if needed. However, none of these documents addressed the responsibility of the BHO provider to provide referral assistance to members who need services not covered by the BHO but found to be needed as a result of conditions disclosed during screening and diagnosis, including coordinating with State agencies appropriate to the member's needs or assisting with appointments or transportation when needed. In addition, documents did not clearly define mechanisms for doing so—e.g., referring to BHO care managers, the Office of Clinical Services, or Healthy Communities. Staff submitted additional policies and procedures that generally described BHO coordination with physical health providers and making referrals to other health care agencies and providers as needed, but did not specifically reference EPSDT services. Staff stated that EPSDT screening results are not readily available to BHO providers and that PCPs do not always respond to inquiries from BHO providers regarding the results of EPSDT screenings.		
Required Actions: CHP must enhance its policies and procedures and provider communications to more specifically address the responsibility of the provider and/or the BHO to provide referral assistance to members who need services not covered by the BHO but found necessary through EPSDT screening and diagnosis, and the processes for doing so.		
10. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. In all other operations, as well, the Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable. *42CFR438.208(b)(4)* *42CFR438.224*	**Documents Submitted:** 1. CareCoordinationPolicy_262L_2BHO—Section I.I **Description of Process:** The policy listed above defines the purposes for coordination of care and the specific groups that should be included in coordination of care activities. Member privacy protection is addressed in Section I.I (p.3). The Care Coordinator ensures that all communications with other providers are in accord with all applicable Federal and State requirements related to the protection of individually identifiable health information. These requirements include those specifically identified in 45 CFR, parts 160 and 164, subparts A and E (HIPAA), to the extent that they are applicable. When there are questions about whether particular	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
Contract: 10.B; Exhibit A—2.4.2.1.1.6	information can be exchanged, the Care Coordinator is directed to consult with the Beacon Compliance Officer to resolve these questions prior to releasing the information.	
11. The Contractor shall form relationships with community partners and government agencies that provide services to members. Agencies include: ◆ Colorado Department of Health Care Policy and Financing, Division of Development Disabilities. ◆ Colorado Department of Human Services, Child Welfare. ◆ Colorado Department of Human Services, Office of Behavioral Health. ◆ Colorado Department of Public Health and Environment, STD/HIV Section. ◆ Colorado Department of Public Health and Environment. ◆ Colorado Department of Corrections. ◆ Colorado Prevention Services Division. Contract: Exhibit A—2.4.2.5; 2.4.5.6	**Documents Submitted:** 1. AlignmentofSystems_286L_CHP-Entire Policy 2. CareCoordinationPolicy_262L_2BHO-Entire Policy 3. AdvancingHealthcareIntegration_283L_CHP-Entire Policy 4. CoordinationwithCorrectionalSystem_287L_CHP-Entire Policy **Description of Processes:** 1. **Coordination with RCCOs**--CHP's current service area, the South/West Service Area, encompasses thee different RCCO regions, Regions 1, 4, and 7. CHP has adapted its own care coordination efforts to align with the plans of each RCCO. CHP has established relationships with each RCCOs in the service area and with specialty providers in order to coordinate and provide care for our most complex Members who are often those with both covered and non-covered behavioral health conditions. 2. **Coordination with FQHCs**--CHP has offered contracts to all essential community providers in the CHP Service Area. We currently contract with FQHCs located in the Service Area and 17 CBHCs across the State. By contracting with these provider groups, CHP has secured a major resource for integrated services for our Members. CHP currently co-locates behavioral health providers in several FQHC locations and reimburses for covered services received in these locations. 3. **Coordination with other Community Partners and Government Agencies**--In addition to RCCO and FQHC involvement, CHP has established and intensively coordinates care with a network of specialty providers. CHP has allied with community and governmental agencies such as Community Centered Boards, Single	Information Only

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Entry Point agencies and organizations providing services to those with Intellectual/Developmental Disabilities, Traumatic Brain Injury, medical conditions, and other non-covered diagnoses. 4. **Coordination with Correctional Systems**--CHP recognizes the challenges faced by our Members released from correctional facilities and has programs in place in all regions to ensure successful transitions to healthcare services upon their release. We are also implementing a centralized program to assist with monitoring and tracking releases from correctional facilities and having behavioral health appointments within two weeks of their release will occur. CHP is implementing a program called Justice Connect, an enhanced identification and referral system that is fully integrated into our management information system. Our Justice Connect system coordinates services and interventions for enrolled Members who transition from correctional facilities back to the community. 5. **Coordination with the Child Welfare System**-- For children in out-of-home placements (foster care, kinship care, and subsidized adoptions), CHP requires providers to make assessments available, upon request from county departments of social services, and to coordinate with county caseworkers, if behavioral health services are provided. This includes coordination of behavioral health and substance use disorder referrals. Currently, the Colorado Department Human Services (CDHS) is working on a project that would enable all children in foster care to receive a trauma screening. CHP will work collaboratively with CDHS and local county offices to ensure that all children who have a positive trauma screen, receive a formal follow-up trauma assessment and, subsequently, any trauma-informed covered services that are indicated.	
Findings: The CHP Advancing Healthcare Integration and Care Coordination policies generally described the intent of CHP to work collaboratively with county and State agencies and social service provider organizations to coordinate member care. The Alignment of Systems policy referenced CHP's collaboration with the		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO**	**Score**
specific agencies identified in the requirement. The Coordinating with Correctional Systems policy defined CHP's commitment to work with correctional facilities to enable services for Medicaid members being released from jails or prisons, including designating a CHP staff person as the single point of contact with correctional facilities. During on-site interviews and case presentations, staff described care coordination relationships with numerous external agencies including the DOC, DHS, SEPs, and CCBs. Staff also stated that CHP staff participate in trainings and collaborative programs with organizations that specialize in services for members with developmental disabilities, traumatic brain injury, or autism.		
12. The Contractor shall ensure that behavioral health services are provided to dual or multi- eligible members and assist members in finding qualified Medicare providers who are willing to provide covered services. If qualified Medicare providers cannot be identified or accessed, the Contractor shall provide medically necessary covered behavioral health services. Contract: Exhibit A—2.4.2.4.2.2.1.	**Documents Submitted:** 1. ServicesforDualEligibleMembers_284L_CHP-Entire Policy **Description of Process:** All of CHP's CBHCs have the ability to bill Medicare for services provided to dually eligible Medicare and Medicaid Members. In addition, the CHP network also includes 69 independent practitioners across the State, including physicians, nurse practitioners, clinical psychologists, and clinical social workers that have the ability to bill Medicare for dually eligible Members. If a dually-credentialed provider is not available in the Member's area, CHP authorizes any medically necessary services with a network provider.	Information Only
Findings: CHP's Services for Dual Eligible Members policy specified that if a qualified Medicare provider cannot be identified or accessed in network, CHP will authorize and provide necessary covered services. Staff described that CHP has a large network of mental health centers and independent providers qualified to provide service to Medicare members. CHP assessed availability of Medicare providers in the network through the Network Plan.		
13. For members with a behavioral health covered diagnosis and a co-occurring noncovered diagnosis, including autism, traumatic brain injury, and developmental disability, the Contractor will assess members using Department-approved criteria and provide medically necessary covered services for the behavioral health diagnosis. ◆ The Contractor has a mechanism for working with developmental disability services, Community Centered Boards (CCBs), Single Entry Point agencies (SEPs), or other appropriate agencies/healthcare providers to secure	**Documents Submitted:** 1. ServicesforMembersWithSpecialNeeds_285L_CHP-Entire Policy 2. AlignmentofSystems_286L_CHP-Entire Document **Description of Process:** CHP has established relationships and intensively coordinates care with a network of specialty providers. CHP has allied with community and governmental agencies such as Community Centered Boards, Single Entry Point agencies and organizations providing services to those with Intellectual/Developmental Disabilities, Traumatic Brain Injury, medical conditions, and other non-covered diagnoses. CHP works closely with	Information Only

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Requirement	**Evidence as Submitted by BHO**	**Score**
agreement regarding the medical necessity of behavioral services. ◆ The Contractor provides care coordination to members, including appointment setting, assistance with paperwork, and follow-up to ensure linkage with the appropriate agency. If the Contractor determines that the member does not have a covered behavioral health diagnosis, the Contractor informs the member about how services may be obtained, and refers them to the appropriate providers (e.g., RCCOs, CCBs, and SEPs). Contract: Exhibit A—2.4.2.4.2.3.2–3; 2.5.10.2.2–3	the RCCOs and primary care providers in a Member-centered, whole person approach to integrated health care with special-needs populations. We realize Member needs are intertwined and do not neatly separate themselves into categories. These needs must be addressed together in a coordinated and integrated fashion to promote whole-person recovery and resiliency. CHP staff has attended the NADD, an association for persons with developmental disabilities and mental health needs, Annual Conference to gain training in providing mental health services and innovative, integrative programs for health care. We have maintained a three-year, ongoing Membership with CO-CANDO, Colorado Collaborative for Autism and Neurodevelopmental Disabilities Options. CO-CANDO provides an advocacy voice for disabled persons and their families, legislative lobbying for services and funding for evidence-based service programs, training opportunities for providers; and access to other needed services. Staff members have also attended Colorado Brain Injury Association regional conference and summit trainings to gain information about improving daily task functioning, providing effective mental health treatments and improving quality of life for Members with a TBI and their families.	

Findings:
CHP policies stated in general terms that the BHO would share results of member needs assessment with all health plans, RCCOs, and providers serving each member with special healthcare needs, maintain relationships with relationships with community agencies to link members with appropriate services and align with other systems of care, and perform care coordination to integrate behavioral health and other services. Staff stated that members with the most complex needs are often those with both covered and noncovered behavioral health diagnoses. CHP designated care coordination specialist positions to address intensive care management for members with complex needs and for members needing long-term support services. During the on-site interview, CHP staff presented a case that demonstrated LTSS care coordination for a member with brain injury due to a medical emergency incident. Coordination services provided included transferring the member from an out-of-state medical facility; securing admission to a long-term care facility that would care for a member with a history of mental health issues and delirium and agitation due to a medical condition (89 facilities refused to accept the member); arranging for a one-on-one care sitter for the member, HCBS waiver services, medical support services through the RCCO, and mental health services to be provided in the nursing facility; and completing all paperwork related to these services.

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Requirement	**Evidence as Submitted by BHO**	**Score**
14. The Contractor maintains policies, procedures, and strategies for helping to transition members from Mental Health Institutes (Institutes) located at Ft. Logan and Pueblo to safe and alternative environments. The Contractor also: ◆ Care coordinates with the Institutes to have plans in place to provide medically necessary covered services once the member has been discharged from the Institute. ◆ Works with local counties and hospitals in its region in order to transition children from hospitals to safe and alternative step-down environments (e.g., home, residential). ◆ Meets with local counties and hospitals to develop transition protocols and procedures to ensure continuity of care and continuation of services for members. ◆ Works with the Institutes to execute communication and transition plans for members. ◆ Assigns a liaison to serve as a regular point of contact with Institute staff and members who will return to or enter the Contractor's geographic service area. ◆ Is responsible for ongoing treatment, case management, and other behavioral health services once the member is discharged from an Institute. ◆ Participates on the Institute's Person Centered Planning Board. Contract: Exhibit A—2.4.2.4.2.8	**Documents Submitted:** 1. TransitioningMembersFromMHInstitutes_282L_CHP-Entire Policy **Description of Process:** Discharge planning starts at admission. CHP employs clinical care managers who work closely with the community behavioral health centers and the inpatient treatment providers to assess the needs of Members and ensure that strong plans to transition out of the hospital are in place. The clinical care managers work with hospital staff to determine medical necessity and authorize care. At the same time, behavioral health staff is in touch with hospital social workers to provide relevant history, crisis plans and coping skills that have been helpful for Members in the past. Continuity of care is the focus of discussion. Through this, Clinical Care Managers ensure that inpatient treatment providers are well informed about the outpatient treatment plan and the Member's progress. The hospital providers are asked to provide their assessment and recommendations to inform the Member's outpatient discharge plan and facilitate a successful discharge. The mix of services and focus of treatment are evaluated collaboratively to determine whether changes need to be made in the plan. Clinical care managers provide oversight of this process, working to make sure care is coordinated closely between our inpatient and outpatient providers. Discharge needs inform our medical necessity decisions and we work to ensure that services are not duplicated. Members who need home and community-based services, housing, transportation or physical health care are linked with appropriate services prior to discharge. A strong collaboration is accomplished to best serve the Member, who, by nature of being in inpatient psychiatric care, may either still be in crisis, or has been in crisis and is in need of	Information Only

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Requirement	**Evidence as Submitted by BHO**	**Score**
	assistance related to daily life functions so that therapeutic concerns and follow-up can be provided in the manner that best supports the Member. Close communication is required to ensure that all parties are aware of the treatment timeline and plan for discharge. Prior to discharge, follow-up appointments are set with the Member's input, and clinical care managers work with inpatient providers to make sure Members know the next steps in their treatment. Outpatient providers follow up with the Member to ensure that they attend their discharge appointments. If appointments are missed, Members receive outreach to help engage them in treatment as quickly as possible. Contacts with the Member's treatment team are frequent during this time of transition to make sure that they are participating in ongoing care as seamlessly as possible.	

Findings:
The Transitioning Members From MH Institutes policy stated that it was the responsibility of CMHC and CHP staff to assign discharge liaisons to work with inpatient discharge planning teams to transition the member from inpatient care and addresses all elements of the requirement. Each CMHC had a liaison that served as the point person for members being discharged from inpatient care. A liaison was also assigned to each of the mental health institutes. The member's transition is planned and executed through collaboration of the inpatient discharge coordinators, CMHC liaisons, and CHP staff support. Upon admission, the CMHC shares information concerning the member's history and treatment plan with the inpatient social worker. In addition, CHP has communicated to the hospitals expectations regarding discharge planning and has developed protocols for arranging community support services (such as transportation or housing) and physical healthcare services prior to member discharge as well as for sharing discharge information with the CMHC. CHP staff members are available to process and resolve any discharge issues with the hospitals. Clinical care managers (utilization management) authorize necessary services on discharge and coordinate information between inpatient and outpatient services to ensure the member's continuity of care. CHP designated a specialized transition coordinator position to assist with the transition of members with complex needs.

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	9	X	1.00	=	9
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	10	**Total Score**		=	9

Total Score ÷ Total Applicable	=	90%

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has written policies and procedures regarding member rights. *42CFR438.100(a)(1)* Contract: Exhibit A—2.6.8.1	**Documents Submitted:** 1. 304LMemberRandR_Policy_2BHO - Entire Policy 2. 310LNonDiscrimination_Policy_2BHO - Entire Policy **Description of Process:** The Member Rights and Responsibilities Policy, 304LMemberRandR_Policy_2BHO and the Non-Discrimination Policy, 310LNonDiscrimination_Policy_2BHO are two policies that guide our position on protecting member rights. The Non-Discrimination policy is the foundation for all member rights policies. The Members Rights and Responsibilities policy meets all state and federal regulations and contract requirements.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor ensures that its staff and affiliated and network providers take member rights into account when furnishing services to members. *42CFR 438.100(a)(2)* Contract: Exhibit A—2.6.8.1	**Documents Submitted:** 1. FacilityContract_2BHO-Section 5.4 (a) Pg. 7, Pg. 28, Exhibit, F.1.f, 2. IPN_Contract_2BHO-Pg. 6, 7, Section 5.4 (a); Pg. 27, F.1.f 3. ProviderManual_CHP - Section 15, Pg. 98-103 *Misc. 4. PRSupplememt_CHPWeb-Sect15_Eng-Enitre Document 5. PRSupplement_CHPWeb-Sect15_Span-Enitre Document 6. SUD_ProvideForum_Presentation_Slides 61-64, _2BHO_PR 7. MemberHandbook_CHP – Pg. 21-23 *Misc 8. Peer-Specialist-Training-Manual_CHP Pg. 43-46 9. Grievance_database_screenshot_CHP, Pg. 3 **Description of Process:** CHP has a variety of methods in place to ensure that network and affiliated providers and staff are knowledgeable about member rights and responsibilities and the requirement to uphold those rights. Both FacilityContract_2BHO and the IPN_Contract_2BHO describe providers' or facilities responsibility for upholding and respecting member rights. Providers are encouraged to post the downloadable member rights poster, located in the provider manual, in providers'	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
	offices and given to members. The ProviderManual_CHP references member rights, how members can contact an advocate if member has a grievance or how to access other OMFA services. ValueOptions/Beacon Health Options conducts face-to-face provider forums where an overview of member rights is presented. Since 2014, our major focus has been on training providers who specialize in Substance Use Disorders, as this is the first time Medicaid has covered SUD services, and most SUD providers have a great deal to lean about Medicaid. SUD_ProviderForum_Presentation_Slides61-64_2BHO was the slide presentation used in SUD provider trainings. CHP also began training peer providers who serve Members with substance use disorders in 2015. An important component of the training is Member Rights. The training was offered to peer specialists who were already working, or who were good candidates for being hired as a peer specialists. The training consisted of a face to face lecture component, homework to read the Beacon Peer Specialist Training Manual_CHP and participate in interactive sessions. The manual is posted on line at http://www.coloradohealthpartnerships.com/members/mbr-peer-training.htm . Pages 43-46 of Peer-Specialist-Training-Manual_CHP describe member rights as well as how member rights affect clinical outcomes. Participants took a test following the training.	
3. The Contractor's policies and procedures ensure that each member is treated by staff and affiliated and network providers in a manner consistent with the following specified rights: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the	CHP's policies and procedures are written in a way that ensures that members are treated consistent with the rights listed below. The rights are distributed to members in numerous ways. **Bullet Point 1:** Members are given information in accordance with the requirements stated in 42CFR438.10. 1. ScreenShot_MemberRights_CHP-Entire Document 2. ContractCompliance_AuditTool_CHP_Pg15-16 - item 1 3. Contract Compliance_Audit Results_CHP-Pg24-27	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment, and the right to a second opinion. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected. ◆ Be furnished healthcare services in accordance with requirements for access and quality of services. *42CFR438.100(b)(2) and (3)* Contract: Exhibit A—2.6.8.1	4. ProviderManual_CHP - Entire document *Misc. 5. 306LMemberMaterials_Policy_2BHO-sections Policy. A-E; II Definition. B; IV. Procedures. A. 1-4. 6. 307LMemberInfoReq_Policy_2BHO- Entire Policy 7. 304LMemberRandR_Policy_2BHO- Entire Policy **Description of Process:** Members are given information in accordance with the requirements stated in 42CFR438.10. The policy 304LMemberRandR_Policy_2BHO is the member rights policy and describes all member rights in more detail. The ScreenShot_OMFA_MemberRights_CHP, contains all of the various member rights, including policies, complaints and grievances, non-discrimination and other rights protections. CHP monitors providers and facilities related to member rights through contract compliance audits, monitoring of grievances with a specific focus on right's violation grievances. Grievance_database_screenshot_CHP shows the data entry page of the grievance data base. Page 3 of this documents shows the checkboxes for rights violations. ContractCompliance_AuditTool_CHP pages 15-17 and Contract_Compliance_AuditResults_CHP_pages 24-27 show the results of our review of CHP mental health centers and their policies on member rights. ProviderManual_CHP instructs providers about their requirement to uphold member rights, and documents that providers need to post. Finally, polices 306LMemberMaterials_Policy_2BHO and I Policy. A-E; II Definition. B; IV. Procedures. A. 1-4 describes requirements for developing and distributing member materials to make them consistent with 42CFR438.10 and policy 307LMemberInfoReq_Policy_2BHO. The entire policy describes all of the content necessary to include in member materials according to 42CFR438.10	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Bullet Point 2: Be treated with respect and with due consideration for his or her dignity and privacy 1. 304LMemberRandR_Policy_2BHO_I.Policy.A.3, 5 2. MemberHandbook_CHP - Inside cover, pages 21-27; page 19 *Misc **Description of Process:** The Members Rights and Responsibilities policy, 304LMemberRandR_Policy_2BHO I.Policy.A.3, 5, is the policy that guides our position on protecting member rights. All CHP members receive a member handbook and can request another copy at any time. MemberHandbook_CHP- The inside cover and pages 21-27; page 19 where it explains what action members can take if they feel their rights have not been respected, as well as confidentiality and how member's personal health information is protected. **Bullet Point 3:** Receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition and ability to understand. 1. 304LMemberRandR_Policy_2BHO_I.Policy.A.6, 7. 2. MemberHandbook_CHP– Page 13, 14 *Misc 3. 257LRequestfor2ndOpinion_Policy_2BHO_EntireDoc **Description of Process:** The member's rights and responsibilities policy, 304LMemberRandR_Policy_2BHO.doc – I.Policy.A.6, 7 discusses the right of members to participate in discussions with their provider(s) regarding appropriate or medically necessary treatment options. MemberHandbook_CHP– Page 13 & 14 references developing a treatment plan collaboratively, how to request alternative treatments and what to do if a member has a disability.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Bullet Point 4: Participate in decisions regarding his or her healthcare, including the right to refuse treatment, and the right to a second opinion. 1. 304LMemberRandR_Policy_2BHO_I.Policy.A.6, 7, 14, 18 2. ProviderManual_CHP-Pages 33&34 *Misc 3. Member Handbook_CHP – page 12, 13, 18 *Misc 4. ScreenShot_LevelofCareGuidelines_2BHO-Entire Document 5. ScreenShot_AchieveSolutions_2BHO-Entire Document **Description of Process:** The member's rights and responsibilities policy, 304LMemberRandR_Policy_2BHO– I.Policy.A.6, 7, 14, 18 states that members have the right to a second opinion. Member rights to a second opinion are also described in ProviderManual_CHP-Section6_SecondOpinion_Page 33&34CHP. Members' rights to a second opinion and contact information to do so are described in Member Handbook_CHP -page 12, 13 & 18. Member Handbook_CHP - pages 12, 13 & 18 describes how decisions are made about care and how a member can get copies of level of care guidelines which explains medical necessity. Members are offered easy access to level of care and clinical guidelines on line. Members can access administrative information on the provider section of the CHP website simply by opening a web page. There are no log-ins or passwords required. This only applies to administrative information. ScreenShot_LevelofCareGuidelines_CHP, which are used to help make informed care decisions. ScreenShot_AchieveSolutions_CHP is a member and provider education tool that is available to our membership and offers a variety of topics on mental health, services, help to make decisions and offers other tools that enable members to take part in their care decisions.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Bullet Point 5: Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, 1. 304LMemberRandR_Policy_2BHO-Section .I.Policy.A.19 **Description of Process:** Members rights and responsibilities policy, 304LMemberRandR_Policy_2BHO –I.Policy.A.19, defines member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion. **Bullet Point 6:** Request and receive a copy of his or her medical records and request that they be amended or corrected. 1. 304LMemberRandR_Policy_2BHO_I.Policy.A.21-27 2. Notice_of_Privacy_Practices_CHP– Entire Document 3. Notice_of_Privacy_Practices _Spanish_CHP– Entire Document 4. CO400MemberPrivacyRights_Policy_2BHO-IV.Procedures.Pg 2 Index.A.1, B.1, C.1, D.1, E.1, F.1 5. CO33_UseAndDisclosureOfPHI_2BHO_EntirePolicy 6. CO34_DesignatedRecordSet_2BHO_EntirePolicy **Description of Process:** Member rights and responsibilities policy, 304LMemberRandR_Policy_2BHO – I.Policy.A.21-27, informs members of their right to get a copy of their protected health information subject to certain limitations. Members are also informed through, Notice_of_Privacy_Practices_CHP and Notice_of_Privacy_Practices _Spanish_CHP, on how they can request to see and get copies of their medical records and make changes or additions to their record. CO400MemberPrivacyRights_2BHO; section IV.Procedure.Index.A.1, B.1, C.1, D.1, E.1, F.1.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
	These additional policies are offered to show that member rights are incorporated throughout our business operations, and as such, we do not just have one policy that describes member's rights. Member rights are addressed within a variety of policies and describe a specific right in more detail. **Bullet Point 7:** Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210) **Description of Process:** 1. 304LMemberRandR_Policy_2BHO– I.Policy, A.4, 10, 11, 12, 13, 14, 15 is the guiding policy for ensuring health care services are furnished in accordance with requirements for access and quality of services (42CFR438.206 and 42CF438.210). 2. ProviderManual_CHP-Section3 pages 12-15, pages 12-15, describes access standards for providers; that providers cannot provide different hours or a different standard of service for Medicaid members than for other clients; and requirements for routine, urgent and emergency services and follow up. 3. Member Handbook_CHP_- page 6, 8 explain access standards for mental health services. 4. ProviderDirectory_2015OCT_2BHO is also distributed to all new enrollees in hard copy format and is downloadable from the CHP websites: 5. N201_Practitioner Credentialing _Process_Policy_2BHO describes the credentialing process all providers are subject to ensure they meet the rigorous credentialing standards. Once in the network a member can select a provider by viewing online provider directory using the referral connect tool on the web site or by calling a clinical services assistant.	

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor or its providers treat the member. 42CFR438.100(c) Contract: Exhibit A—2.6.8.1	**Documents Submitted:** 1. ProviderManual_CHP - pages 98-100 2. MemberHandbook_CHP – inside cover, page 4, 21, 22, 23, 24 *Misc 3. Screenshot_OMFA_Description_RightsProtection_CHP-Entire Document 4. 304LMemberRandR_Policy_2BHO-I.Policy.A.17 **Description of Process:** The Office of Member and Family Affairs (OMFA) is tasked with the responsibility to uphold member rights without retaliation to the member. This is done through member and provider education and through the grievance process. 304LMemberRandR_Policy_2BHO I.Policy.A.17 is the guiding policy to ensure members rights and responsibilities are upheld. ProviderManual_CHP Pages 98-1002 discusses member rights and responsibilities and the importance of members being able to exercise those rights. The MemberHandbook_CHP_Inside Cover, Page 4, 21-24 explains CHP's non-discrimination value and how they can exercise their rights without retaliation through the grievance process. The landing page of the description of OMFA responsibilities identifies the tasks that OMFA staff are responsible for that are related to member rights protections as shown in Screenshot_OMFA_Description_RightsProtection_CHP. ValueOptions/Beacon Health Options recovery training encourages members to advocate for themselves.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and titles II and III of the Americans with Disabilities Act. *42CFR438.100(d)*	**Documents Submitted:** 1. 310LNonDiscrimination_Policy_2BHO – Entire policy 2. 304LMemberRandR_Policy_2BHO_I.Policy.A.4 3. MemberHandbook_CHP– inside cover *Misc 4. GrievanceMonitoring_Rights_Q1toQ42015_CHP_Pg2 5. Grievance Form_CHP-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
Contract: Exhibit A—2.6.8.1	6. Grievance Survey_CHP-Entire Document **Description of Process:** Members are informed of our non-discrimination policy in the member handbook under the listing of member rights and on inside cover of the MemberHandbook_CHP. This information is also clearly detailed in policies and procedures. 310LNonDiscrimination_Policy_2BHO and 304LMemberRandR_Policy_2BHO_I.Policy.A.4. Rights violations are monitored through the grievance process. Rights violations is one of the grievance categories in our grievance reporting system and we are able to pull a report of grievances related to member rights and take action if any is warranted. ValueOptions/Beacon Health Options nondiscrimination policy was developed based on federal regulations which address discrimination. Member may submit a grievance or violation of Rights by phone, email or by requesting a Grievance Form_CHP. Additionally, as shown in Grievance Survey_CHP, CHP will then follow-up with a survey, allowing the Member to acknowledge if they have been treated any differently, since filing their grievance.	
6. The Contractor shall post and distribute member rights to individuals, including: stakeholders, members, providers, member's families, and case workers. Contract: Exhibit A—2.6.8.2	**Documents Submitted** 1. ProviderManual_CHP-Pages 98-100 2. Member Handbook_Pages 21-22 and throughout Handbook 3. ScreenShot_MemberRights_CHP-Entire Document 4. PR_Supplemement_CHPWeb_Sect15_Eng_CHP-Entire Document 5. PR_Supplement_CHPWeb_Sect15_Span__CHP-Entire Document 6. criminal_justice_welcome_letter_CHP **7.** BHOMemberMailing_FlowChart_2BHO **Description of Process:** CHP posts member rights statements at mental health centers, provider offices and ancillary programs such as drop-in centers. CHP's partner	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IV—Member Rights and Protections		
Requirement	**Evidence as Submitted by BHO**	**Score**
	mental health centers are required to post this information and CHP has audited the public posting of rights statements in contract compliance audits. Although this requirement was not in the audit tool this last year, it was removed from the tool because the centers got scores of 100% in audits for the previous 3 years in this area. Providers are required to either post the rights statement, or give the member a copy of the statement during the intake process. Smaller independent network providers typically hand new patients a copy of the member rights statement/ member handbook. Providers are educated on Member Rights and may download printable posters, as directed in ProviderManual_CHP- Section 15_Pages 98-100 and PR_Supplemement_CHPWeb_Sect15_Eng_CHP PR_Supplement_CHPWeb_Sect15_Span_CHP. Members, Stakeholders, families, and staff at provider offices may access Member Rights from the Member Handbook, - Member Handbook_Pages 21-22 and throughout Handbook. We distribute the handbook widely, so that not only do members and providers have ready access to the handbook, stakeholders and other agencies serving Medicaid receive handbooks regularly. Also, we recently began an effort for members who become enrolled shortly before release from jail or prison. They receive a welcome letter and member handbook in one of the last meetings with their caseworker before being released to the outside. criminal_justice_welcome_letter_CHP is included along with their member handbook. They may also locate Member Rights on the CHP Website, ScreenShot_MemberRights_CHP. Case Workers, families, providers Member's and Advocate's may also reach out directly to OMFA via email to order Member or Provider supplies; BHOMemberMailing_FlowChart_PDF.	

Results for Standard IV—Member Rights and Protections							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	6	**Total Score**		=	6

Total Score ÷ Total Applicable	=	100%

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. ◆ The Contractor shall use National Committee for Quality Assurance (NCQA) credentialing and recredentialing standards and guidelines as the uniform and required standards for all contracts. Contract: Exhibit A—2.9.7.2.3.1 NCQA CR1	**Documents Submitted:** 1. N101OverviewOfNationalNetworkPolicy_2BHO-EntireDoc 2. N201PractitionerCredentialingProcess_2BHO-EntireDoc 3. N203FacilityProviderCredentialingProcess_2BHO-EntireDoc 4. N501PractitionerRecredentialingProcess_2BHO-EntireDoc 5. N502FacilityProgramClinicRecredentialingProcess_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options is a NCQA accredited CVO and carefully evaluates the credentials of each applicant seeking network participation based on uniform, objective criteria detailed in our Credentialing and Primary Source Verification processes and policies (see N101, N201, N203, N501, and N502).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, and or licensed professional counselors). *42CFR438.214(a)* NCQA CR1—Element A1	**Documents Submitted:** 1. N301DevelopmentOfCredentialingCriteria_2BHO-page 1 Section II 2. N205DisciplineSpecificCredentialingCriteriaForPractitioners_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options. maintains a network of behavioral health providers. The delegate has specific policies (see N301 and N205) and procedures that detail the types of behavioral health (non-physician) practitioners and medical practitioners it will credential.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.B. The verification sources used. NCQA CR1—Element A2	**Documents Submitted:** 1. N401PrimarySourceVerificationPolicy_2BHO-EntireDoc 2. N401ASamplePrimarySourceVerificationReport_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options requires potential and current providers to provide specific information to meet the minimal criteria for inclusion in the provider network. This information is detailed in the N401 Primary Source Verification policy and procedure and N401A sample.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.C. The criteria for credentialing and recredentialing. NCQA CR1—Element A3	**Documents Submitted:** 1. N205DisciplineSpecificCredentialingCriteriaForPractitioners_2BHO-EntireDocument 2. N206CredentialingCriteriaForFacilityOrganizationalProviders_2BHO-EntireDocument 3. N501PractitionerRecredentialingProcess_2BHO-EntireDocument 4. N502FacilityProgramClinicRecredentialingProcess_2BHO-EntireDocument **Description of Process:** As described in the attached policies (see N205, N206, N501, and N502) ValueOptions/Beacon Health Options maintains specific criteria for credentialing and recredentialing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.D. The process for making credentialing and recredentialing decisions. NCQA CR1—Element A4	**Documents Submitted:** 1. N101OverviewOfNationalNetworksPolicy_2BHO- EntireDocument 2. N201PractitionerCredentialingProcess_2BHO- EntireDocument 3. N501PractitionerRecredentialingProcess_2BHO- EntireDocument 4. N203FacilityProviderCredentialingProcess_2BHO- EntireDocument 5. N502FacilityProgramClinicRecredentialingProcess_2BHO-	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	EntireDocument 6. N601RoleOfNationalCredentialingCommittee_2BHO-EntireDocument 7. N604RoleOfLocalCredentialingCommittee_2BHO- EntireDocument **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options has policies that detail the credentialing and recredentialing decision process (see N101, N201, N501, N203, N502, N601, and N604).	
2.E. The process for managing credentialing/ recredentialing files that meet the Contractor's established criteria. NCQA CR1—Element A5	**Documents Submitted:** 1. N202OrganizationOfPractitionerCredentialingAndRecredentialinFile_2BHO-EntireDocument **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options has a policy and procedure that clearly outlines the management and organization of credentialing and recredentialing files. All of these files are maintained electronically and include a minimum set of information on all providers who submit an application to be included in the provider network (see N202).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.F. The process for delegating credentialing or recredentialing (if applicable). NCQA CR1—Element A6	**Documents Submitted:** 1. CredentialingRecredentialingDelegationPolicy_CHP-EntireDoc 2. ManagementServicesAgreement2014_CHP-EntireDoc 3. DelegationAgree2014_CHP-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	ValueOptions/Beacon Health Options (refer to CHP CredentialingRecredentialingDelegationPolicy_CHP, DelegationAgree2014, and the ManagementServicesAgreement2014_CHP).	
2.G. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes; and that it takes proactive steps to prevent and monitor discriminatory practices). NCQA CR1—Element A7	**Documents Submitted:** 1. N101OverviewOfNationalNetworksPolicy_2BHO-Page 2,3 Section V, B and C 2. BiAnnual2015NonDiscriminatoryReportSample_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policy N101 (and BiAnnual2015NonDiscriminatoryReportSample_2BHO) clearly state that credentialing and recredentialing decisions are made in a non-discriminatory manner	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: VO/Beacon policies repeatedly stated its commitment to and outlined procedures for ensuring that credentialing and recredentialing decisions are made in a nondiscriminatory manner. However, during the on-site interview, staff members clarified that one of the roles of the LCC is to review requests from providers desiring participation in the network to determine which are allowed to submit credentialing applications. Beacon had no written documents that described this preliminary process or the criteria used to make decisions.		
Required Actions: If Beacon chooses to use a preliminary process for determining which providers are allowed to submit credentialing applications, it must document the process. Documentation must include the criteria used to make determinations, any appeal rights available to providers denied applications, and the mechanisms used to ensure nondiscriminatory practices.		
2.H. The process for notifying practitioners if information obtained during the Contractor's credentialing/recredentialing process varies substantially from the information they provided to the Contractor. NCQA CR1—Element A8	**Documents Submitted:** 1. N207PractitionerRightsAndNotificationPolicy_2BHO-Page 3,SectionV.B.1. **Description of Process:** The BHO delegates credentialing and recredentialing to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policy N207 states that providers are notified within 10 calendar days if staff identify discrepancies during the credentialing or recredentialing process.	
2.I. The process for ensuring that practitioners are notified of credentialing and recredentialing decisions within 60 calendar days of the credentialing committee's decision. NCQA CR1—Element A9	**Documents Submitted:** 1. N201PractitionerCredentialingProcessPolicy_2BHO-Page4, SectionV,G2,3 2. N601RoleOfNationalCredentialingCommittee_2BHO-Page3,SectionV,F1 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policy N201 and N601states that practitioners are notified of the credentialing/recredentialing decision within 60 calendar days or within 5 business days for denial or disenrollment of the day of the date of the decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.J. The medical director or other designated physician's direct responsibility and participation in the credentialing/ recredentialing program. NCQA CR1—Element A10	**Documents Submitted:** 1. N601RoleOfNationalCredentialingCommittee_2BHO-Page3, SectionV,F1 2. N604RoleOfLocalCredentialingCommittee_2BHO-Page2,SectionV,B,C,E **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policies (N601 and N604) on the National and Local Credentialing Committees state that the Chief Medical Officer or the designated Medical Director has direct credentialing responsibilities	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/ recredentialing process. NCQA CR1—Element A11	**Documents Submitted:** 1. N409ConfidentialityOfProviderOtherCredentialingInformation_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policy N409 indicates that all information that is provider-specific in the provider's credentialing file is confidentially maintained. Furthermore, it is ValueOptions policy that any information in the provider's credentialing file will not be released without explicit consent from the provider	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty. NCQA CR1—Element A12	**Documents Submitted:** 1. N412ProviderDirectoryAndOtherEnrolleeInformation_2BHO-Page1,Section III **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policy (N412) indicates that any information listed in the provider directory comes directly from the provider credentialing database. Information in the provider credentialing database may not be altered and is quality-checked by the credentialing specialist and/or the credentialing manager.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.M. The Contractor notifies practitioners about their rights: ◆ The right to review information submitted to support their credentialing or recredentialing application. NCQA CR1—Element B1	**Documents Submitted:** 1. N207PractitionerRightsAndNotificationPolicy_2BHO-Page2,SectionV,A **Description of Process:** The BHO delegates credentialing and recredentialing to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policy N207 states that practitioners have the right to review information submitted to support their credentialing application.	
2.N. The right to correct erroneous information. NCQA CR1—Element B2	**Documents Submitted:** 1. N207PractitionerRightsAndNotificationPolicy_2BHO-Page3,SectionV.B. **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policy N207 states that practitioners have the right to correct erroneous information in their credentialing application.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.O. The right to receive the status of their credentialing or recredentialing application, upon request. NCQA CR1—Element B3	**Documents Submitted:** 1. N207PractitionerRightsAndNotificationPolicy_BHO_Page4,Section V.C **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policy N207 states that practitioners have the right to request information regarding the status of their credentialing application and be provided that information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.P. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints, and adverse events between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions. ◆ Collecting and reviewing sanctions or limitations on licensure.	**Documents Submitted:** 1. N710OngoingMonitoringOfProviderSanctions_2BHO-EntireDoc 2. SanctionReviewLog2015_2BHO-EntireDoc 3. N703InvoluntarySuspensionQualityOfCare_2BHO-EntireDoc 4. Q3.08QualityOfCareAndAdverseIncidents_2BHO –EntireDoc *Misc 5. QM4.21SentinelEventsAdverseIncidentsMajorQualityOfCareIssues AndOtherReportableIncidents_2BHO-EntireDoc	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
◆ Collecting and reviewing complaints, ◆ Collecting and reviewing information from identified adverse events. ◆ Implementing appropriate interventions when it identified instances of poor quality related to the above. NCQA CR6—Element A	6. NCCMinutes10132015Sample_2BHO-EntireDoc 7. CLCCMinutes2015JUL_2BHO-Page 2;NewIssues 8. CLCCAdvisoryForum2015MAY_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. Monitoring of sanctions, complaint and adverse events occurs locally for the initial review and recommendations (see N710, Sanction Review Log, N703, Q3.08, and QM4.21); these issues are then referred to the Local Credentialing Committee for review and on to ValueOptions/Beacon Health Options National Credentialing Committee (see NCC, CLCC Minutes and Advisory Form).	
2.Q. The range of actions available to the Contractor against the practitioner (for quality reasons). NCQA CR7—Element A1	**Documents Submitted:** 1. N701PractitioneAndProviderCompliance_2BHO-Pages2-4,SectionV 2. N703InvoluntarySuspensionQualityOfCare-2BHO-Pages3-4,SectionV,EandG 3. N705PractitionerDisenrollments_2BHO-EntireDocument **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policies detail the actions available to manage network providers who do not meet minimum standards of quality. Policy N701 details the written warning, monitoring, and consultation process. Policies N703 and N705 detail the process for involuntary suspension and disenrollment from the provider network.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
2.R. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities (including State licensing agencies for each practitioner type and the National Practitioner Data Bank [NPDB]). NCQA CR 7—Elements A2 and B	**Documents Submitted:** 1. N703InvoluntarySuspensionQualityOfCare_2BHO-EntireDocument 2. N705PractitionerDisenrollments_2BHO-Page5,SectionV,B8-9 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policies detail the actions available to manage network providers who do not meet minimum standards of quality. Included are policies that address procedures for taking action against providers and reporting those actions to the appropriate authorities. (See N703 and N705)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2.S. A well-defined appeal process for instances in which the Contractor has taken action against a practitioner for quality reasons, which includes: ◆ Providing written notification indicating that a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process. ◆ Allowing the practitioner to request a hearing and the specific time period for submitting the request. ◆ Allowing at least 30 days after the notification for the practitioner to request a hearing. ◆ Allowing the practitioner to be represented by an attorney or another person of the practitioner's choice. ◆ Appointing a hearing officer or panel of the individuals to review the appeal. ◆ Providing written notification of the appeal decision that contains the specific reasons for the decision. NCQA CR7—Elements A3and C	**Documents Submitted:** 1. N606ProviderAppealProcess_2BHO-EntireDoc 2. N607FairHearingProcess_2BHO-EntireDoc 3. VOStandardAgreement_2BHO-Page9,Section6.7 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policies detail the process available to practitioners if they choose to formally appeal decisions of the ValueOptions®' National Credentialing Committee (see N606, N607, and VO Standard Agreement).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
2.T. Making the appeal process known to practitioners. NCQA CR7—Elements A4 and C	**Documents Submitted:** 1. ProviderManual_CHP-Page51-52 *Misc. 2. VOStandardAgreement_2BHO-Page9,Section6.7 3. DisenrollmentLetter_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options process for informing practitioners of the appeal process is detailed in the Colorado Medicaid and National Provider Handbooks (ProviderManual_CHP), DisenrollmentLetter_2BHO and in the VOStandardAgreement.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
3. The Contractor designates a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners. NCQA CR2—Element A1	**Documents Submitted:** 1. N601RoleOfNationalCredentialingCommittee_2BHO-EntireDoc 2. N604RoleOfLocalCredentialingCommittee_2BHO-EntireDoc 3. NCCMinutes10132015_2BHO-Page 1 4. CLCCMinutes2015JUL_2BHO-Page1 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options uses a peer-review process via the Local Credentialing Committee and a National Credentialing Committee to make credentialing/recredentialing decisions (see N601 and N604). The committee's membership includes a range of participating providers from specific disciplines indicating a peer review process is used (see NCC and CLCC Minutes).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
4. The credentialing committee: ◆ Reviews credentials for practitioners who do not meet established thresholds. ◆ Ensures that files which meet established criteria are reviewed and approved by a medical director or designated physician. NCQA CR2—Elements A2 and A3	**Documents Submitted:** 1. N604RoleOfLocalCredentialingCommittee_2BHO-EntireDoc 2. N601RoleOfNationalCredentialingCommittee_2BHO-EntireDoc 3. NCCMinutes10132015_2BHO-Page 4-12 4. CLCCMinutes2015JUL_2BHO-Page2 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. Minutes from the National and Local Credentialing Committees reflect the review of provider credentials who do not meet minimum thresholds and that the medical director (or equally qualified designee) review/approve practitioner files (see N601 and N604).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The Contractor conducts timely verification (at credentialing) of information, using primary sources, to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification is within the prescribed time limits and includes: ◆ A current, valid license to practice (verification time limit is 180 calendar days). ◆ A valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate if applicable (effective at the time of the credentialing decision). ◆ Education and training, including board certification, if applicable (verification of the highest of graduation from medical/ professional school, residency, or board certification—board certification time limit is 180 calendar days).	**Documents Submitted:** 1. N401PrimarySourceVerificationPolicy_2BHO-EntireDoc 2. N401AsamplePrimarySourceVerificationReport_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. The attached policies and checklist detail the verification process and elements reviewed during the credentialing process (N401 and N401A).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
◆ Health professional work history—last five years (verification time limit is 365 calendar days). ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner (verification time limit is 180 calendar days). NCQA CR3—Element A		
6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation. ◆ Lack of present illegal drug use. ◆ History of loss of license and felony convictions. ◆ History of loss or limitation of privileges or disciplinary actions. ◆ Current malpractice/professional liability insurance coverage (minimums= 1/mil/1 mil). ◆ The correctness and completeness of the application. NCQA CR3—Element C Contract: 13.B.(*v*)	**Documents Submitted:** 1. N201PractitionerCredentialingProcess_2BHO-Page 3, Section V, E and G 2. N501PractitionerRecredentialingProcess_2BHO-Page 3, Section V E 3. COPractitionerAppUniform_2BHO-Page 17, Section X, Page 19, Section A, Page 20 Section C, F and G, Page 21 Section 1, Page 25 Section 3, 4, Page 26 Section 1, 2 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. It is ValueOptions/Beacon Health Options s policy that any practitioner who applies for inclusion into the Colorado Medicaid provider network must complete an application that includes a current attestation that addresses the following issues: reasons for inability to perform essential functions, lack of illegal drug use, any loss of license, any felony convictions, any loss or limitation of privileges, proof of malpractice insurance, and to the correctness/completeness of their application (See N201, N501 and COPractitionerAppUniform).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
7. The Contractor verifies the following sanction activities for initial credentialing and recredentialing: ◆ State sanctions, restrictions on licensure, or limitations on scope of practice. ◆ Medicare and Medicaid sanctions. NCQA CR3—Element B	**Documents Submitted:** 1. N401PrimarySourceVerificationPolicy_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. Per ValueOptions/Beacon Health Options policy N401 on the credentialing process, the credentialing committees receive information on provider sanctions prior to making a credentialing decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has a process to ensure that the offices of all practitioners meet its office-site standards. The organization sets standards and performance thresholds for: ◆ Physical accessibility. ◆ Physical appearance. ◆ Adequacy of waiting and examining room space. ◆ Adequacy of treatment record-keeping. NCQA CR5—Element A	**Documents Submitted:** 1. N406APractitionerSiteVisit_2BHO-EntireDoc 2. N406ABPractitionerSiteVisitTool_2BHO-EntireDoc 3. N406BFacilityOrganizationSiteVisit_2BHO-EntireDoc 4. N406BAFacilityOrganizationSiteVisitTool_2BHO-EntireDoc 5. Site_Visit_Example1_2BHO-Entire Document 6. Site_Visit_Example2_2BHO-Entire Document 7. FY2014_FINAL_ContractComplianceMonitoringTool_CHP-Page 9-11, 16 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options has policies that detail minimum standards for office space and medical record documentation criteria. In addition, ValueOptions/Beacon Health Options has policies that explain how these standards are monitored via the site review process.(See N406A, N406AB, 406B, N406BA). Moreover, ValueOptions/Beacon Health Options monitors it's providers for compliance through regular site visits. See Site_Visit_Example1_2BHO and Site_Visit_Example2_2BHO. ValueOptions/Beacon Health also	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
	monitors its providers annually through the implementation of a contract compliance audit. See FY2014_FINAL_ContractComplianceMonitoringTool_CHP. This audit includes but is not limited to auditing the Mental Heal Centers for policies and procedures surrounding compliance with the ADA as well as areas where members are seen are free from potential safety risks.	
9. The Contractor implements appropriate interventions by: ◆ Continually monitoring member complaints for all practitioner sites. ◆ Conducting site visits of offices within 60 calendar days of determining that the complaint threshold was met. ◆ Instituting actions to improve offices that do not meet thresholds. ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds. ◆ Documenting follow-up visits for offices that had subsequent deficiencies. NCQA CR5—Element B	**Documents Submitted:** 1. N406APractitionerSiteVisit_2BHO-EntireDoc 2. QualityOfPractitionerSiteReports_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options policies state that required follow-up activities are triggered by the site review process or member complaints. These policies include corrective actions and the continued monitoring of member complaints. Complaints reports are run every six months and presented to the NCC. To date, there have been no practitioner sites that meet the criteria to require a Site Visit be conducted.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
10. The Contractor formally recredentials its practitioners at least every 36 months. NCQA CR4	**Documents Submitted:** 1. N501PractitionerRecredentialingProcess_2BHO-EntireDoc 2. N502FacilityProgramClinicRecredentialingProcess_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options formally recredentials its providers every 36 months. This process utilizes information verified from primary sources and is specifically detailed in policies N501 and N502.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
Findings: VO/Beacon's policies and procedures required that all providers be recredentialed every 36 months; however, three of 10 recredentialing files reviewed on-site were approved by the NCC more than 36 months after the prior approval date.		
Required Actions: CHP must ensure that its providers are recredentialed at least every 36 months.		
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms—initially and at least every three years—that the provider is in good standing with state and federal regulatory bodies. NCQA CR8—Element A1	**Documents Submitted:** 1. N203FacilityProviderCredentialingProcess_2BHO- Page 3, Section V. I 2. N206CredentialingCriteriaForFacilityOrganizationalProviders_2BHO-Page 1, Section III, Page 2, Section IV.A 3. N502FacilityProgramClinicRecredentialingProcess_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. During the credentialing and recredentialing process, ValueOptions/Beacon Health Options staff confirms that organizational providers are in good standing with state and federal regulatory bodies (see N203, N206, and N502).	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: VO/Beacon's policies and procedures addressed the processes used for the initial and ongoing assessment of organizational providers. While the policies stated that organizations must be recredentialed at least every 36 months, two of the five organizational files reviewed on-site demonstrated that the recredentialing process had not been completed within this 36-month time frame.		
Required Actions: CHP must ensure that its organizational providers are recredentialed at least every 36 months.		

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Requirement	**Evidence Submitted by the BHO**	**Score**
11.B. The Contractor confirms—initially and at least every three years—that the provider has been reviewed and approved by an accrediting body. NCQA CR8—Element A2	**Documents Submitted:** 1. N206CredentialingCriteriaForFacilityOrganizationalProviders_2BHO-Page 2, 3 Section V. A 5 2. N502FacilityProgramClinicRecredentialingProcess_2BHO-Page 2, 3, Section V. E and F **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options credentialing/recredentialing criteria, as stated in policy N206 and N502, for organizational providers confirms whether the provider has been reviewed and approved by an accrediting body.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.C. The Contractor conducts—initially and at least every three years—an on-site quality assessment if there is no accreditation status. NCQA CR8—Element A3	**Documents Submitted:** 1. N206CredentialingCriteriaForFacilityOrganizationalProviders_2BHO-Page 2, Section V. A 5 2. N406BFacilityOrganizationSiteVisit_2BHO-EntireDoc 3. N502FacilityProgramClinicRecredentialingProcess_2BHO-Page 3, Section V. F 4. SiteVisitExample1_2BHO-Entire Doc 5. SiteVisitExample2_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. If during the credentialing/recredentialing process for organizational providers ValueOptions/Beacon Health Options is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions/Beacon Health Options conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
11.D. The Contractor's policies specify the sources used to confirm: ◆ That providers are in good standing with state and federal requirements. ◆ The provider's accreditation status. (Includes applicable state or federal agency or applicable accrediting bodies for each type of organizational provider, agent of the applicable agency/accrediting body, copies of credentials—e.g., licensure, accreditation report or letter—from the provider.) NCQA CR8—Element A, Factors 1 and 2	**Documents Submitted:** 1. N502FacilityProgramClinicRecredentialingProcess_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options credentialing/recredentialing criteria for organizational providers confirms whether the provider has been reviewed and approved by an accrediting body and confirms that the organization continues to be in good standing with state and federal regulatory bodies at minimum every 3 years. If ValueOptions/Beacon Health Options is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions/Beacon Health Options conducts an on-site assessment of the organization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11.E. The Contractor's policies and procedures include: ◆ On-site quality assessment criteria for each type of unaccredited organizational provider. ◆ A process for ensuring that that the provider credentials its practitioners. NCQA CR8—Element A, Factor 3	**Documents Submitted:** 1. N206CredentialingCriteriaForFacilityOrganizationalProviders_2BHO- Page 2, Sections V, A, 5 2. N406BAFacilityOrganizationSiteVisitTool_2BHO- Page 3, 4 Number 9 - 15 3. VOFacilityAgreement_2BHO- Page 5, Section 3.5, Page 7, section 5.2 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. ValueOptions/Beacon Health Options credentialing/recredentialing criteria for organizational providers confirms whether the provider has been reviewed and approved by an accrediting body and confirms that the organization continues to be in good standing with state and federal regulatory bodies	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
	at minimum every 3 years. If ValueOptions/Beacon Health Options is unable to confirm whether the provider has been reviewed and approved by an accrediting body, then ValueOptions/Beacon Health Options conducts an on-site assessment of the organization (see N206 and Site Visit tool N406BA). ValueOptions/Beacon Health Options Facility Agreement holds providers accountable for credentialing/recredentialing their staff (see Facility Agreement).	
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards. NCQA CR8—Element A, Factor 3	**Documents Submitted:** 1. N406BFacilityOrganizationSiteVisit_2BHO-Page 2, Section V, A and Page 4, Section V, N **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. If a provider indicates a state level or CMS review is completed, ValueOptions/Beacon Health Options reviews the site visit to ensure criteria is met and the organization passed inspection. There are no Colorado contracted facility organizations that fall into this category.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
Beacon's Facility Organization Site Visit policy stated that a CMS or State review could be accepted in lieu of a site visit as long as the results were current (the review occurred within the date range covered by the operating certificate). The policy did not specify that Beacon would confirm that the review criteria used by CMS or the State meet its own quality assessment criteria or standards. On-site record review demonstrated that CHP/Beacon exercised this right with one of the five organizations in the sample. The file included a letter from OBH that summarized the results of the review and listed the corrective actions required as a result of the review. The file did not include a copy of the assessment criteria used by OBH. The file also did not include any follow-up documentation to demonstrate that the organization completed the corrective actions.

Required Actions:
If CHP/Beacon elects to substitute a CMS or State review in lieu of a site visit, it must confirm that the criteria used by CMS or the State encompass all criteria used in its own assessment. Additionally, CHP/Beacon must ensure that the organization sufficiently addresses all corrective actions required as a result of the CMS or State review.

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Requirement	**Evidence Submitted by the BHO**	**Score**
13. The Contractor's organizational provider assessment policies and process include assessment of at least: ◆ Inpatient facilities. ◆ Residential facilities. ◆ Ambulatory facilities. NCQA CR8—Element B	**Documents Submitted:** 1. N203FacilityProviderCredentialingProcess_2BHO-EntireDoc 2. N206CredentialingCriteriaForFacilityOrganizationalProviders_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health. The ValueOptions/Beacon Health organizational site review policies and process include a review of the following facilities: inpatient, residential, and ambulatory. This information is detailed in policy N206 and N203.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor has documentation that it has assessed contracted behavioral healthcare (organizational) providers. NCQA CR8—Element C	**Documents Submitted:** 1. N203FacilityProviderCredentialingProcess_2BHO-EntireDoc 2. N206CredentialingCriteriaForFacilityOrganizationalProviders_2BHO-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health. The ValueOptions/Beacon Health organizational site review policies and process include a review of the following facilities: inpatient, residential, and ambulatory. This information is detailed in policy N206 and N203.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
15. If the Contractor delegates any NCQA-required credentialing activities, there is evidence of oversight of the delegated activities. NCQA CR9	**Documents Submitted:** 1. Credentialing and Recredentialing Delegation Policy_CHP-EntireDoc 2. DelegationAgree2014_CHP-Section: Provider Relations & Credentialing, page 13-14, 19 – 20, and Article V Corrective Action **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health (refer to Credentialing and Recredentialing Delegation Policy_CHP). In addition, the BHO has a delegation and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
	procedures that outlines the requirements of the NCQA CR 12 standards as follows: • Retains the right to approve, suspend, and terminate individual practitioners, providers, and sites. Refer to DelegationAgree2014_CHP-page 13-14 • Audits credentialing files annually against NCQA standards. Refer to DelegationAgree2014_CHP-page 13 -14 • Performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. Refer to DelegationAgree2014_CHP-page 13 -14 • Evaluates regular reports. Refer to DelegationAgree2014_CHP-page 19 - 20) The organization identifies and follows up on opportunities for improvement, if applicable. Refer to DelegationAgree2014_ CHP-page3, Article V – Corrective Action)	
16. The Contractor has a written delegation document with the delegate that: ◆ Is mutually agreed upon. ◆ Describes the delegated activities and responsibilities of the Contractor and the delegated entity. ◆ Describes the delegated activities. ◆ Requires at least semiannual reporting by the delegated entity to the Contractor. ◆ Describes the process by which the Contractor evaluates the delegated entity's performance. ◆ Describes the remedies available to the Contractor (including revocation of the delegation agreement) if the delegate does not fulfill its obligations. NCQA CR 9—Element A	**Documents Submitted:** 1. DelegationAgree2014_CHP-EntireDoc **Description of Process:** Attached are the delegation agreements for the BHO with an Amendment which describes the elements listed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence Submitted by the BHO**	**Score**
17. If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes: ◆ A list of allowed use of PHI. ◆ A description of delegate safeguards to protect the information from inappropriate use or further disclosure. ◆ A stipulation that the delegate will ensure that subdelegates have similar safeguards. ◆ A stipulation that the delegate will provide members with access to their PHI. ◆ A stipulation that the delegate will inform the Contractor if inappropriate uses of the information occur. ◆ A stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends. NCQA CR9—Element B	**Documents Submitted:** 1. ManagementServicesAgreement2014_CHP-EntireDoc (Business Associate Agreement is attached at the end of the document) 2. CredentialingandRecredentialingDelegationPolicy_CHP-EntireDoc **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options (refer to Credentialing and Recredentialing Delegation Policy_CHP). In addition, the BHO has a Management Services Agreement that outlines the requirements of the NCQA CR 12, element B.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement. NCQA CR9—Element C	**Documents Submitted:** 1. DelegationAgree2014_CHP-EntireDoc 2. MinutesCLCC2015Jan09_2BHO- Page 1 **Description of Process:** The BHO delegates credentialing and recredentialing to ValueOptions/Beacon Health Options. However the BHO retains the right to approve, suspend, and terminate individual practitioners, providers and sites. The BHO is also a voting member on the local credentialing committee (see example minutes)	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A
Findings: The July 1, 2014, delegation agreement between CHP and VO/Beacon does not specify that CHP retains the right to approve, suspend, or terminate contracts with individual practitioners, providers, and sites.		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
Required Actions: CHP must specify in its delegation agreement with VO/Beacon that it retains the right to approve, suspend, or terminate contracts with individual practitioners, providers, and sites.		
19. For delegation agreements in effect less than 12 months, the Contractor evaluated delegate capacity before the delegation document was signed. NCQA CR9—Element D	N/A in 2014/2015	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
20. For delegation agreements in effect 12 months or longer, the Contractor audits credentialing files against NCQA standards for each year that the delegation has been in effect. NCQA CR9—Element E1	**Documents Submitted:** 1. DelegationAgree2014_CHP-EntireDoc **Description of Process:** The BHO will be conducting a credentialing/recredentialing audit scheduled to take place in January of 2016. The results from the audit will be available to HSAG during the onsite audit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. For delegation arrangements in effect 12 months or longer, the Contractor performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations. NCQA CR9—Element E2	**Documents Submitted:** 1. DelegationAgree2014_CHP -EntireDoc **Description of Process:** The BHO will be conducting a credentialing/recredentialing audit scheduled to take place in January of 2016. The results from the audit will be available to HSAG during the onsite audit.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
22. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually). NCQA CR9—Element E3	**Documents Submitted:** 1. COQRTLYCREDRPT2015OCT06_2BHO-EntireDoc 2. COQRTLYCREDRPT2015APR06_2BHO-EntireDoc 3. Disenrollment2015JUL14_2BHO-EntireDoc 4. Disenrollment2015MAR30_2BHO-EntireDoc **Description of Process:** All reports are submitted as specified in the deliverables to each BHO as evidenced by emails to the BHO.	☐ Met ☐ Partially Met ☒ Not Met ☐ N/A

Standard VIII—Credentialing and Recredentialing		
Requirement	**Evidence Submitted by the BHO**	**Score**
Findings: During the on-site interview, staff stated that CHP's Class B board is responsible for oversight of delegated activities; however, CHP could not produce evidence that the board reviewed any credentialing or recredentialing reports submitted by VO/Beacon during the review period.		
Required Actions: CHP must document that it evaluates (at least semiannually) credentialing and recredentialing reports submitted by its delegate.		
23. The Contractor identified and followed up on opportunities for improvement (at least once in each of the past two years), if applicable. NCQA CR9—Element F	None to date pending audit results.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard VIII—Credentialing and Recredentialing							
Total	Met	=	39	X	1.00	=	39
	Partially Met	=	4	X	.00	=	0
	Not Met	=	2	X	.00	=	0
	N/A	=	1	X	NA	=	0
Total Applicable		=	45	**Total Score**		=	39

Total Score ÷ Total Applicable	=	87%

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program for services it furnishes to its members. 42CFR438.*240(a)* Contract: Exhibit A—2.8.1	**Documents Submitted:** 1. QM Delegation Policy_CHP – Entire Policy 2. 2016_QualityManagementProgramDescription_ CHP – Entire Document 3. FY16_QMUMWorkPlan_Final_CHP-Entire Document 4. OCT2015 Class B Minutes_CHP-Page 2 5. Minutes_CAUMC-QISCMeetingMinutes_2015SEP11_CHP-Page 2 6. WorkPlan_Review_ScreenShot_CHP-Entire Document **Description of Process:** CHP delegates all quality management functions to ValueOptions/Beacon Health Options (QMDelegationPolicy_CHP). ValueOptions/Beacon Health Options, along with the CHP Quality Improvement Steering Committee /Clinical/Utilization Management Committee (QISC/CAUMC) develops an annual Program Description and Work Plan (2016_QualityManagementProgramDescription_ CHP, FY16_QMUMWorkPlan_Final) which details the planned quality improvement activities for the fiscal year. The annual plan is reviewed and approved by CHP's QISC/CAUMC (Minutes_CAUMC-QISCMeetingMinutes_2015SEP11_CHP) and the Class B Board (OCT2015 Class B Minutes_CHP). The QISC/CAUMC committee meets monthly to discuss progress made towards performance improvement, the QM/UM Work Plan goals (WorkPlan_Review_ScreenShot_CHP) and other quality related activities.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
2. The Contractor's QAPI Program includes mechanisms to detect both underutilization and overutilization of services. *42CFR438.240(b)(3)* Contract: Exhibit A—2.8.5.1.1.2	**Documents Submitted:** 1. 2016_QualityManagementProgramDescription_ CHP -Pages 14, 15, 24, 27, 48 and 53 2. FY15_ QMUMAnnualEval_CHP –page 5 3. FY15Q3_TOP5DX_2015APR23_CHP-Entire Document 4. Minutes_CAUMC-QISC_2015JUL10_CHP-Page 7 5. Q3_FY15_ALL_BHO_PI_CHP-Entire Document 6. IPN SUMMARY--JULY 2015_CHP-Entire Document 7. Minutes_CAUMC-QISCMeetingMinutes_2015SEP11_CHP-Page 3 8. PerformanceGoals_LastThreeQuarters_CHP-Entire Document **Description of Process:** ValueOptions/Beacon Health Options ensures mechanisms are in place to detect and evaluate both over-and under-utilization, as noted in the 2016_QualityManagementProgramDescription_ CHP as well as the QMUMAnnualEvaluation_FY12_CHP. Mechanisms in place to monitor both over- and under-utilization include: the FY15Q3_TOP5DX_2015APR23_CHP report, and the Q3_FY15_ALL_BHO_PI_CHP report. FY15Q3_TOP5DX_2015APR23_CHP report is a tool which allows for the comparison of IPN and MHC services for the same diagnosis. The Q3_FY15_ALL_BHO_PI_CHP report examines utilization of ER visits, Average Length of Stay (ALOS) as well as Discharges per 1,000 members. This report is reviewed in the QISC/CAUMC meeting quarterly (Minutes_CAUMC-QISC_2015JUL10_CHP). Furthermore, IPN SUMMARY--JULY 2015_CHP is reviewed quarterly at the QISC/CAUMC meeting (Minutes_CAUMC-QISCMeetingMinutes_2015SEP11_CHP) in order to evaluate potential IPN over- and under-utilization. Furthermore, the QISC/CAUMC reviews provider performance in the areas of hospital readmissions,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	seven and thirty day post-discharge follow up, average length of hospital stay, inpatient utilization as well as ER visits through the review of PerformanceGoals_LastThreeQuarters_CHP.	
3. The Contractor's QAPI Program includes mechanisms to assess the quality and appropriateness of care furnished to members. *42CFR438.240(b)(4)* Contract: Exhibit A—2.8.5.1.1.3	**Documents Submitted:** 1. Q3.08QualityOfCareAndAdverseIncidents_2BHO – Entire Policy *Misc 2. QM16.16CO-A_Addendum_prev4.03(legacy320)_ProviderTreatmentRecordReviewandAuditProcess_CHP-Entire Policy 3. Provider_TreatmentRecordReviewAnalysisandReporting_Attachment A_SC_QM CHP-Entire Document 4. Provider_TreatmentRecordReviewAnalysisandReporting_Attachment B_2015_SC_QM CHP-Entire Document 5. 2016_QualityManagementProgramDescription_ CHP –Pages-7,14,15,33,36,38 & 53 6. FY15_QMUMAnnualEval_CHP – Pages 5 and 19 7. Q2FY15_ResultsReport _2015Apr07_QM_CHP - Entire Document 8. TrendingRpt_AuditResults_FY12-13-14_CHP-Entire Document 9. ADVINCSUMMARY_FY15_CHP- Entire document 10. QM4.20CO-A_addendum_prev3.09(legacyQ316)_Quality of Care Issues_Outlier Practice Patterns_CHP- Entire Policy 11. QM4.20CO-A_attachment B_QualityofCare_WeightingOfRisk_CHP-Entire Document 12. 2014 Colorado Factfinders by CMHC_CHP-Page 1 13. Complaints_Q3FY14toQ2FY15_CHP-Entire Document **Description of Process:** ValueOptions/Beacon Health Options uses several instruments to assess the quality and appropriateness of care provided to all members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Policy Q3.08QualityOfCareAndAdverseIncidents_2BHO establishes that the Colorado Engagement Center (EC) will, "thoroughly investigate, review and respond appropriately to all reported potential quality of care and adverse incidents using the quality improvement process at each mental health center or external provider, with assistance from the EC Medical, Clinical or Quality Director as appropriate. This includes investigation, follow-up, and tracking consistent with the circumstances of the event, patient/member safety, and potential liability issues." Furthermore, policy QM16.16CO-A_Addendum_prev4.03(legacy320)_ProviderTreatmentRecordReviewandAuditProcess_CHP and QM4.20CO-A_addendum_prev3.09(legacyQ316)_Quality of Care Issues_Outlier Practice Patterns_CHP. These instruments include conducting regular clinical chart audits as represented in Q2FY15_ResultsReport_ 2015Apr07_QM_CHP as well as monitoring access to care standards, member satisfaction, adverse incidents and member complaints through the TrendingRpt_AuditResults_FY12-13-14_CHP. Guidelines for treatment record documentation audits can be found in, Provider_TreatmentRecordReviewAnalysisandReporting_Attachment A_SC_QM CHP and the guidelines for treatment record compliance audit follow up actions are listed in, Provider_TreatmentRecordReviewAnalysisandReporting_Attachment B_2015_SC_QM CHP In addition, adverse incidents are monitored through the ADVINCSUMMARY_FY15_CHP report. The 2016_QualityManagementProgramDescription_ CHP, the FY15_QMUMAnnualEval_CHP, QM4.20CO-A_attachment B_QualityofCare_WeightingOfRisk_CHP along with the policies listed above; provide information regarding the instruments used in order to assess quality and appropriateness of care for members.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	The document titled, Complaints_Q3FY14toQ2FY15_CHP demonstrates where the program monitors and trends complaints and grievances by category for the fiscal year. Finally, the 2014 Colorado Factfinders by CMHC_CHP demonstrates how the quality program evaluates satisfaction with care.	
4. The Contractor shall monitor its providers' performances on an ongoing basis and hold them accountable to a formal review according to a periodic schedule. Contract: Exhibit A—2.8.2	**Documents Submitted:** 1. AspenPointe_068797_2015SPT16_CHP-Entire Document 2. Crest_757244_results_CHP-Entire Document 3. AccessToCare_Q4FY15_CHP-Entire Document 4. 2015 411 Audit Summary Report of the CHP Response Data File_CHP-Entire Document 5. Minutes_CAUMC-QISC_2015MAY08_CHP-Page 4 6. PerformanceMeasures_BenchmarkReport_Q3FY15_CHP- Entire Document 7. Intake_to_1st_Follow_Up_CHP-Entire Document 8. 2015CAPEducationLtr_AspenPt_2015May21_CHP Entire Document 9. 411 Audit CAP response – 2015_CHP-Entire Document 10. Q4.04_Provider Performance Monitoring_2BHO-Entire Policy 11. QM_403b_attachment_SUD Audit Process_2BHO-Entire Document 12. SUD Audit Process-2BHO-Entire Document **Description of Process:** ValueOptions/Beacon Health Options monitors provider performance as described in (Q4.04_Provider Performance Monitoring_2BHO). The documents noted below are examples of documents used in the provider monitoring process. As indicated in the policy, provider performance is assessed at least every three years, and a letter summarizing the provider's performance is sent to the provider. The provider is invited to contact us with questions, or to obtain further	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	information. AccessToCare_Q4FY15_CHP, 2015 411 Audit Summary Report of the CHP Response Data File_CHP, the PerformanceMeasures_BenchmarkReport_Q3FY15_CHP, the 2015CAPEducationLtr_AspenPt_2015May21_CHP, the 411 Audit CAP response – 2015_CHP, and the Intake_to_1st_Follow_Up_CHP report. In addition, the documents titled, QM_403b_attachment_SUD Audit Process_ 2BHO and SUD Audit Process-2BHO demonstrate the audit process for the audits of SUD providers. The QISC/CAUMC committee reviews results of these monitoring activities and initiatives. (Minutes_CAUMC-QISC_2015MAY08_CHP-Page 4). Additional evidence of formal provider monitoring includes: AspenPointe_068797_2015SPT16 and the Crest_757244_results_CHP. The letters contain specific information summarizing the results of various monitoring activities. The ultimate goal is to create an online dashboard where providers can access their individual scores to better understand their own performance. A centralized data repository is being created to allow QM staff to gather provider performance results and measures for metric comparisons across providers. This would result from the creation of a SQL Server database and thirteen (13) internal web-based free text forms. This structure will allow for data entry and a centralized database for individual provider monitoring results, scores and measures.	
5. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program on at least an annual basis. The annual quality report describes: ◆ The Contractor's performance on the standard measures on which it is required to report. ◆ The results of each performance improvement project.	**Documents Submitted:** 1. 2016_QualityManagementProgramDescription_ CHP- Page 53-54 2. FY15_ QMUMAnnualEval_CHP-Pages 1-24 3. Minutes_CAUMC-QISCMeetingMinutes_2015SEP11_CHP-Page 2 4. OCT2015 Class B Minutes_CHP-Page 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
◆ The Contractor's detailed findings of program effectiveness. *42CFR438.240(e)(1) and (2)* Contract: Exhibit A—2.8.5.2; 2.8.6.1; 2.8.14	**Description of Process:** ValueOptions/Beacon Health Options and the CHP QISC/CAUMC conduct an annual evaluation of the Quality Management Program that includes evaluating the effectiveness and impact of the Quality program. Results of the evaluation are documented in the annual report (FY15_ QMUMAnnualEval_CHP) and reviewed annually by QISC/CAUMC (Minutes_CAUMC-QISCMeetingMinutes_2015SEP11_CHP) as well as the Class B Board (OCT2015 Class B Minutes_CHP-Page 2). The 2016_QualityManagementProgramDescription_ CHP details the evaluation process and requirements.	
6. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field. ◆ Consider the needs of the Contractor's members. ◆ Are adopted in consultation with contracting healthcare professionals. ◆ Are reviewed and updated periodically as appropriate. *42CFR438.236(b)* Contract: Exhibit A—2.8.4.1	**Documents Submitted:** 1. 104L Developing and Updating Clinical Criteria LOC Guidelines_2BHO-Entire Document 2. 105L Developing and Updating Treatment Guidelines_2BHO - Entire Document **Description of Process:** Policies 104L Developing and Updating Clinical Criteria LOC Guidelines and 105L Developing and Updating Treatment Guidelines, listed above, fully describe the process for developing, updating, and adopting level of care and treatment guidelines.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
7. The Contractor disseminates the guidelines to all affected providers, and upon request, to members, potential members, and the public, at no cost. *42CFR438.236(c)* Contract: Exhibit A—2.6.7.9.1; 2.8.4.1	**Documents Submitted:** 1. 236LDistributionofClinicalLevelofCareGuidelinesPolicy_2BHO-Entire Document 2. ProviderManual_CHP-Page 41 *Misc 3. CHP BHO website—see link below 4. Clinical_Guidelines_CHPWebsite_ScreenShot_CHP-Entire Document 5. 20150515_provider newsletter_CHP-Page-4	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	6. 20150115_provider newsletter_CHP-Page-5-6 7. Notice of Action Standard- Not Mtg Med Nec Form_2013Sept03_CHP-Page 2 8. 5141.9.02 Survey Scores (Individual Summary)_Clinical_2BHO-Entire Document 9. MemberHandbook_CHP-Page 13*Misc 10. ClassB_Apr_Jun_Jul_minutes_2015_CHP-Pages 3, 9 & 13 11. Acute Inpatient Treatment-LOC_2BHO-Entire Document 12. Acute Treatment Unit Services-LOC_2BHO-Entire Document 13. ADULT RESIDENTIAL TREATMENT SERVICES-LOC_2BHO-Entire Document 14. alternative family care-LOC_2BHO-Entire Document 15. alternative_outpatient_services-LOC_2BHO-Entire Document 16. Case Management-LOC_2BHO-Entire Document 17. child_adol_day treatment_services-LOC_2BHO-Entire Document 18. community_support_programs-LOC_2BHO-Entire Document 19. Crisis Stabilization Unit-LOC_2BHO-Entire Document 20. intensive_outpatient_programs_adult-LOC_2BHO-Entire Document 21. OUTPATIENT SUBSTANCE USE COUNSELING SERVICES-LOC_2BHO-Entire Document 22. outpatient_crisis_services-LOC_2BHO-Entire Document 23. outpatient_services-LOC_2BHO-Entire Document 24. PARTIAL HOSPITALIZATION-LOC_2BHO-Entire Document 25. practice_parameters_child_less_five-LOC_2BHO-Entire Document 26. PSYCHOLOGICAL AND NEUROPSYCHOLOGICAL TESTING-LOC_2BHO-Entire Document 27. Residential Treatment for Children and Adolescents-LOC_2BHO-Entire Document 28. RESPITE CARE SERVICES-LOC_2BHO-Entire Document 29. SUBSTANCE USE DISORDER SOCIAL DETOXIFICATION SERVICES-LOC_2BHO-Entire Document	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	30. SUBSTANCE USE INTENSIVE OUTPATIENT PROGRAM-LOC_2BHO-Entire Document 31. SUD LABORATORY MONITORING-LOC_2BHO-Entire Document 32. wraparound_services-LOC_2BHO-Entire Document 33. ColoradoWelcomeLetter_2BHO-Page 1 34. AuthRequirementsCrisisServicesEmailBlast_2BHO-Entire Document 35. AuthRequirementsOPServicesEmailBlast_2BHO-Entire Document 36. SCALetterFacilities_2BHO-Page 2, Number 11 37. SCALetterPractitioner_2BHO-Page 2 **Description of Process:** 236LDistributionofClinicalLevelofCareGuidelinesPolicy_2BHO addresses this requirement. The entire policy is applicable. The guidelines (numbers 13-34 above) are reviewed annually and revised as necessary. Members, guardians, potential members, providers, and the public have access to these guidelines on the BHO website at no cost (see link below as well as ProviderManual_CHP and Clinical_Guidelines_CHPWebsite_ScreenShot_CHP). Members are informed about the guidelines through the Member Handbook_CHP and through the NOA process, if applicable (see Notice of Action Standard-Not Mtg Med Nec Form_2013Sept03_CHP). http://www.coloradohealthpartnerships.com/provider/prv_clin_gd.htm ValueOptions/Beacon Health Options informs any and all providers rendering care to its members to ensure providers are informed and kept current about guidelines and guideline changes. (20150515_provider	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	newsletter_CHP and 20150115_provider newsletter_CHP). Contracted network providers are informed initially in there ColoradoWelcomeLetter_2BHO and in the ProviderManual_CHP. Throughout the year trainings and one-on-one education is conducted as well as provider communication given to providers through email. (AuthRequirementsCrisisServicesEmailBlast and AuthRequirementsOPServicesEmailBlast). Single Case Agreement (SCA) providers are informed in their SCALetterFacilities and SCALetterPractitioner and through the ProviderManual_CHP. The application of LOC criteria is a routine part of case presentations during clinical rounds. Care management staff are tested annually {5141.9.02 Survey Scores (Individual Summary)_Clinical_2BHO} to assess their consistency in applying the LOC criteria in UM determinations. LOC guidelines are approved at the Class B Board Meetings. (ClassB_Apr_Jun_Jul_minutes_2015_CHP)	
8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* Contract: Exhibit A— 2.8.4.1	**Documents Submitted:** 1. 104L Developing and Updating Clinical Criteria/LOC Guidelines_2BHO Section IV, Procedures, Pages 1-2. 2. 105L Developing and Updating Treatment Guidelines_2BHO-Section IV, Procedures, Pages 2-4. 3. QMDelegationPolicy_CHP- Entire policy 4. Clinical_Guidelines_CHPWebsite_ScreenShot_CHP-Entire Document 5. Notice of Action Standard- Not Mtg Med Nec Form_2013Sept03_CHP-Page 2 6. 5141.9.02 Survey Scores (Individual Summary)_Clinical_2BHO-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	7. MemberHandbook_CHP-Page 13*Misc **Description of Process:** In Policy 105L Developing and Updating Treatment Guidelines and Policy 104L Developing and Updating Clinical Criteria/LOC Criteria, it is noted that relevant utilization management criteria, member education materials, benefit interpretations and practitioner communications are considered by Value Options/Beacon Health Options when guidelines are developed or revised to help foster consistency to these areas affected by the guidelines. As seen in the CHP QM Delegation Policy _CHP, CHP delegates all quality management functions to Value Options/Beacon Health Options. All LOC guidelines are reviewed annually by the CHP QI-UM Committee, and then referred to the Board for approval. Diagnosis-based treatment guidelines are reviewed and reapproved through a Value Options/Beacon Health Options National process at least every two years. These treatment guidelines are updated on the BHO website (Clinical_Guidelines_CHPWebsite_ScreenShot_CHP), but only require re-approval by the QI-UM Committee and Board when there are significant changes to the guideline's content. Care management staff are provided training regarding use of the guidelines during their initial orientation, when new LOC criteria are developed, or when the LOC criteria are substantially revised. The application of LOC criteria is a routine part of case presentations during clinical rounds. Care management staff are tested annually (5141.9.02 Survey Scores (Individual Summary)_Clinical_2BHO) to assess their consistency in applying the LOC criteria in UM determinations. Members have access to treatment guidelines and LOC Criteria through the BHO's website:	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	http://www.coloradohealthpartnerships.com/provider/prv_clin_gd.htm. They also are informed about these guidelines through the Member Handbook_CHP and through the Notice of Action process, when requested services are denied (Notice of Action Standard- Not Mtg Med Nec Form_2013Sept03_CHP)	
9. The Contractor monitors member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided. Contract: Exhibit A—2.8.9.1	**Documents Submitted:** 1. Minutes_CAUMC-QISC_2015FEB06_ECHO_CHP–Page 3 2. ECHO correlations_CHP-Entire Document 3. ECHOreport2014byMHC_report_CHP-Entire Document 4. Minutes_CAUMC-QISC_2015JUL10_CHP-Page 6 5. PerformanceMeasures_BenchmarkReport_Q3FY15_CHP-Entire Document 6. TRENDINGREPORT_QRT4FY15_Final_2015July30_CHP- Entire Document 7. QISC_CAUMC_Minutes_October_CHP-Page 4 **Description of Process:** CHP monitors perceptions of well-being and functional status as well as accessibility and adequacy of services through review of the ECHO Survey (ECHO correlations and ECHOreport2014byMHC_report) by the QISC/CAUMC (Minutes_CAUMC-QISC_2015FEB06_ECHO_CHP). This survey is relatively new, taking the place of the MHSIP/YSSF survey. These reports are reviewed for trends within the BHO as well as comparisons across BHO's. CHP also uses the PerformanceMeasures_BenchmarkReport_Q3FY15_CHP and the TRENDINGREPORT_QRT4FY15_Final_2015July30_CHP in order to address member perceptions of well-being and functional status, as well as accessibility and adequacy of services provided. See Minutes_CAUMC-QISC_2015JUL10_CHP and QISC_CAUMC_Minutes_October_CHP for details of the discussions held at the QISC/CAUMC meeting.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
10. The Contractor investigates, analyzes, tracks, and trends quality of care (QOC) concerns. (Client complaints about care are not quality of care concerns under this section.) When a quality of care concern is raised, the Contractor: ◆ Investigates the QOC issue(s). ◆ Conducts follow-up with the member to determine if the immediate healthcare needs are being met. ◆ Sends a resolution letter to the originator of the QOC concern. ◆ Refers QOC issues to the Contractor's peer review committee, when appropriate. ◆ Refers the QOC issue to the appropriate regulatory agency, or licensing board or agency, when appropriate. ◆ Documents the incident in a QOC file that includes a description of the QOC concern, steps taken in the QOC investigation, corrective action(s) implemented, and any referrals to peer review or a regulatory agency. Contract: Exhibit A—2.8.10.2	**Documents Submitted:** 1. Q3.08QualityOfCareAndAdverseIncidents_2BHO *Misc 2. ADVINCSUMMARY_FY15_CHP- Entire document 3. QOC_ResolutionLtr_CHP – Entire Document 4. QOC_AcknowlLtr_CHP – Entire Document 5. QOC trend report 2013 and 2014_CHP-Entire Document 6. QOCC_Minutes_FINAL_BHO_2015MAY15_CHP-Entire Document 7. QOCInvestigationDoc_CHP – Entire Document 8. QOC Resulting from AI_CHP– Entire Document 9. CAP Request Letter_CHP– Entire Document 10. QM4.20CO-A_addendum_prev3.09(legacyQ316)_Quality of Care Issues_Outlier Practice Patterns_CHP- Entire Policy 11. QM4.20CO-A_attachment B_QualityofCare_WeightingOfRisk_CHP-Entire Document **Description of Process:** ValueOptions/Beacon Health Options has a process for investigating, analyzing, tracking and trending quality of care concerns (ADVINCSUMMARY_FY15_CHP). The process is detailed in the quality of care policies listed above (Q3.08QualityOfCareAndAdverseIncidents_2BHO) and (QM4.20CO-A_addendum_prev3.09(legacyQ316)_Quality of Care Issues_Outlier Practice Patterns_CHP.) Investigations are completed on reported adverse incidents that are classified as major or sentinel events; if a potential quality of care issue is identified during the investigation of an adverse incident, it is documented as a quality of care issue as well. Reported quality of care concerns are investigated and reviewed by the Quality of Care Committee (QOCC) for investigational review and disposition. The document titled QOCC_Minutes_FINAL_BHO_2015MAY15_CHP provides a summary of each CHP QOC issue and subsequent	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	investigation to date that was included for Committee review in the May 2015 QOCC. An example of a quality of care investigation (QOCInvestigationDoc_CHP), and a quality of care trend report (QOC trend report 2013 and 2014_CHP) are also included for review, as noted above. As indicated in the Quality of Care (QOC) Issues Policy, an acknowledgement letter is sent (QOC_AcknowlLtr_CHP), and an investigation completed (QOCInvestigationDoc_CHP). Upon receipt, each QOC issue is evaluated to determine the urgency of the issue and assess immediate follow-up actions to assure well-being of the member. Since adverse incidents may also be quality of care issues, all adverse incidents are evaluated upon receipt to determine whether there are any urgent safety issues (QOC Resulting from AI_CHP) to be addressed – noted in the Critical/Adverse Incident Policy listed above (Q3.08QualityOfCareAndAdverseIncidents_2BHO). The QOCC reviews the results of the investigation and makes a determination as to whether the investigation has identified a quality of care issue, and provides direction as to the appropriate follow-up, which may include obtaining more information, developing and monitoring a corrective action, etc. (CAP Request Letter_CHP and QOC_ResolutionLtr_CHP)	
11. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data. *42CFR438.242(a)* Contract: Exhibit A—2.8.12.1	**Documents Submitted:** 1. ITDelegationPolicy_CHP-Entire Document 2. HealthInfoSystemFlow_2BHO-Entire Document 3. Combined_Data_Report_Card_June_2015_2BHO-Entrie Document **Description of Process:** CHP delegates the information technology and health information systems processing to ValueOptions/Beacon Health Options (please refer ITDelegationPolicy_CHP). ValueOptions® health information systems	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	(HealthInfoSystemFlow_2BHO) depictes how the system captures data including, but not limited to: authorizations, claims, eligibility, provider networks, and encounters. This information is synchronized with a Data Warehouse, a machine optimized for reporting and analysis. This information is also used to generate data extracts and create reports to support the BHO's operations. The Combined_Data_Report_Card_June_2015_2BHO demonstrates how data that is received is turned into a useable report.	
12. The Contractor's health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, third party liability, and disenrollments for other than loss of Medicaid eligibility. *42CFR438.242(a)* Contract: Exhibit A—2.8.12.1	**Documents Submitted:** 1. UtilizationPaidClaimsAnalysis_CHP-Entire Document 2. GrievanceAndAppeals_CHP-Entire Document 3. GrievanceSummaryReport_CHP-Entire Document 4. Combined_Data_Report_Card_June_2015_2BHO-Entire Document **Description of Process:** The ValueOptions/Beacon Health Options health information system is structured to provide data for reporting utilization (see UtilizationPaidClaimsAnalysis201112_CHP), grievance, and appeal data (see GrievanceAndAppeals_2BHO and GrievanceSummaryReport_2BHO). The ValueOptions/Beacon Health Options information system has the ability to check the place of service for encounters submitted – for certain locations such as jails or correctional facilities for adults, ValueOptions/Beacon Health Options is able to identify temporary loss of Medicaid eligibility and prevent those encounters from being submitted to the State (see the following errors in the Combined_Data_Report_Card_June_2015_2BHO, Error Summary Tab): • 50: Adult in correctional facility is NOT eligible for Medicaid services. • 57: Place of service not consistent with USCM procedure specification.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Information on dis-enrollments for other than loss of Medicaid eligibility is provided by HCPF, such as the date of death report. Please note that the "Date of Death" reports are large in size and contain PHI – they are available upon request, but not submitted as evidence.	
13. The Contractor collects data on member and provider characteristics and on services furnished to members (through an encounter data system). *42CFR438.242(b)(1)* Contract: Exhibit A—2.9.4.1	**Documents Submitted:** 1. EncounterTableStructure_2BHO-Entire Document 2. EncounterReferenceTables_20150918_2BHO-Entire Document **Description of Process:** Data collected on member and provider characteristics and on services furnished to members is stored in local Data Warehouse in the Encounter Tables. Data is received from State, CMH's and VO Claims System is processed through VO Encounter System and stored in Data Warehouse. The EncounterTableStructure_2BHO file shows the Encounter table structure and all the data collected on member and provider characteristics and services furnished. EncounterReferenceTables_20150918_2BHO shows the descriptions of the fields in the Encounter database.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
14. The Contractor's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. *42CFR438.242(b)(2)* Contract: Exhibit A—2.9.4.1.2; 2.9.3.7; 2.9.3.8	**Documents Submitted:** 1. ListOfEditsPerformedAgainstClaimsAndEncounters_2BHO-Entire Document 2. xx201506_LOG_2BHO-Entire Document 3. xx201506_ERR_2BHO-Entire Document 4. xx201506_DUP_2BHO-Entire Document 5. xx201506_MOD_2BHO-Entire Document 6. xx_duplicates_hold_inventory_2BHO-Entire Document 7. xx_eligibility_hold_inventory_2BHO-Entire Document 8. VO_FlatFileLayout_2BHO-Entire Document 9. Combined_Data_Report_Card_June_2015_2BHO-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: The accuracy and completeness of data is assessed at reception/load time and feedback is sent to the submitter (for each submission) in the form of multiple log files: **xx201506_LOG:** A detailed accounting of each record that had an error (or warning). The end of the LOG file includes a summary, by error type and frequency. **xx201506_ERR_2BHO:** A file containing only key elements of failed records; this allows submitters the ability to focus on errors and identify if a trend exists which could be resolved at a procedural level, rather than on a line-by-line basis. **xx201506_DUP_2BHO:** A file containing records from the submission that appear to be duplicates. This file shows which previous records where accepted (an in what file) as well as the duplicate record that is being withheld from the current submission. A summary of duplicates detected appears at the end of the report. **xx201506_MOD_2BHO:** The selection of procedure modifiers is an important method of conveying to the State the special circumstances under which the service was provided. To help he submitter verify that the procedure modifier selected was the correct one, this file offers a line-by-line accounting of key properties of the record and the selected modifier. **xx_duplicates_hold_inventory_2BHO:** A complete account of ALL records that have been held from the submitter for being a duplicate. The first part of the report shows which records are held, and the previously-submitted records which rendered it a duplicate. The second part of the report shows a summary of duplicate records, total units and total charges, by submission. The last part of the report show the complete total by count, total units and total charges. **xx_eligibility_hold_inventory_2BHO:**	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	A complete list of all records that have been held for eligibility reasons. Eligibility is based on the date of service being between the effective and expiration dates of at least one(1) eligibility record received from the State. Records which fail this test are reported back to the submitter here. As this is a historical file, the first part is every record in order of Medicaid ID and Service Date. The second part is an aggregate by member, in descending order by total charges (the ones at the top of the list are worth more if resolved, as they tie up more funds). The last part of the report shows the total number of records, units and charges that are held for failing eligibility. Standardizing the collection of encounter data is addressed by employing the State of Colorado's Uniform Service Coding Manual (available on site), which not only describes the standard layout for submitting encounters (pages 264-276), but also clearly specifies the necessary and required attributed of all encounters submitted to the State, by procedure code (pages 35-197). ValueOptions/Beacon Health Options uses the Uniform Service Coding Manual to augment existing edits for claims and encounters, resulting in early detection/reporting and holding of unacceptable records. A list of edits performed on claims and encounters is included as demonstrated in ListOfEditsPerformedAgainstClaimsAndEncounters_2BHO. The accuracy and timeliness of submitted data is best viewed through the use of the monthly Data Report Cards (Combined_Data_Report_Card_June_2015_2BHO). The tabs in this document show overall error trends in both a chart and a spreadsheet. A reconciliation tab allows for in-depth exploration of the data submitted, its disposition/status and aggregate values. A timeliness tab shows when the submissions were sent to VO-CO, when they were processed, and when data from that file was sent to the State. A color-coding scheme is used to convey early, on-time or late submission.	

Standard X—Quality Assessment and Performance Improvement		
Requirement	**Evidence as Submitted by BHO**	**Score**
	All submitters are using standardized formats; for submitters of encounters, the VO-CO Flat File format (VO_FlatFileLayout_2BHO) is being used. For claim, both UB-04 and CMS-1500 forms are used. These standardized formats allow submitters and VO-CO staff to leverage their knowledge across multiple MHCs and enhancements that are implemented for one can be shared by all.	

Results for Standard X—Quality Assessment and Performance Improvement							
Total	Met	=	14	X	1.00	=	14
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	N/A	=	0	X	NA	=	0
Total Applicable		=	14	**Total Score**		=	14

Total Score ÷ Total Applicable	=	100%

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

The completed record review tools follow this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Credentialing Record Review Tool
for Colorado Health Partnership, LLC

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	January 11–12, 2016
Reviewer:	Kathy Bartilotta
Participating Plan Staff Member:	Alyssa Rose

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	*****	*****	*****	*****	*****	*****	*****	*****	*****	*****
Provider Type (MD, PhD, NP, PA, MSW)	MD	MD	LPC	LPC	LCSW	LPC	MD	LPC	PhD	LCSW
Application/Attestation Date	02/11/14	12/23/13	07/07/14	05/07/15	01/12/15	04/19/14	05/01/14	01/06/13	12/11/14	04/13/14
Credentialing Date (Committee/Medical Director Approval Date)	05/13/2014	03/25/2014	07/29/2014	06/02/2015	02/10/2015	07/22/2014	07/08/2014	05/21/2013	04/21/2015	08/12/2014
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☒ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒
◆ Education and training, including board certification (if the practitioner states on the application that he or she is board certified)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Work history	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in required amount	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider credentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
# Applicable elements	**9**	**9**	**8**	**8**	**8**	**8**	**9**	**8**	**8**	**8**
# Compliant elements	**9**	**9**	**8**	**8**	**8**	**8**	**9**	**8**	**8**	**8**
Percentage compliant	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Total Record Review Score					**Total Applicable: 83**	**Total Compliant: 83**	**Total Percentage: 100%**

Comments:

Appendix B. Colorado Department of Health Care Policy & Financing
2015–2016 Recredentialing Record Review Tool
for Colorado Health Partnerships, LLC

Review Period:	January 1, 2015–December 31, 2015
Date of Review:	January 11–12, 2016
Reviewer:	Rachel Henrichs
Participating Plan Staff Member:	Alyssa Rose

SAMPLE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Provider ID#	*****	*****		*****	*****	*****		*****	*****	*****
Provider Type (MD, PhD, NP, PA, MSW)	LCSW	PsyD		MD	LPC	LCSW		LMFT	LPC	LPC
Application/Attestation Date	11/15/14	01/14/14		12/30/13	09/27/13	02/22/15		07/18/13	06/10/14	01/16/15
Last Credentialing/Recredentialing Date	04/17/12	05/16/11		05/16/11	02/22/11	04/17/12		12/14/10	10/04/11	06/12/12
Recredentialing Date (Committee/Medical Director Approval Date)	04/28/2015	05/13/2014		05/13/2014	12/17/2013	05/26/2015		03/18/2014	10/14/2014	08/18/2015
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☒
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☒ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☒	Y☒ N☐ NA☐
◆ History of professional liability claims	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Signed application and attestation	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☒ N☐
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☒ N☐	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☒ N☐	Y☐ N☒	Y☐ N☐	Y☐ N☒	Y☒ N☐	Y☐ N☒
# Applicable elements	**7**	**7**		**9**	**7**	**7**		**7**	**7**	**8**
# Compliant elements	**7**	**7**		**9**	**7**	**6**		**6**	**7**	**7**
Percentage compliant	**100%**	**100%**		**100%**	**100%**	**86%**		**86%**	**100%**	**88%**

OVERSAMPLE	1	2	3	4	5					
Provider ID#	*****		*****							
Provider Type (MD, PhD, NP, PA, MSW)	LPC		LCSW							
Application/Attestation Date	9/16/14		1/20/14							
Last Credentialing/Recredentialing Date	11/29/11		5/17/11							
Recredentialing Date (Committee/Medical Director Approval Date)	12/23/2014		05/13/2014							
The Contractor, using primary sources, verifies that the following are present:										
◆ A current, valid license to practice (with verification that no State sanctions exist)	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐					
◆ A valid DEA or CDS certificate (if applicable)	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☐					
◆ Board certification status (verifies status only if the practitioner states on the application that he/she is board certified)	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☒	Y☐ N☐ NA☐	Y☐ N☐ NA☐					
◆ Malpractice history	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐					
◆ Current malpractice insurance in the required amount	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐					
◆ Verification that the provider has not been excluded from federal participation	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐					
◆ Signed application and attestation	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐					
◆ The provider recredentialing was completed within verification time limits (see specific verification element—180/365 days)	Y☒ N☐	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐					
◆ Recredentialing was completed within 36 months of last credentialing/recredentialing date	Y☐ N☒	Y☐ N☐	Y☒ N☐	Y☐ N☐	Y☐ N☐					
# Applicable elements	**7**		**7**							
# Compliant elements	**6**		**7**							
Percentage compliant	**86%**		**100%**							
Total Record Review Score					**Total Applicable: 73**		**Total Point Score: 69**		**Total Percentage: 95%**	

Comments:

Record Number 3 and Oversample 2 were initial credentialing files. Record Number 7 was missing from the records provided for review. The file was located on the second day and offered for review; however, HSAG had already replaced the file with one from the oversample and completed its review.

Recredentialing for record Number 6 was completed 37 months after the last credentialing/recredentialing date.

Recredentialing for record Number 10 was completed 38 months after the last credentialing/recredentialing date.

Recredentialing for Oversample 1 was completed 37 months after the last credentialing/recredentialing date.

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

Table C-1 lists the participants in the FY 2015–2016 site review of **CHP**.

Table C-1—HSAG Reviewers and BHO Participants

HSAG Review Team	Title
Katherine Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	Compliance Auditor
CHP Participants	**Title**
Erica Arnold-Miller	Vice President, Quality Management
Tami Ballard	Clinical Director
Lynne Bakalyan	Intensive Case Manager
Jim Bonk	Vice President, Operations
Steve Coen, PhD	Clinical Peer Advisor
Kat Fitzgerald	Quality Management Specialist
Tina Gonzales	Criminal Justice Systems Coordinator
Kim Griffith	Appeals/OMFA Lead Coordinator/Advocate
Jen S. Hale Galson	Director, Long-Term Services and Support
Haline Grublak	Director, Member and Family Affairs
Bill Mackie	Programmer/Analyst
Tina McCrory	Chief Operations Officer, CHP
Alyssa Rose	Director of Provider Relations, Beacon Health Options
Myron Unruh	Vice President, Colorado Springs Engagement Center
Wayne Watkins	Director, Information Technology
Jeremy White	Quality Manager
Department Observers	**Title**
Christian Koltonski	Quality Health Improvement Unit
Troy Peck	Contract Specialist

Appendix D. Corrective Action Plan Template for FY 2015–2016

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

For this step,	HSAG completed the following activities:
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. 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, persons responsible, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department or HSAG will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the CAP, the BHO should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site (with an e-mail notification regarding the posting). The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

For this step,	HSAG completed the following activities:
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department or HSAG will inform the BHO as to whether (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the BHO must submit additional documentation. The Department or HSAG will inform each BHO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable healthcare regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2015–2016 Corrective Action Plan *for* CHP

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
9. The Contractor must arrange for the provision of all *medically necessary services** identified under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, 42 CFR Sections 441.50 to 441.62, including: ◆ Referral assistance for treatment not covered by the plan, but found to be needed as a result of conditions disclosed during screening and diagnosis. (Referral assistance must include giving the family or beneficiary the names, addresses, and telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family.) ▪ At a minimum, the Contractor must assure that the medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. ◆ Making appropriate use of State health agencies, State vocational rehabilitation agencies, Title V grantees (Maternal and Child Health/Crippled Children's Services), and other public health, mental health, and education programs and related programs, such as Head Start, Title XX (Social Services) programs, and the Special Supplemental Food Program for Women, Infants and Children (WIC). ◆ Offering the family or beneficiary necessary assistance with transportation and necessary assistance with scheduling appointments for EPSDT services.	The EPSDT policy required the BHO provider to contact the PCP to determine if an EPSDT screening has been conducted and to request that the PCP conduct the screening, if necessary. The provider manual explained EPSDT services and stated that the BHO provider should contact the PCP to request results of EPSDT screenings. The provider manual also described the role of family health coordinators as the case managers for EPSDT services. CHP's clinical audit tool included an element to assess whether the record has a note asking the member about a well-child visit in the past year and referring the member to a PCP, if needed. However, none of these documents addressed the responsibility of the BHO provider to provide referral assistance to members who need services not covered by the BHO but found to be needed as a result of conditions disclosed during screening and diagnosis, including coordinating with State agencies appropriate to the member's needs or assisting with appointments or transportation when needed. In addition, documents did not clearly define mechanisms for doing so—e.g., referring to BHO care managers, the Office of Clinical Services, or Healthy Communities.	CHP must enhance its policies and procedures and provider communications to more specifically address the responsibility of the provider and/or the BHO to provide referral assistance to members who need services not covered by the BHO but found necessary through EPSDT screening and diagnosis, and the processes for doing so.

Standard III—Coordination and Continuity of Care		
Requirement	**Findings**	**Required Action**
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
2.G. The process for ensuring that credentialing and recredentialing are conducted in a nondiscriminatory manner (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes; and that it takes proactive steps to prevent and monitor discriminatory practices).	VO/Beacon policies repeatedly stated its commitment to and outlined procedures for ensuring that credentialing and recredentialing decisions are made in a nondiscriminatory manner. However, during the on-site interview, staff members clarified that one of the roles of the LCC is to review requests from providers desiring participation in the network to determine which are allowed to submit credentialing applications. Beacon had no written documents that described this preliminary process or the criteria used to make decisions.	If Beacon chooses to use a preliminary process for determining which providers are allowed to submit credentialing applications, it must document the process. Documentation must include the criteria used to make determinations, any appeal rights available to providers denied applications, and the mechanisms used to ensure nondiscriminatory practices.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
10. The Contractor formally recredentials its practitioners at least every 36 months.	VO/Beacon's policies and procedures required that all providers be recredentialed every 36 months; however, three of 10 recredentialing files reviewed on-site were approved by the NCC more than 36 months after the prior approval date.	CHP must ensure that its providers are recredentialed at least every 36 months.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include: 11.A. The Contractor confirms—initially and at least every three years—that the provider is in good standing with state and federal regulatory bodies.	VO/Beacon's policies and procedures addressed the processes used for the initial and ongoing assessment of organizational providers. While the policies stated that organizations must be recredentialed at least every 36 months, two of the five organizational files reviewed on-site demonstrated that the recredentialing process had not been completed within this 36-month time frame.	CHP must ensure that its organizational providers are recredentialed at least every 36 months.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
12. The Contractor's policy may substitute a CMS or State quality review in lieu of a site visit under the following circumstances: ◆ The CMS or state review is no more than three years old. ◆ The organization obtains a survey report or letter from CMS or the state, from either the provider or from the agency, stating that the facility was reviewed and passed inspection. ◆ The report meets the organization's quality assessment criteria or standards.	Beacon's Facility Organization Site Visit policy stated that a CMS or State review could be accepted in lieu of a site visit as long as the results were current. The policy did not specify that Beacon would confirm that the review criteria used by CMS or the State meet its own quality assessment criteria or standards. On-site record review demonstrated that CHP/Beacon exercised this right with one of the five organizations in the sample. The file included a letter from OBH that summarized the results of the review and listed the corrective actions required as a result of the review. The file did not include a copy of the assessment criteria used by OBH. The file also did not include any follow-up documentation to demonstrate that the organization completed the corrective actions.	If CHP/Beacon elects to substitute a CMS or State review in lieu of a site visit, it must confirm that the criteria used by CMS or the State encompass all criteria used in its own assessment. Additionally, CHP/Beacon must ensure that the organization sufficiently addresses all corrective actions required as a result of the CMS or State review.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
18. The Contractor retains the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision making. This right is reflected in the delegation agreement.	The July 1, 2014, delegation agreement between CHP and VO/Beacon does not specify that CHP retains the right to approve, suspend, or terminate contracts with individual practitioners, providers, and sites.	CHP must specify in its delegation agreement with VO/Beacon that it retains the right to approve, suspend, or terminate contracts with individual practitioners, providers, and sites.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Standard VIII—Credentialing and Recredentialing		
Requirement	**Findings**	**Required Action**
22. For delegation arrangements in effect 12 months or longer, the Contractor evaluates regular reports (at least semiannually).	During the on-site interview, staff stated that CHP's Class B board is responsible for oversight of delegated activities; however, CHP could not produce evidence that the board reviewed any credentialing or recredentialing reports submitted by VO/Beacon during the review period.	CHP must document that it evaluates (at least semiannually) credentialing and recredentialing reports submitted by its delegate.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to Be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review 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: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ 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. ◆ 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 four standards and on-site activities. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ 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 lists of all Medicaid credentialing and recredentialing records that occurred between January 1, 2015, and December 31, 2015, to the extent available at the time of the site-review request. HSAG used a random sampling technique to select records for review during the site visit. ◆ 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.

For this step,	HSAG completed the following activities:
	◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO credentialing and recredentialing. ◆ 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.) ◆ 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 2015–2016 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings. ◆ 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. ◆ HSAG submitted the site review report to the BHO and the Department for review and comment. ◆ HSAG incorporated the BHO's and Department's comments, as applicable and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.