COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2016–2017 Site Review Report

for

Colorado Health Partnerships, LLC

April 2017

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), with revisions published May 2016, 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 FY 2016–2017 site review activities for the review period of January 1, 2016, through December 31, 2016. 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 three standard areas reviewed this year. Section 2 contains graphical representation of results for all standards reviewed over the past two three-year cycles. Section 3 describes the background and methodology used for the 2016–2017 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2015–2016 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials record reviews. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the BHO will be required to complete for FY 2016–2017 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 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.

Table 1-1 presents the scores for **Colorado Health Partnerships, LLC** (**CHP**) for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standards	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable/ To Be Determined	Score (% of Met Elements)
I. Coverage and Authorization of Services	31	29	27	2	0	2	93%
II. Access and Availability	10	10	10	0	0	0	100%
Totals	**41**	**39**	**37**	**2**	**0**	**2**	**95%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

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

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

Record Review	# of Elements	# of Applicable Elements	# Met	# Not Met	# Not Applicable	Score (% of Met Elements)
Denials	100	60	59	1	40	98%
Totals	**100**	**60**	**59**	**1**	**40**	**98%**

*The overall score is calculated by adding the total number of *Met* elements and dividing by the total number of applicable elements.

Standard I—Coverage and Authorization of Services

Summary of Strengths and Findings as Evidence of Compliance

CHP delegated all authorization activities to its administrative services partner, Beacon Health Options (Beacon). Beacon had Utilization Management (UM) policies and procedures that addressed all major elements of authorization requirements. UM staff applied established level of care guidelines—e.g. inpatient, partial hospitalization, residential, and day treatment—to determine medical necessity for all higher levels of care. All requests that did not meet criteria were referred to a **CHP** medical director or clinical peer advisor for final determination of medical necessity. **CHP** conducted annual interrater reliability testing and quarterly clinical care manager and clinical peer advisor audits to ensure that criteria, available documentation, and reviewer interpretations were consistently applied among all UM staff. Beacon also used the list of covered BHO diagnoses to initially determine whether or not the services being requested applied to a diagnosis covered by the BHO. Staff members stated that UM staff contact the requesting provider when necessary to obtain additional information prior to making a UM decision. Notices of Action sent to the member, with a copy to the requesting provider, included required content, were written in language easy to understand, and were available in English and Spanish or other languages upon request. **CHP** had updated the notices of action effective November 2016 to reflect the revised 60-day time frame for requesting a State fair hearing. **CHP** had implemented mechanisms to ensure that information in individual letters used non-technical language to the degree possible. The Medical Necessity Determinations policy accurately identified time frames for mailing notices of action. On-site denials record review confirmed the following:

- Denials record reviews included seven new requests—three standard and four expedited—and three retrospective claims reviews. No cases included an extension of the decision time frame.
- Cases were 100 percent compliant with: written notice of action sent to member and requesting provider; denial decision made by a qualified provider; notice of action included required content; and correspondence with the member was easy to understand.
- Nine of 10 records demonstrated that **CHP** mailed notice of action letters within the required time frame.
- No cases required contact with the provider due to lack of information. (See recommendation following.)
- All cases denied for "not a covered service/diagnosis" informed the member how to obtain covered fee-for-service or wrap-around services. (See recommendation following.)

Policies, procedures, and provider and member materials accurately defined "emergency medical condition" and "services" and communicated that emergency services were available in or out of network without authorization. Staff members stated that emergency services are never questioned for medical necessity, but that all emergency room (ER) claims were retrospectively reviewed for the presence of a BHO-covered diagnosis. Policies and procedures accurately addressed payment of emergency and poststabilization services, per requirements.

Summary of Findings Resulting in Opportunities for Improvement

While **CHP** defined "medical necessity" equivalent to the definition outlined in the contract, the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—included the addition of EPSDT-specific criteria. Therefore, **CHP** is advised to immediately update the definition of "medical necessity" accordingly. HSAG recommends that **CHP** refer to 10-CCR 2505-10 8.076.1.8 (a-g) and 8.7016.1.8.1 for guidance.

HSAG observed that **CHP** frequently denied services for the reason "not a covered diagnosis"—seven of 10 records reviewed and 67 percent of all 2016 denials. Some of these denials included retrospective review of emergency service claims. Policies and procedures stated and staff members confirmed that **CHP** never denies emergency services for medical necessity. However, a **CHP** medical director reviews every ER claim for the presence of a BHO-covered diagnosis, which is based on clinical review of information and notes available in the medical record. In the three ER claims denial cases reviewed on-site, the medical reviewer had changed the primary diagnosis from what was submitted in the ER claim to a diagnosis found in the ER medical record notes after the emergency. The claim was then denied for reason of "not a covered diagnosis." The frequency and circumstances related to **CHP**'s denials for "not a covered diagnosis" raised some questions as to consistency and appropriateness of the covered diagnosis determinations. Nevertheless, these decisions are based on the clinical judgment of the medical director/peer advisor and, as such, are not within the scope of evaluation of compliance with federal and State regulations. Therefore, HSAG referred these cases to the Department for further evaluation and assigned a score of "To Be Determined" (TBD) for the following requirements:

- The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.
- The Contractor will be responsible for emergency services when the primary diagnosis is psychiatric in nature, even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis.

HSAG included TBD scores with "not applicable" (NA) scores for purposes of scoring the compliance audit.

Although **CHP** has a mechanism for consulting with providers prior to making authorization decisions, **CHP** also employs a formal process for a post-denial consultation with the provider (the requesting provider may ask for reconsideration after **CHP** denies an authorization request). HSAG cautions that a post-denial redetermination is an appeal and must be treated as such. Therefore, **CHP** should ensure compliance with regulations concerning appeals (reviewed in another standard) when considering a post-denial redetermination. Furthermore, HSAG recommends that **CHP** more assertively contact a provider *prior to* making a denial decision when in doubt about the information provided and in each case in which the clinical reviewer is considering denying services based on "not a covered diagnosis."

As observed in denial record reviews, notice of action (NOA) letters that deny services due to "not a covered diagnosis" included a statement directing members to call the Department's customer service line for help in determining whether or not the denied service is covered under another Health First

Colorado health plan. As discussed with **CHP** staff members during the on-site interview, the Department does not consider this to be an effective mechanism for assisting members with coverage under another health plan or with access to wrap-around services. (The Department's customer service personnel do not have access to the member's clinical information and are not trained to make such a determination.) In addition, this process does not meet **CHP**'s care coordination requirements (reviewed in another standard). HSAG strongly recommends that **CHP** modify its NOA language for denials due to "not a covered diagnosis/service" to direct members to call the BHO care managers/coordinators for assistance with any contacts with the Department or with referrals to other health plans or agencies. HSAG also recommends that the Department work with the BHOs to define appropriate procedures for BHO care coordinators to contact the Department concerning coverage for services that are not covered by the BHO but are covered under the State plan via fee-for-service (FFS) or other Medicaid waiver programs.

HSAG observed during on-site denial record reviews that **CHP** routinely sends a copy of any notice of action to the requesting provider unless the request was generated as a result of member assessment by the community mental health center (CMHC). In these cases, **CHP** notifies the CMHC verbally. While this process is in compliance with federal and State requirements, HSAG recommends that **CHP** also notify the requesting CMHC in writing so as to be consistent with procedures for notifying other providers and to ensure that all providers involved in the authorization request have documented results of the authorization decision.

Reviewers observed that the definition of "emergency medical condition" in the Emergency and Post-stabilization policy varied from the definition included in the member handbook and provider manual. Although the definition was compliant in all documents, HSAG recommends that **CHP** use consistent language to define "emergency medical condition" in all documents and communications. Similarly, reviewers observed that the member handbook stated the member may obtain emergency services from any hospital "in your area" and referred the member to a list of hospitals. HSAG recommends that **CHP** consider simplifying the language in the member handbook to ensure that members clearly understand that they can access emergency services anywhere—in or out of network.

Summary of Findings Resulting in Required Actions

The Medical Necessity Determinations policy stated that for decisions regarding claims payment, "the member and provider receive written notice of action, mailed *as soon as possible after the denial takes place.*" Staff members stated that it is **CHP**'s policy to make a claim payment determination within 30 days of receiving the claim and to send NOAs within that 30-day time frame based on staff workload priorities. HSAG interpreted "at the time of the action affecting the claim" as meaning on the day the determination is made or within three days thereafter. As evidenced in denial record reviews of retrospective claims, **CHP** notified the member and provider within an acceptable time frame in only two of three cases. **CHP** must clarify its policies and procedures and ensure that it sends members and providers a NOA for denial of claims payment on the day of the decision or within three days thereafter.

Policies and procedures clearly outlined **CHP**'s ability to extend the authorization decision time frame by 14 days based on member request or the need for additional information. In addition, the policy

stated that **CHP** may extend the time frame "due to matters justifiably beyond the control of the BHO," which staff described as an occurrence such as a natural disaster. Federal language clearly states that the Contractor may extend the authorization decision only if "there is a need for additional information and that the extension is in the member's best interest." **CHP** must modify the language in its policies and procedures accordingly.

Standard II—Access and Availability

Summary of Strengths and Findings as Evidence of Compliance

CHP delegates management of its provider network to its partner, Beacon. Beacon had policies and procedures that described the processes for monitoring its network to ensure that all members have access to the full spectrum of covered services. Beacon used mapping software to compare the locations of its providers to the addresses of its members. Beacon considered numbers, types, and specialties of providers as well as languages spoken and whether or not providers were accepting new members. Beacon collected and monitored grievances related to members' abilities to access services. Beacon also used various member and provider surveys to gauge member and provider perceptions of the availability of services.

During the on-site interview, **CHP** staff members described innovative methods used to expand its network capacity. **CHP** offered providers incentives to geographically expand service areas, and **CHP** expanded its participation in the Colorado Psychiatric Access and Consultation for Kids (C-PACK) program. **CHP** also partnered with Ieso Digital Health to pilot a program that provides members with one-on-one cognitive behavioral therapy through a typed conversation between the member and a qualified therapist in a secure online therapy room.

CHP used single case agreements (SCAs) to provide members with access to services outside its service area. **CHP** staff members estimated that most SCAs are granted to ensure continuity of care; however, **CHP**'s policies allow for SCAs to be used for second opinions and for services not available within the network. The SCAs included language that prohibited providers from billing members for covered services and required that providers collect a member's written consent agreeing to payment of non-covered services prior to the provision of service.

CHP had well-publicized policies that delineated the standards for timely access and that required providers' adherence to those standards. **CHP** provided documentation that demonstrated ongoing monitoring of both CMHCs and independent providers to ensure compliance as well as evidence of follow-up with providers who failed to meet the described expectations.

CHP's cultural competency plan affirmed **CHP**'s commitment to ensuring a culturally competent system of care for members and providers. The plan outlined goals and objectives, described management accountability and oversight mechanisms, and is updated annually to ensure cohesiveness with its network's changing demographics. **CHP** contracted with numerous providers fluent in foreign languages (including Spanish and American Sign Language), provided printed member materials in

Spanish, and offered interpretation services for any language free of charge. **CHP** offered cultural competency training to all providers and made PowerPoint presentations available on its website. Furthermore, **CHP** monitored its members' perceptions of the cultural competence of services using surveys, grievance reports, and member forums.

Summary of Findings Resulting in Opportunities for Improvement

HSAG identified no findings resulting in opportunities for improvement related to access and availability.

Summary of Findings Resulting in Required Actions

HSAG identified no required corrective actions for this standard.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment Services

Summary of Strengths and Findings as Evidence of Compliance

CHP and Beacon developed a comprehensive EPSDT policy that addressed all components of the EPSDT requirements for the BHO and provided a good foundation for implementing EPSDT requirements. During the on-site interview, staff stated that **CHP** assigned most responsibilities for implementing the policy to the CMHCs/providers. **CHP**'s policy, provider manual, and provider training identified that provider responsibilities for EPSDT services included: determining if the member is getting EPSDT screenings, assisting the member as needed with obtaining a primary care physician (PCP), communicating with the member's PCP regarding results of screenings, and providing any behavioral health screenings indicated as a result of PCP screenings and referral. **CHP** also addressed requirements for documenting results of EPSDT screenings and examinations in the medical record in its policy and provider training. **CHP** developed a provider audit tool which included all components of EPSDT requirements. **CHP** implemented the provider audit tool with the CMHCs just prior to the on-site audit.

Despite the opportunities for improvement outlined following, **CHP** has made significant efforts over the past year to implement processes that address the BHO's responsibilities related to EPSDT. **CHP** has initiated a pilot program with one of its CMHCs and the area Regional Care Collaborative Organization (RCCO) to implement an integrated care coordination process to increase well-child checks and delivery of EPSDT services.

Summary of Findings Resulting in Opportunities for Improvement

Although the EPSDT policy outlined the comprehensive EPSDT requirements and **CHP**'s intent related to the EPSDT program, **CHP** had defined few procedures or processes to operationalize the components of the policy. Staff members stated that **CHP**'s providers are primarily responsible to implement EPSDT requirements; however, the policy, training, and communications related to provider responsibilities were outlined at a high-level and/or were incomplete. During the on-site interview, staff members acknowledged that **CHP** was evolving toward more comprehensive EPSDT training, communications, procedures, and mechanisms for BHO care coordination activities. HSAG recommends that **CHP** proceed with establishing a coordinated structure and functions to integrate EPSDT requirements into all applicable operations, including provider communications and staff training. HSAG encourages **CHP** to work with the Department's EPSDT Administrator, Gina Robinson, to obtain guidance and trainings related to implementation of the Department's EPSDT requirements.

The Beacon EPSDT policy included the EPSDT definition of "medical necessity" and the criteria for approval of authorization requests as outlined in the requirement. However, **CHP** should note that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that the Beacon EPSDT policy incorporates the definition of "medical necessity" for EPSDT services as outlined in the Findings section of Standard I, element 4, of the compliance monitoring tool.

Summary of Findings Resulting in Recommendations

Staff members confirmed that the BHO providers are primarily responsible to "reasonably ensure the provision of all applicable components of periodic health screens (assessments) to EPSDT beneficiaries who are receiving BHO services." However, **CHP** failed to educate BHO providers on the components of EPSDT periodic health screens. Procedures or mechanisms to accomplish this requirement were limited to referring the member to a PCP and contacting the PCP to obtain EPSDT results. In addition, materials were unclear as to how actively the provider or BHO would assist members in obtaining necessary EPSDT screenings. HSAG recommends that **CHP** enhance procedures, provider communications, and training to clarify expectations and mechanisms for assisting EPSDT-eligible members who are receiving BHO services with obtaining all applicable components of periodic health screens.

CHP submitted evidence that it used the member handbook to describe EPSDT services to members and stated expecting CMHC providers to have direct communication with individual members in treatment regarding EPSDT services. However, neither the provider manual nor provider training materials addressed the providers' responsibilities for communicating with members regarding EPSDT benefits. In addition, **CHP** provided no examples of ongoing or periodic BHO or CMHC member communications—e.g., member newsletters, flyers, member mailings—to inform members of their EPSDT benefits and how to access them. HSAG recommends that **CHP** enhance its communications to

members about the EPSDT program to include ongoing or periodic communications regarding services available and how to access them.

The EPSDT policy stated that the BHO would authorize any identified diagnostic or treatment services, including substance abuse needs, that meet the definition of "medical necessity" as well as the criteria for authorization specific to EPSDT, accurately outlining the EPSDT definition of "medical necessity" and criteria for authorization. However, the **CHP** Quality Management/Utilization Management (QM/UM) Program Description included no EPSDT-specific authorization procedures, no EPSDT medical necessity criteria, no EPSDT-related review criteria or clinical guidelines, and no reference to the Beacon EPSDT policy. Therefore, it appeared that **CHP** had not incorporated the expanded "medical necessity" definition related to EPSDT services into its UM practices or developed UM procedures to operationalize the EPSDT policy. HSAG recommends that **CHP** modify or develop policies and procedures to demonstrate that UM staff members are using EPSDT-specific criteria and definition of "medical necessity" when authorizing EPSDT-related services. HSAG recommends that **CHP** more clearly integrate operational UM procedures with the definition of "medical necessity" and the authorization criteria outlined in the EPSDT policy.

Staff members stated that if the necessary EPSDT diagnostic service or treatment is not covered by the BHO benefit, the behavioral health provider is responsible for coordinating a referral to a provider who can deliver the service. However, **CHP** had no written procedures, provider training, or other information to provide evidence that its providers had the resources to successfully assist members with obtaining non-covered services. In addition, **CHP** had no procedures or communications to provide evidence that BHO care coordinators would assist providers in making such referrals, nor did the Quality Management/Utilization Management Program Description address the responsibility of UM care managers to assist with referrals for services not covered by the BHO. Also, while the EPSDT policy reiterated all information as outlined in the requirement related to providing referral assistance for treatment not covered by the plan—i.e., coordinating with other programs that may provide EPSDT-related services and referring children and their families to the Healthy Communities program—accountabilities and procedures for implementing policy statements were confusing or not adequately addressed. Denial record reviews demonstrated that notices of action to members eligible for EPSDT services referred the member to the Department's customer service line for help determining whether or not a denied service was covered under another Health First Colorado health plan. The notice of action letter included no BHO care coordinator contact information or reference to Healthy Communities. HSAG recommends that **CHP** define a more detailed approach, clarify accountabilities, and develop cohesive procedures for ensuring that treatment of mental health conditions related to EPSDT that are not covered under the BHO contract are adequately addressed, including providing referral assistance and coordinating with other programs. Procedures must address active involvement of BHO care coordinators (and/or documented responsibilities of affiliated organizations) to assist members and/or providers and to obtain all documents required for access to non-covered services. HSAG recommends that **CHP** also, for members 20 years of age and under, implement a notice of action letter that includes contact information for BHO care coordinators—rather than the Department's customer service line—to assist members and providers with access to needed services or with contacting Healthy Communities.

The EPSDT policy stated that if the provider is not licensed or equipped to render necessary treatment or further diagnosis, it is the responsibility of the primary therapist to refer the member to an appropriate provider who may outreach to the BHO care managers or Healthy Communities to obtain assistance with referrals. This policy statement was not included in the provider manual or provider training documents; nor were there any procedures to instruct providers or other staff on mechanisms or accountabilities for completing the referral process. HSAG recommends that **CHP** develop procedures and/or enhance provider communications to clearly specify the provider's responsibilities for making referrals to appropriate practitioners or to Healthy Communities and define mechanisms for effectively doing so.

CHP incorporated into the Beacon policy verbatim the requirement to share PHI with Healthy Communities. However, **CHP** provided no evidence of having incorporated the requirement into provider communications or internal operating procedures. HSAG recommends that **CHP** develop mechanisms to communicate this requirement to providers and other pertinent staff members in order to fully operationalize the policy.

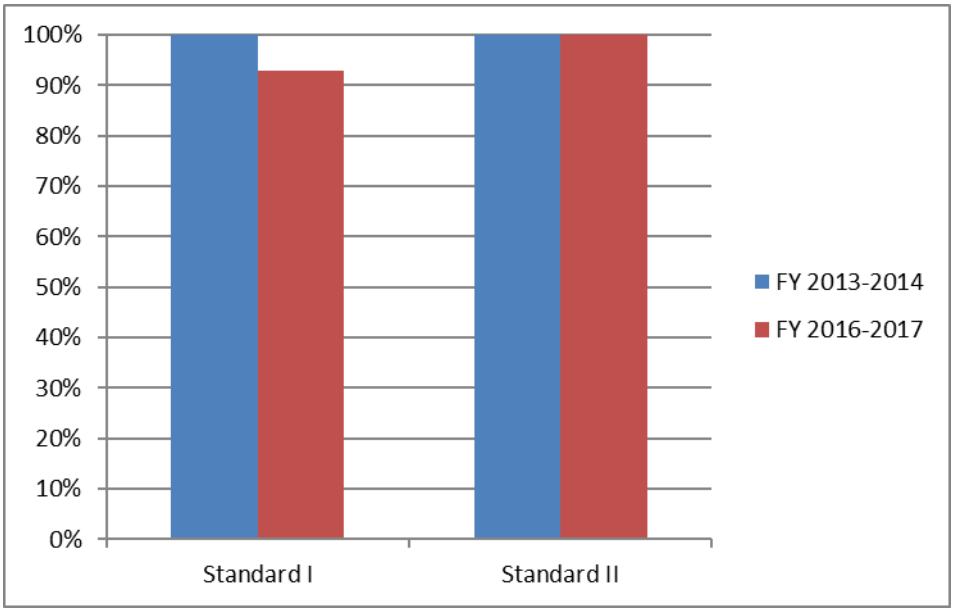
CHP provided no evidence of comprehensive EPSDT-focused trainings, provider communications, or tools for BHO providers that represented "systematic" communication with network providers regarding EPSDT requirements. HSAG recommends that **CHP** develop a mechanism for systematic (i.e., regular and periodic) communication with network providers regarding comprehensive EPSDT services and responsibilities.

Comparison of Results

Comparison of FY 2013–2014 Results to FY 2016–2017 Results

Figure 2-1 shows the scores from the FY 2013–2014 site review (when Standard I and Standard II were previously reviewed) compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **CHP**'s contract with the State may have changed, and may have contributed to performance changes.

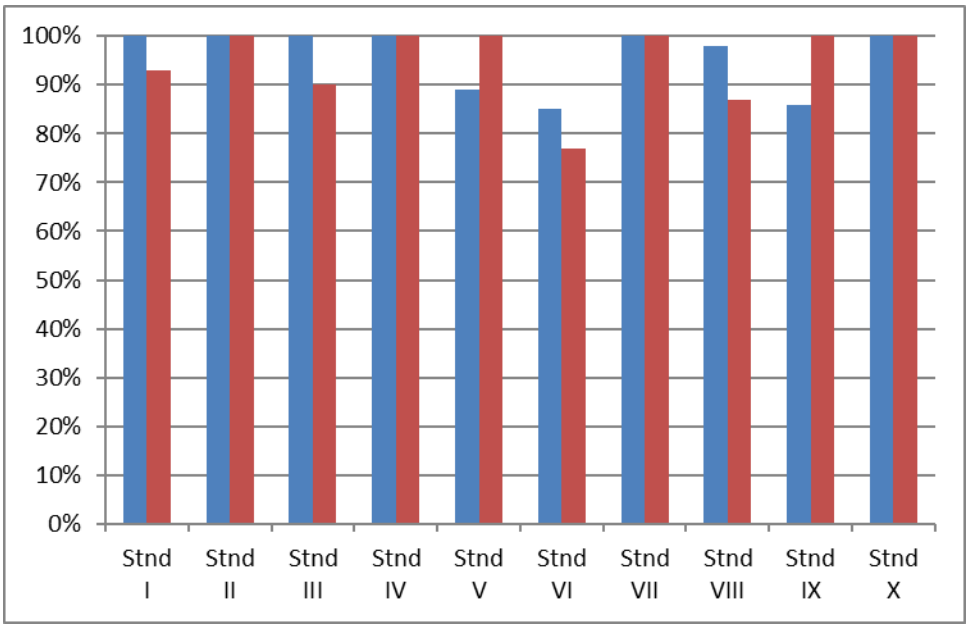
Figure 2-1—Comparison of FY 2013–2014 Results to FY 2016–2017 Results



Review of Compliance Scores for All Standards

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

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



Note: Results shown in blue are from FY 2011–2012, FY 2012–2013, and FY 2013–2014. Results shown in red are from FY 2014–2015, FY 2015–2016, and FY 2016–2017.

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

Table 2-1—List of Standards by Review Year

Standard	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
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	
XI—EPSDT Services						X

3. Overview and Background

Overview of FY 2016–2017 Compliance Monitoring Activities

For the fiscal year (FY) 2016–2017 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability.

HSAG reviewed an additional EPSDT standard for all BHOs during the FY 2016–2017 compliance site reviews. This standard was developed collaboratively by HSAG and the Department using federal EPSDT regulations and guidance in addition to State statutes that address EPSDT. The FY 2016–2017 findings for this standard can be found in Appendix A. A narrative summary of findings for this standard is also presented in the Executive Summary. During the on-site reviews, the Department identified that, while the BHO contracts require BHOs to comply with "all federal and State EPSDT regulations," the BHO contracts did not include the specificity delineated in the compliance monitoring tool. Therefore, the EPSDT findings will be used only to inform the development and implementation of EPSDT contracting provisions for the Regional Accountable Entities (RAEs) that will assume the capitated behavioral health contracts beginning in FY 2018–2019. No corrective actions are required based on this compliance monitoring review. The State's EQRO vendor will review the EPSDT standard again in FY 2019–2020.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the three standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued May 6, 2016. HSAG conducted a desk review of materials submitted prior to the on-site review activities: a review of records, documents, and materials provided on-site; and on-site interviews of key BHO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to BHO service and claims denials.

A sample of the BHO's administrative records related to Medicaid service and claims denials was reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of five records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. For the record review, the BHO received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each required element. Results of

record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[3-1] Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The three standards chosen for the FY 2016–2017 site reviews represent a portion of the Medicaid managed care requirements. The following standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

Objective of the Site Review

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

- The BHO's compliance with federal health care regulations and managed care contract requirements in the three areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, 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.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Aug 24, 2016.

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

FY 2015–2016 Corrective Action Methodology

As a follow-up to the FY 2015–2016 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 2015–2016 compliance monitoring site review.

Summary of FY 2015–2016 Required Actions

Based on findings from the site review activities, **CHP** was required to submit a corrective action plan that addressed one element related to coordination and continuity of care and six elements related to credentialing and recredentialing. For coordination and continuity of care, **CHP** was required to enhance policies and procedures and provider communications to more specifically address referral processes and the BHO's and providers' responsibility to provide referral assistance to members who need services not covered by the BHO but found necessary as a result of EPSDT screening and diagnosis. For credentialing and recredentialing, **CHP** was required to more clearly delineate its preliminary review process and its procedures for recredentialing organizations and to more closely adhere to its recredentialing timelines.

Summary of Corrective Action/Document Review

CHP submitted its CAP to HSAG and the Department in May 2016 and began submitting documents that demonstrated implementation of its plan in September 2016. HSAG and the Department worked closely with **CHP** to ensure that the BHO fully addressed and implemented all aspects of the required actions.

Summary of Continued Required Actions

As of December 2016, the only outstanding item from **CHP**'s FY 2015–2016 CAP required **CHP** to revise its organizational recredentialing policy. **CHP** was working with its management team to obtain the necessary approvals. HSAG and the Department expected that **CHP** would have all required actions corrected by the end of January 2017.

Appendix A. Compliance Monitoring Tool

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor must ensure that the services provided are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. • No less than the amount, duration, and scope furnished under fee-for-service Medicaid. *42 CFR 438.210(a)(3)(i)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.2.8, 2.2.7	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO –Entire policy 2. Member Handbook_CHP page 15 *Misc **Description of Process:** This element is delegated to Beacon Health Options (Beacon) by Colorado Health Partnerships (CHP). Decisions regarding the amount, duration, or scope of services are limited only to whether or not they meet medical necessity criteria see policy 202L Medical Necessity_2BHO (Document 1). There are no limits if medical necessity criteria is met and therefore not less than the amount, duration and scope furnished under fee-for-service Medicaid. This is outlined for members in the CHP member handbook (Member Handbook_CHP).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
2. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42 CFR 438.210(a)(3)(ii)* Contract: Amendment 6, Exhibit A-2—2.2.9	**Documents Submitted/Location within Documents:** 1. LOC Guideline _23-Hour_Observation_2BHO - Entire document 2. LOC Guideline _Acute Inpatient Treatment_2BHO- Entire document 3. LOC Guideline _Acute_Treatment_Unit_Services_2BHO - Entire document 4. LOC Guideline _Adult_Residential_Treatment_Services_2BHO - Entire document 5. LOC Guideline _Advocacy_Svcs_2BHO - Entire document 6. LOC Guideline _Alternative outpatient services_2BHO - Entire document 7. LOC Guideline _Alternative_Family_Care_2BHO - Entire document	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ TBD

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	8. LOC Guideline _Case_Management_Services_2BHO - Entire document 9. LOC Guideline _Child_Adol_Day_Treatment_Services_2BHO - Entire document 10. LOC Guideline _Community_Support_Programs_2BHO - Entire document 11. LOC Guideline_Client_Operated_Services_Adult_2BHO 12. LOC Guideline _Intensive_Outpatient_Programs_Adult_2BHO - Entire document 13. LOC Guideline _IOP_ChildAdol_Sex_Disorder_TX_2BHO - Entire document 14. LOC Guideline _Outpatient_Crisis_Intervention_Services_2BHO - Entire document 15. LOC Guideline _Parameters_for_Treating_Children_Under_5_2BHO - Entire document 16. LOC Guideline _Partial_Hospitalization_2BHO - Entire document 17. LOC Guideline _Peer_Support_Services_2BHO - Entire document 18. LOC Guideline _Psychological-Neuropsychological_Testing_2BHO - Entire document 19. LOC Guideline _Residential_Treatment_Children-Adolescents_2BHO - Entire document 20. LOC Guideline _Respite_Care_Services_2BHO - Entire document	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	21. LOC Guideline _Wrap_Around_Services_2BHO - Entire document 22. 202L Medical Necessity_2BHO – Page 2, Section II, B; Page 3, Section IV, C and D 23. 303L Peer Advisor Adverse Determinations_2BHO – Entire policy 24. Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO-Entire Document 25. Rounds Log Nov 2015 thru 100516-entire document **Description of Process:** This element is delegated to Beacon Health Options (Beacon) by Colorado Health Partnerships (CHP). Beacon staff refer to the medical necessity policy (202L Medical Necessity_2BHO; document 23), the list of covered diagnoses (Exhibit D-2_Covered Behavioral Health Diagnoses, document 24) and the clinical level of care criteria (documents 1-21) to authorize care, based on individual case review to ensure that care is not arbitrarily reduced or denied based on diagnostic categories or conditions. Care can be denied only by the BHO's Medical Director or the Clinical Peer Advisor (303L Peer Advisor Adverse Determinations_2BHO; document 23). Variables such as the member's situation and other care available are also taken into account in each individual situation as demonstrated by the Rounds Log Nov 2015 thru 100516_2BHO (document 25). Staff work with providers to review the context of the member's care, and give input into best discharge plans to help members stabilize in the long run, with the member's best interest in mind. Beacon staff refers cases for possible adverse	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	clinical decisions to the Medical Director/Peer Advisor for review (202L Medical Necessity_2BHO document 23).	

Findings:
CHP had extensive well-defined level of care criteria applied by UM staff when making authorization decisions related to medical necessity. In addition, the UM process required consideration of covered BHO diagnoses when making a coverage decision. All questions related to whether or not the member had a covered diagnosis were referred to the clinical peer advisors/medical directors, whose determination of covered diagnosis logically prevailed over the application of medical necessity criteria. During on-site review of denial records, HSAG observed that medical directors used information available in the medical record to make decisions regarding the primary diagnosis. However, it was unclear in some cases why the medical director made a decision of "not a covered diagnosis." For example, in some cases multiple diagnoses were listed and the medical director selected a non-covered diagnosis as the primary reason for needed treatment. Therefore, it was unclear whether or not the Contractor arbitrarily denied a required service "solely because of diagnosis." In addition, the frequency with which CHP assigned "not a covered diagnosis" as the denial reason—7 of 10 denial record reviews and 67 percent of all 2016 denials—raised questions as to the appropriateness of these determinations. Nevertheless, the decision of "not a covered diagnosis" is based on the clinical judgment of the medical director/peer advisor and, as such, is not within the scope of the compliance audit. Therefore, HSAG referred these cases to the Department for further evaluation. For purposes of this compliance audit, HSAG marked this requirement as "To Be Determined" (TBD) and will treat it as a "Not Applicable" score.

3. The Contractor may place appropriate limits on a service: • On the basis of criteria applied under the State plan (medical necessity). • For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purposes. *42 CFR 438.210(a)(4)(i) and (ii)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.2.10	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO – Page 2, Section II. A. 2. LOC Guideline_23-Hour_Observation_2BHO- Entire document 3. LOC Guideline _23-Hour_Observation_2BHO - Entire document 4. LOC Guideline _Acute Inpatient Treatment_2BHO- Entire document 5. LOC Guideline _Acute_Treatment_Unit_Services_2BHO - Entire document 6. LOC Guideline _Adult_Residential_Treatment_Services_2BHO - Entire document 7. LOC Guideline _Advocacy_Svcs_2BHO - Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	8. LOC Guideline _Alternative outpatient services_2BHO - Entire document 9. LOC Guideline _Alternative_Family_Care_2BHO - Entire document 10. LOC Guideline _Case_Management_Services_2BHO - Entire document 11. LOC Guideline _Child_Adol_Day_Treatment_Services_2BHO - Entire document 12. LOC Guideline _Community_Support_Programs_2BHO - Entire document 13. LOC Guideline_Client_Operated_Services_Adult_2BHO 14. LOC Guideline _Intensive_Outpatient_Programs_Adult_2BHO - Entire document 15. LOC Guideline _IOP_ChildAdol_Sex_Disorder_TX_2BHO - Entire document 16. LOC Guideline _Outpatient_Crisis_Intervention_Services_2BHO - Entire document 17. LOC Guideline _Parameters_for_Treating_Children_Under_5_2BHO - Entire document 18. LOC Guideline _Partial_Hospitalization_2BHO - Entire document 19. LOC Guideline _Peer_Support_Services_2BHO - Entire document 20. LOC Guideline _Psychological-Neuropsychological_Testing_2BHO - Entire document	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	21. LOC Guideline _Residential_Treatment_Children-Adolescents_2BHO - Entire document 22. LOC Guideline _Respite_Care_Services_2BHO - Entire document 23. LOC Guideline _Wrap_Around_Services_2BHO - Entire document 24. Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO-Entire Document **Description of Process:** The Medical Necessity policy incorporates the elements of the State's definition for Medical Necessity (202L Medical Necessity_2BHO – Page 2, Section II. A). Covered Diagnoses lists are stipulated by contract (Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO). The level of Care Guidelines provide the basis for any limits placed on services authorized to control utilization and focus it on the members who will benefit from services and achieve their goals. (Documents 2-22). Each Level of Care guideline starts with a clear description of the service, and continues with inclusion and exclusion criteria designed to authorize care for the members who would reasonably be expected to benefit from the service. Criteria are clearly outlined to continue authorization for members who are progressing in treatment or who have treatment plans adjusted by providers to address any lack of progress. Care managers actively work with providers during reviews, based on the LOC criteria to shape treatment so that it will achieve the purposes needed by members.	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The Contractor specifies what constitutes "medically necessary services" in a manner that: • Is no more restrictive than that used in the State Medicaid program. – Is in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care. – Is reasonably necessary for the diagnosis or treatment of a covered behavioral health disorder or to improve, stabilize, or prevent deterioration of functioning resulting from such a disorder. – Is clinically appropriate in terms of type, frequency, extent, site, and duration. – Is furnished in the most appropriate and least restrictive setting where services can be safely provided. – Cannot be omitted without adversely affecting the member's behavioral health and/or physical health conditions associated with the member's covered behavioral health diagnosis or the quality of care rendered. • Addresses the extent to which the Contractor is responsible for covering services related to the following: – The prevention, diagnosis, and treatment of health impairments.	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO –Entire policy 2. 223LTreatmentPlanning_Policy_2BHO-Entire Policy 3. Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO-entire document 4. LOC Guideline _23-Hour_Observation_2BHO - Entire document 5. LOC Guideline _Acute Inpatient Treatment_2BHO- Entire document 6. LOC Guideline _Acute_Treatment_Unit_Services_2BHO - Entire document 7. LOC Guideline _Adult_Residential_Treatment_Services_2BHO - Entire document 8. LOC Guideline _Advocacy_Svcs_2BHO - Entire document 9. LOC Guideline _Alternative outpatient services_2BHO - Entire document 10. LOC Guideline _Alternative_Family_Care_2BHO - Entire document 11. LOC Guideline _Case_Management_Services_2BHO - Entire document 12. LOC Guideline _Child_Adol_Day_Treatment_Services_2BHO - Entire document 13. LOC Guideline _Community_Support_Programs_2BHO - Entire document 14. LOC Guideline_Client_Operated_Services_Adult_2BHO 15. LOC Guideline _Intensive_Outpatient_Programs_Adult_2BHO - Entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– The ability to achieve age-appropriate growth and development. – The ability to attain, maintain, or regain functional capacity. *42 CFR 438.210(a)(5)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—1.1.1.34	16. LOC Guideline _IOP_ChildAdol_Sex_Disorder_TX_2BHO - Entire document 17. LOC Guideline _Outpatient_Crisis_Intervention_Services_2BHO - Entire document 18. LOC Guideline _Parameters_for_Treating_Children_Under_5_2BHO - Entire document 19. LOC Guideline _Partial_Hospitalization_2BHO - Entire document 20. LOC Guideline _Peer_Support_Services_2BHO - Entire document 21. LOC Guideline _Psychological-Neuropsychological_Testing_2BHO - Entire document 22. LOC Guideline _Residential_Treatment_Children-Adolescents_2BHO - Entire document 23. LOC Guideline _Respite_Care_Services_2BHO - Entire document 24. LOC Guideline _Wrap_Around_Services_2BHO - Entire document 25. 104L Developing and Updating Clinical Criteria_Level of Care Criteria_2BHO – Entire Policy **Description of Process:** This element is delegated to Beacon by Colorado Health Partnership (CHP). Medically necessary services are needed for the diagnosis or treatment of health impairments and also to prevent deterioration in functioning as a result of a covered mental health disorder (202L Medical Necessity_2BHO –Entire policy, especially Section IV.A, document 1). Our treatment planning	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	policy (223LTreatmentPlanning_Policy_2BHO document 2) outlines the focus of treatment by starting with an individualized assessment of the member, starting with the DSM V diagnosis. The assessment includes not only a behavioral health diagnosis, but developmental and personality factors, physical health factors, social and developmental stressors as well as the member's functioning level. The policy notes that treatment goals need to be focused and measurable to address these identified problems. CHP's Level of Care guidelines (documents 4-25) apply these principles to specific types of treatment and levels of care. Each LOC guideline is designed to take into account the needs of the member to help them in the recovery process from their behavioral health disorder. For example, for children, academic success is a core focus of age appropriate development and success. Helping children and adolescents in the school setting contributes to their ability to maintain or regain a functional capacity and appropriate participation in the school environment is an age appropriate milestone for our youngest members. Therefore, the LOC Guideline _Child_Adol_Day_Treatment_Services_2BHO (Document 12, above) focuses on the current academic impairment in the admission and discharge criteria. Similarly, the LOC Guideline _Adult_Residential_Treatment_Services_2BHO (document 7) also provides in the definition, a focus on the attainment of life skills to help members with activities of daily living. These are life tasks that a member needs to accomplish in order to be able to transition to a less restrictive level of care, once they go back to the community. Services are rehabilitative in nature and as such, designed to help members return to or attain a higher level of functioning. All of our LOC guidelines are written	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	with these principles in mind. Beacon policies are based on the State Medicaid Program's definition for medical necessity and the covered diagnoses (Exhibit D-2_Covered Behavioral Health Diagnoses_2BHO, document 3) provides the scope of covered diagnoses that we are responsible to treat. The level of care guidelines also undergo annual review and revision (as indicated) by various committees (104L Developing and Updating Clinical Criteria Level of Care Criteria_2BHO, (document 25).	

Findings:
While CHP defined "medical necessity" equivalent to the definition outlined in this requirement, the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—included the addition of EPSDT-specific criteria. Therefore, CHP is advised to immediately update the definition of "medical necessity" accordingly. Please reference 10-CCR 2505-10 8.076.1.8 (a-g) and 8.7016.1.8.1 for guidance:

8.076.1.8. Medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all.
b. Is provided in accordance with generally accepted professional standards for health care in the United States.
c. Is clinically appropriate in terms of type, frequency, extent, site, and duration.
d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider.
e. Is delivered in the most appropriate setting(s) required by the client's condition.
f. Is not experimental or investigational.
g. Is not more costly than other equally effective treatment options.

8.076.1.8.1 For EPSDT-specific criteria, see 10 C.C.R. 2505-10, Section 8.280.4.E.
"For the purposes of EPSDT, medical necessity includes a good or service that will, or is reasonably expected to, assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living; and meets the criteria set forth in Section 8.076.1.8(b-g)."

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor has in place written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42 CFR 438.210(b)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.9	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO, Section I, H; Section II, A 2. 203LMedicalNecessityDetermination_2BHO – Section IV, F, 1-5 and IV, G, 1-5 Pages 8-11. 3. 204LIntakeDataCollectInitialAuthHLOC_2BHO- entire policy 4. 206LDataCollectionContinuedAuthHLOC_ 2BHO- entire policy **Description of Process:** Beacon policies clearly define and outline the procedures and information needed for each type of authorization- initial and continuing authorizations in policies (documents 3 and 4). The first step in the process is to gather the data and determine if Medical Necessity is being met (202L Medical Necessity_2BHO and 203LMedicalNecessityDetermination_2BHO – Section IV, F, 1-5 and IV, G, 1-5 Pages 8-11, documents 1 and 2 respectively). The process for reviewing initial authorization of care is reflected in 204L_IntakeDataCollectInitial Auth HLOC_2BHO, document 3). If addition services are requested, the process for conducting continuing reviews is reflected in 206L_DataCollectionContinuted AuthHLOC, (document 4).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure consistent application of review for authorizing decisions. *42 CFR 438.210(b)(2)(i)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.15	**Documents Submitted/Location within Documents:** 1. 408L Care Management Documentation Audit_2BHO – entire document 2. CCM Doc Audit Tool Conc Rvw_2BHO-Entire Document 3. CCM Doc Audit Tool Initial Rvw_2BHO-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: Beacon has a policy and procedure in place that outlines the process to ensure consistent application of the review for authorizing decisions (408L Care Management Documentation Audit_2BHO, document 1). Beacon clinical care managers complete quarterly peer audits utilizing a web-based audit tool that focuses on the content of documentation for UM decision making (CCM Doc Audit Tool Conc Rvw_2BHO and CCM Doc Audit Tool Initial Rvw_2BHO, documents 2 and 3). The audit reviews inpatient and ATU admissions that occurred the previous quarter. Each CCM has 2 admissions per month randomly selected, then their peers review the documentation in Care Connect. The cases are selected by either the Clinical Services Supervisor or the Clinical Director, and distributed to the CCM team to complete. The web-based tool calculates the scoring for the documentation audit, which includes timeliness of decision making as well. If the results of the audit are below standard (85%), corrective action training is taken to improve staff knowledge. The results are reported to the team and to the CHP board, through submission of a written report.	
7. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *4 2CFR 438.210(b)(2)(ii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.16	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_2BHO – Section IV, G, page 3 2. 203LMedicalNecessityDetermination_2BHO – Section IV, M., pages 13-14 3. 303L Peer Advisor Adverse Determinations_2BHO– Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon policies direct staff to contact the provider, when necessary, for a review determination (policy 203L Peer Advisor Adverse Determinations_2BHO, document 3). In addition, Beacon policies outline a formal process which includes consultation with a requesting provider, upon request, for reconsideration when initial or continued authorization is denied (303L Peer Advisor Adverse Determinations_2BHO). Authorizations or denials of services involve immediate telephonic notification of providers. (203L Medical Necessity Determination_Policy_2BHO – Document 2) If providers fail to request additional services, Beacon staff will reach out to coordinate with the provider to determine whether the member has discharged from care. If there is not enough information available to make a determination, the provider is notified along with details about the information needed. (202L Medical Necessity_2BHO – Document 1). Attempts are made to contact the requesting provider for reconsideration/peer to peer review before finalizing any adverse clinical decisions (203L_203LMedicalNecessityDetermination_2BHO, IV.A.6, page 4, document 2)	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor's UM program ensures that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease. *42 CFR 438.210(b)(3)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.15.3	**Documents Submitted/Location within Documents:** 1. QM_UM_Program Description_CHP, pages 37/38 *Misc 2. 303L Peer Advisor Adverse Determinations_2BHO – Entire Document **Description of Process:** The QM_UM_Program Description_CHP (document 1) describes the processes in place to ensure that any decision to deny a service authorization request or to authorize a service in the amount, duration, or scope that is less than requested is make by a healthcare professional who has appropriate clinical expertise in treatment the member's condition or disease. This is also reinforced via Policy 303L Peer Advisor Adverse Determinations_2BHO (Document 2).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor has in place processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42 CFR 438.210(c)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.1 10 CCR 2505-10 8.209.4.A	**Documents Submitted/Location within Documents:** 1. 203LMedicalNecessityDetermination_2BHO– IV, D.4/5. page 6; IV, E.4/5, pages 7-8; IV, F 4/5; G 4/5; H-5, page 12; I, pages 12-13 2. Denial_NOA_Appeal Process_2BHO- Entire Document **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon policy outlines the processes for notifying the requesting provider and involved member of any decision to deny or authorize less care than requested, for all types of requests and levels of care. Specifically, refer to policy 203LMedicalNecessityDetermination_2BHO sections listed below:	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	• **Section IV.D.4/5** outlines that for denials/limited authorization or urgent prospective requests, the requesting provider is notified telephonically at the time of determination, and that the member, facility and provider all receive written notice of the determination; • **Section IV.E.4/5** outlines the same notification guidelines indicated above for urgent concurrent reviews; • **Section IV.F4/5** outlines the same notification guidelines indicated above for routine initial reviews; • **Section IV.G.4/5** outlines the same notification guidelines indicated above for routine concurrent reviews. • **Section IV.H.5** outlines the notification guidelines indicated above for retrospective reviews. In addition the clinical staff have available to them a workflow that outlines these requirements and timeframes (Denial_NOA_Appeal Process_2BHO, document 2).	
10. The Contractor provides notice of standard authorization decisions as expeditiously as the member's health condition requires and not to exceed 10 calendar days from receipt of the request for service. *42 CFR 438.210(d)(1)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 10CCR2505—10, Sec 8.209.4.A.3.c	**Documents Submitted/Location within Documents:** 1. 203LMedicalNecessityDetermination _2BHO-Entire Policy **Description of Process:** Policy 203LMedicalNecessityDetermination_ 2BHO outlines the timeframes for mailing of Notices of Action: • For termination, suspension or reduction of previously authorized services, notices must be mailed at least 10 days before the date of the intended action (Section IV, F.5 pages 9)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	• For denial of payment (such as for retro reviews), at the time of the action affecting the claim (Section IV, H.5, page12) • All authorization decisions are made as expeditiously as the member's health condition requires (Section IV, A.2, page 3) • For standard service authorization decisions that deny or limit services- within 10 calendar days of the receipt of request for service (Sections IV.G.5, pages 10 and 11) • For service authorization decisions not reached within the required timeframes, on the date timeframes expire (Section IV, G.2, pages 9 and 10) • For expedited decisions, letters are mailed no later than 3 calendar days from the receipt of request for services (Section IV.D.5, page 6; IV.E.5, pages 7 and 8)	
11. For cases in which a provider indicates, or the Contractor determines, that the standard authorization time frame could seriously jeopardize a member's life or health or ability to attain, maintain, or regain maximum function, the Contractor makes an expedited authorization decision and provides notice as expeditiously as the member's health condition requires and not to exceed 3 working days from receipt of the request for service. *42 CFR 438.210(d)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.15.2	**Documents Submitted/Location within Documents:** 203LMedicalNecessityDetermination_ 2BHO-Entire Policy **Description of Process:** Policy 203LMedicalNecessityDetermination_2BHO outlines the timeframes for Notices of Action: • All authorization decisions are made as expeditiously as the member's health condition requires (Section IV, A.2, page 3) • For expedited decisions, letters are mailed no later than 3 calendar days from the receipt of request for services (Section IV.D.5, page 6; IV.E.5, pages 7 and 8)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
12. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(2)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 and 2.5.15.2.1	**Documents Submitted/Location within Documents:** 1. 203LMedicalNecessityDetermination_2BHO Pages 7-10, Sections IV.D2 and 3 and IV.E2 and pages 13-15 Sections IV.F.3 and IV.E.3 **Description of Process:** Beacon rarely extends decision timeframes, however when extensions are made, policy 203LMedicalNecessityDetermination_2BHO provides the guidelines that are followed. For expedited authorizations, due to the urgent nature of the care and to meet URAC requirements, authorization decisions must be made within 72 hours, so extensions are only given due to lack of information to make any decision or if the member requests an extension. • **Section IV.D.2** outlines the timeframe for possible extension, when requested by the member, is up to 14 calendar days for an urgent (expedited) case for an initial authorization decision. • **Section IV.D.3** outlines the timeframe for possible extension when there is a lack of information to make **any** authorization decision is up to 14 calendar days. • **Section IV.E.2** outlines the timeframe for possible extension is up to 14 calendar days for an urgent (expedited case) for a concurrent authorization decision. For standard (routine) authorizations: • **Section IV.F.2-3 and IV.G2-.3** notes a 14 calendar day extension is available if there is a lack of information to make	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	an authorization decision, or if the member requests an extension for initial or concurrent authorization decisions. **Section IV.F.3** notes a 14 day extension is available if there are circumstances beyond the control of Beacon.	
Findings: Policies and procedures clearly outlined CHP's ability to extend the authorization decision time frame by 14 days based on member request or the need for additional information. In addition, the policy stated that CHP may extend the time frame "due to matters justifiably beyond the control of the BHO," which staff described as an occurrence such as a natural disaster. Federal language clearly states that the Contractor may extend the authorization decision only if "there is a need for additional information and that the extension is in the member's best interest."		
Required Actions: CHP must modify the language in its policies and procedures to remove "due to matters beyond the control of the BHO" as a reason for extending the authorization decision time frame.		
13. Notices of action must meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42 CFR 438.404(a); 438.10 (b) and (c)(2)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5 10CCR2505—10, Sec 8.209.4.A.1	**Documents Submitted/Location within Documents:** 1. 306LMemberMaterials_Development_2BHO-I.A-E 2. Notice of Action CHP Non Covered Diagnosis_CHP-Entire Document 3. Notice of Action CHP Non Covered Diagnosis_Spanish_CHP-Entire Document 4. Notice of Action CHP Not Mtg Med Nec Form_CHP-Entire Document 5. Notice of Action CHP Not Mtg Med Nec_Spanish_CHP-Entire Document 6. Notice of Action CHP Service Not Covered Spanish_CHP-Entire Document 7. Notice of Action CHP Service Not Covered_CHP-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: Beacon follows our policy on member materials development for any member materials. All member materials are translated into Spanish, which has been deemed as a prevalent language by the state. We recognize that a large proportion of Medicaid enrollees have low health literacy, so we follow guidelines developed by CMS in developing the Beacon member materials policy for low literacy readers. For example, when we present a concept that may be unknown to a low literacy reader, we offer a definition in simple language. The Notice of Action letter is translated into Spanish, and we are prepared to translate it into other languages should a member request this. We test our materials to ensure they are at or below the 6th grade reading level. We continue to use templates specific to the denial reason: • Notice of Action CHP Non Covered Diagnosis_CHP • Notice of Action CHP Non Covered Diagnosis_Spanish_CHP • Notice of Action CHP Not Mtg Med Nec Form_CHP • Notice of Action CHP Not Mtg Med Nec_Spanish_CHP • Notice of Action CHP Service Not Covered Spanish_CHP • Notice of Action CHP Service Not Covered_CHP	
14. Notices of action must contain: • The action the Contractor (or its delegate) has taken or intends to take. • The reasons for the action. • The member's or provider's (on behalf of the member) right to file an appeal and procedures for filing. • The date the appeal is due.	**Documents Submitted/Location within Documents:** 1. Notice of Action CHP Non Covered Diagnosis_CHP-Entire Document 2. Notice of Action CHP Non Covered Diagnosis_Spanish_CHP-Entire Document 3. Notice of Action CHP Not Mtg Med Nec Form_CHP-Entire Document 4. Notice of Action CHP Not Mtg Med Nec_Spanish_CHP-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• The member's right to request a State fair hearing. • The procedures for exercising the right to a State fair hearing. • The circumstances under which expedited resolution is available and how to request it. • The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. • The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). *42 CFR 438.404(b)* *(Requirement to be updated 7/2017—see appendix)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.6	5. Notice of Action CHP Service Not Covered Spanish_CHP-Entire Document 6. Notice of Action CHP Service Not Covered_CHP-Entire Document 7. GrievanceAppeal_Guide_CHP-Entire Document **Description of Process:** Beacon ensures that members receive Notices of Action which contain all of the required elements. In our effort to only include elements in the letter which pertain specifically to the member in question, we include our separate Grievance and Appeal Guide (GrievanceAppeal_Guide_CHP) which we mail with every Notice of Action. The included letter templates: • Notice of Action CHP Non Covered Diagnosis_CHP • Notice of Action CHP Non Covered Diagnosis_Spanish_CHP • Notice of Action CHP Not Mtg Med Nec Form_CHP • Notice of Action CHP Not Mtg Med Nec_Spanish_CHP • Notice of Action CHP Service Not Covered Spanish_CHP • Notice of Action CHP Service Not Covered_CHP	
15. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except:	**Documents Submitted/Location within Documents:** 1. 203LMedicalNecessityDetermination _2BHO-Entire Policy **Description of Process:** Policy 203LMedicalNecessityDetermination_ 2BHO outlines the timeframes for mailing of Notices of Action: • For termination, suspension or reduction of previously authorized services, notices must be mailed at least 10 days	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands that service termination or reduction will occur. o The member has been admitted to an institution in which the member is ineligible for Medicaid services. o The member's address is determined unknown based on returned mail with no forwarding address. o The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. o A change in the level of medical care is prescribed by the member's physician. o The notice involves an adverse determination with regard to preadmission screening requirements. o The transfer or discharge from a facility will occur in an expedited fashion.	before the date of the intended action (Section IV.I. pages 12-13) • For denial of payment (such as for retro reviews), at the time of the action affecting the claim (Section IV.H.5, page 12) • All authorization decisions are made as expeditiously as the member's health condition requires (Section IV.A.2, page 3) • For standard service authorization decisions that deny or limit services- within 10 calendar days of the receipt of request for service (Sections IV.F.4, page 9 and IV.G.5, page 10-11) • For service authorization decisions not reached within the required timeframes, on the date timeframes expire (Section IV. A.5, page 3-4) • For expedited decisions, letters are mailed no later than 3 calendar days from the receipt of request for services (Section IV.D.5, page 6 and IV.E.5, pages 7-8)	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• For denial of payment, at the time of any action affecting the claim. • For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. • For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services. • For service authorization decisions not reached within the required time frames on the date time frames expire. • If the Contractor extends the time frame, as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR 438.210 (d) *42 CFR 438.404(c)* *42 CFR 431.211,431.213, and 431.214* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5 10CCR2505—10, Sec 8.209.4.A (3) (a-c)		
Findings: Staff members stated that it is CHP's policy to make a retrospective claim payment determination and send a notice of action within 30 days of receipt of the claim. The requirement is that the notice of action be mailed "at the time of any action affecting the claim." In one of three on-site reviews of retrospective claim denials the notice of action was not mailed within a reasonable time frame (within three days) after the denial decision was made.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Required Actions: CHP must clarify its policies and procedures and ensure that it sends members and providers a notice of action for denial of claims payment "at the time of any action affecting the claim"—interpreted by HSAG as on the date of denial or within three days of the decision.		
16. If the Contractor extends the time frame for making a service authorization decision, it: • Provides the member written notice of the reason for the decision to extend the time frame. • Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. *42 CFR 438.404(c)(4)(i)* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5.5.2 10CCR2505—10, Section 8.209.4.A.3.c (i)	**Documents Submitted/Location within Documents:** **1.** 203L MedicalNecessityDetermination_ 2BHO – Sections IV.D.3.a , IV.E.3.a, IV.F.2-3 and IV.G.2-3 **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon policy details the requirements to send written notification to the member and to carry out the determination as expeditiously as the member's health condition requires. Written notification requirements can be found in Beacon Colorado 203LMedicalNecessityDetermination_ 2BHO in the following locations: • IV.D.3.a, page 5-6 • IV.E.3.a, page 7 • IV.F.2-3, page 8-9 • IV.G.2, pages 9 • IV.G.3, page 10 The policy also outlines the fact that authorization decisions are made as required by the member's health condition, and no later than the date the extension expires: • IV.D.1, page 5 • IV.E.1, pages 6-7 • V.F.1, page 8 • IV.G.1, page 9	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
17. The Contractor provides that compensation to individuals or entities that conduct utilization management (UM) activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR 438.210(e)* Contract: Amendment 6, Exhibit A-2—2.5.15.4	**Documents Submitted/Location within Documents:** 1. C421Obj in clin dec mkg CSNT 117.1_2BHO -entire policy 2. New_Hire_and_Annual_Attestation_2BHO, page 3 3. Code of Conduct_Copy of Certificate_2BHO-Entire Document 4. Code of Conduct_Annual Training_2BHO-entire document **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon has policies in place that define conflict of interest and specifically state that employees are not provided incentives, nor permitted to accept gifts in relation to any UM activities. (C421Obj in clin dec mkg CSNT 117.1_2BHO - entire policy, document 1). New employees as well as on an annual basis, Beacon staff receives training regarding conflict of interest and employee code of conduct, including signing an annual attestation (New_Hire_and_Annual_Attestation_2BHO, page 3, document 2; Code of Conduct_Annual Training_2BHO, document 4 and Code of Conduct, Copy of certificate_2BHO, document 3) agreeing with policies that they are not given incentives to deny or limit care for members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
18. The Contractor defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices_Policy_2BHO – Page 2-3, Section II.A 2. Provider Manual_2BHO– Section 4- Utilization Management Procedures, page 21 *Misc 3. Member Handbook_CHP_Page 13*Misc	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.20	**Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon 270L Emergency and PostStabilization Services policy defines emergency medical conditions that coincide with the State's definition of Medical Necessity (document 1). Members receive information in the member handbook (Member Handbook_CHP) about what defines an emergency or crisis and how to obtain emergency services (document 3). Beacon staff assists members and directs them to the nearest facility/ER when there is any question of an emergency medical condition. The definition of emergency medical condition is identified in the Member Handbook (Member Handbook_CHP document) and the Provider Manual_2BHO (document 2,).	
19. The Contractor defines "emergency services" as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and needed to evaluate or stabilize an emergency medical condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.21	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices_Policy_2BHO – Pages 3, Section II.C. 2. Provider Manual_BHO– Section 4- Utilization Management Procedures, page 21-22.*Misc **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon 270L Emergency and PostStabilizationServices_Policy_2BHO policy provides this exact definition of Emergency Services This definition is also given to providers in the Provider Maual_2BHO.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
20. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42 CFR 438.114(c)(1)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.1	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices_Policy_2BHO – Page 1, Section I.A. 2. Colorado Reference Guide _2BHO- #22, page 12 **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Policy 270L Emergency and PostStabilizationServices_2BHO (document 1) provides an overview of how emergency services are covered and reimbursed. Beacon Colorado ER claims procedures indicates members can access these services without prior authorization (Colorado Reference Guide_2BHO, document 2 page 12). This procedure document states that claims for emergency services are accepted and paid for to any provider, regardless of network status	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor informs members that prior authorization is not required for emergency services. *42 CFR 438.10(f)(6)(viii)(B)* Contract: Amendment 6, Exhibit A-2—2.6.11.1.13.4	**Documents Submitted/Location within Documents:** 1. Member Handbook_CHP – Page 13-14 *Misc 2. Provider Manual_2BHO– Section 4- Utilization Management Procedures, pages 21-22 *Misc 3. Colorado Reference Guide _2BHO- #22, page 12 **Description of Process:** Beacon informs members via the Member Handbook (document 1) that prior authorization is not required for emergency services. In addition, Providers are made aware that emergency services do not require prior authorization (Provider Manual_2BHO, page 21). As Members are not responsible for payment of any emergency service claims, the Claims Processors follow the guidance	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	established in the Colorado Reference Guide_2BHO, page 12 in addressing such claims.	
22. The Contractor may not deny payment for treatment obtained under the following circumstances: • A member had an emergency medical condition, as defined in 42 CFR 438.114(a) (see #18 above). • Situations which a prudent layperson who possesses an average knowledge of health and medicine would perceive as an emergency medical condition but the absence of immediate medical attention would not have had the following outcomes: – Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. – Serious impairment to bodily functions. – Serious dysfunction of any bodily organ or part. • A representative of the Contractor's organization instructed the member to seek emergency services. *42 CFR 438.114(c)(ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.1, 2.2.4.3.4.2	**Documents Submitted/Location within Documents:** 1. 270L Emergency PostStabilizationServices – Policy_2BHO- Pages 1-, Section I.B.1 2. Colorado Reference Guide _2BHO-entire document 3. Member Handbook_CHP – Page 13 and 14 *Misc 4. Provider Manual_2BHO– Section 4- Utilization Management Procedures, page 21 *Misc **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon 270L Emergency PostStabilizationServices – Policy_2BHO clearly outlines that payment may not be denied under either of these circumstances. There is no authorization requirement at all for emergency services. These services are not denied when billed as emergency services, regardless of the actual outcome (Colorado Reference Guide_2BHO, document 2). Members and Providers are also informed of this requirement through the Provider and Member handbooks (Member Handbook_CHP and Provider Manual_2BHO).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
23. The Contractor does not: • Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. • Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor, or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42 CFR 438.114(d)(1)(i) and (ii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.4.3	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices_Policy_2BHO –Page 1, Section I.C.1-2 2. Colorado Reference Guide _2BHO-entire document **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon 270L Emergency PostStabilizationServices – Policy does not limit what constitutes an emergency medical condition based on diagnoses, symptoms or refuse to cover emergency services based on the provider, hospital or fiscal agent not notifying the primary care providers within 10 days of presentation for services. During claims processing, Beacon staff pays these claims, without the need for an authorization. Providers are not required to notify Beacon of ER services or request authorizations to obtain reimbursement (Colorado Reference Guide_2BHO, document 2)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor will be responsible for emergency services: • When the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. • For *practitioner* emergency room claims for members with a primary substance use or mental health disorder diagnosis. (The Contractor is not financially responsible for outpatient emergency room services for members with a primary	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices – Policy_2BHO- Page 1, Section I.A, C.1 2. Colorado Reference Guide _2BHO- #22, page 12 **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon 270L Emergency and PostStabilization Services policy indicates that Beacon is responsible to pay for ER services when the primary diagnosis is	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ TBD

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
substance use disorder diagnosis or when the primary diagnosis is medical in nature.) Contract: Amendment 6, Exhibit A-2—2.2.4.3.11, 2.2.4.3.12, 2.2.4.3.13	psychiatric in nature, even if the ER services also included some procedures to treat a secondary medical diagnosis. During claims processing, Beacon staff allows for payment of these claims, without the need for an authorization. (Colorado Reference Guide_2BHO, document 2) denied	
Findings: The Emergency and Poststabilization Services policy addressed the BHO's responsibility to pay for emergency services when the primary diagnosis is psychiatric in nature. HSAG observed in the on-site denial record reviews several cases in which the emergency services claim documented a primary behavioral health diagnosis later re-determined by CHP's medical reviewer as being "not a covered diagnosis" because the reviewer believed the root cause of the behaviors was related to a non-covered diagnosis (e.g., substance use, autism). Therefore, it was unclear to the reviewer whether or not the Contractor appropriately authorized payment "when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis." However, the decision of "not a covered diagnosis" is based on the clinical judgment of the medical director/peer advisor and, as such, is outside the scope of the compliance audit. HSAG referred these cases to the Department for further evaluation. For purposes of this compliance audit, HSAG marked this requirement as "To Be Determined" (TBD) and will treat it as a "Not Applicable" score.		
25. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR 438.114(d)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.5	**Documents Submitted/Location within Documents:** 1. DelegationAgreement_CHP - Entire policy *Misc 2. 270L Emergency and PostStabilizationServices – Policy_2BHO -Page 1, Section I.D. 3. Member Handbook_CHP –Page 13 &14 *****Misc **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon 270L Emergency and PostStabilization Services policy releases the member from liability for payment for any subsequent screening and treatment needed to stabilize an emergency medical condition. Members are informed via the member handbook (Member Handbook_CHP) that the member is not responsible to pay for services covered by	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	the Medicaid plan. Members are instructed to call the Behavioral Health Organization if the member receives a bill for services.	
26. The Contractor allows the attending emergency physician or the provider actually treating the member to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, who is responsible for coverage and payment. *42 CFR 438.114(d)(3)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.6	**Documents Submitted/Location within Documents:** 1. DelegationAgreement_CHP - Entire policy *Misc 2. 270L Emergency and PostStabilizationServices – Policy_2BHO-Page 2, Section I..E **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon 270L Emergency and PostStabilization Services policy states the attending physician/facility makes decisions independent of any contact with the Behavioral Health Organization regarding stabilization, as there is no preauthorization required for emergency services, and no authorization needs to be on file for the claim to be paid. The provider makes treatment decisions and submits the bill after services have been rendered.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
27. The Contractor defines "poststabilization care services" as covered services, related to an emergency medical condition, that are provided after a member is stabilized to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR 438.114(a)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—1.1.1.47	**Documents Submitted/Location within Documents:** 1. DelegationAgreement_CHP - Entire policy *Misc 2. 270L Emergency and PostStabilizationServices – Policy_2BHO-Page 3, Section II.D. **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon 270L Emergency and PostStabilization Services policy clearly defines post stabilization care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
28. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42 CFR 438.114(e)* *42 CFR 422.113(c)(i)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.7	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices – Policy_2BHO-Page 2, Section I.D **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon is financially responsible for post stabilization care services obtained within or outside the network that have been pre-approved by a plan provider or other organization representative. Policy 270 L Section I. D. clearly states this financial responsibility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative but are administered to maintain the member's stabilized condition under the following circumstances: • Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. • The Contractor does not respond to a request for pre-approval within 1 hour. • The Contractor cannot be contacted. • The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care, and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the	**Documents Submitted/Location within Documents:** 1. 270L PostStabilizationServices –Policy_2BHO-Page 2, Section I.G. 2-4 **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon is financially responsible for post stabilization care services obtained within or outside the network that have NOT been pre-approved by a plan provider or other organization representative but are administered to stabilize the member's condition in several circumstances. Policy 270 L Section I. G.2-4. clearly states this financial responsibility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
opportunity to consult with a plan physician; and the treating physician may continue with care of the patient until a plan physician is reached or the Contractor's financial responsibility for poststabilization care services it has not pre-approved ends. *42 CFR 438.114(e)* *42 CFR 422.113(c)(ii) and (iii)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.8, 2.2.4.3.8.1, 2.2.4.3.8.2, 2.2.4.3.8.3		
30. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: • A plan physician with privileges at the treating hospital assumes responsibility for the member's care. • A plan physician assumes responsibility for the member's care through transfer. • A plan representative and the treating physician reach an agreement concerning the member's care. • The member is discharged. *42 CFR 438.114(e)* *42 CFR 422.113(c)(2)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.9	**Documents Submitted/Location within Documents:** 270L Emergency and PostStabilizationServices –Policy_2BHO-Page 3-4, Section IV.A-C Member Handbook_CHP-Page 14 *Misc **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon policy details the additional circumstances by which Beacon maintains financial responsibility for provided services. Policy 270 L states that members are not charged for these services regardless of whether the services are obtained through Beacon or not. The member handbook also lets members know that they are not responsible to pay for any Medicaid covered services. Members are not charged for these services regardless of whether they go through Beacon or not.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
31. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42 CFR 438.114(e)* *42 CFR 422.113(c)* *(Requirement updated 7/2016—as shown)* Contract: Amendment 6, Exhibit A-2—2.2.4.3.8.4	**Documents Submitted/Location within Documents:** 1. 270L Emergency and PostStabilizationServices – Policy_2BHO-Page 1, Section I. D. 2. Member Handbook_CHP-Page 14*Misc **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). Beacon policy details the additional circumstances by which Beacon maintains financial responsibility for provided services. Policy 270 L states that members are not charged for these services regardless of whether the services are obtained through Beacon or not. The member handbook also lets members know that they are not responsible to pay for any Medicaid covered services. Members are not charged for these services regardless of whether they go through Beacon or not.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	27	X	1.00	=	27
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable/ To Be Determined	=	2	X	NA	=	NA
Total Applicable		=	29	**Total Score**		=	27

Total Score ÷ Total Applicable	=	93%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains and monitors a network of providers sufficient to provide access to all covered behavioral health and substance use disorder services. *42 CFR 438.206(b)(1)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.1, 2.5.9	**Documents Submitted/Location within Documents:** 1. QM24.22CO-A_Measurement of Access and Availability-CHP-Entire document. 2. PR302 NetworkDesignAndAccessStandard_2BHO-Entire Policy 3. IPN_EmergencyAccessToCare_Q4FY16_CHP-EntireDocument 4. AccessToCare_Q4FY16_CHP-Entire Document 5. Q4 FY16 NWAdequacy Report – 20160706_2BHO-Entire Document 6. FY 2016 Annual Needs Assessment_052016_2BHO-Entire Document 7. CHP Provider Directory Lang Update-2016-09-14-14-59-32_CHP-Entire Document 8. L604_Policy CHP LCC –Colorado CHP LCC Review Standards_FINAL_CHP-Entire Policy **Description of Process:** This element is delegated to Beacon Health Options by Colorado Health Partnerships (CHP). Beacon Health Options has several policies that describe the activities involved to assess and maintain a comprehensive provider network to serve the needs of eligible Health First Colorado (Medicaid) members as noted in the local (L604_Policy CHP LCC –Colorado CHP LCC Review Standards_FINAL_CHP) and national policy (PR302 NetworkDesignAndAccessStandard_2BHOs and QM24.22CO-A_Measurement of Access and Availability-2BHO). In addition	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	to policies, Beacon Health Options conducts a variety of provider monitoring activities to assure providers are meeting the needs of BHO Health First Colorado (Medicaid) members. These activities include monitoring of accessibility and availability (AccessToCare_Q4FY16_CHP) and (IPN_EmergencyAccessToCare_Q4FY16_CHP). The BHO maintains other network reports that monitor the number and mix of the providers included in the network to serve member needs based on expected utilization and population (Q4 FY16 NWAdequacy Report – 20160706_2BHO), (FY 2016 Annual Needs Assessment_052016_2BHO), and (CHP Provider Directory Lang Update-2016-09-14-14-59-32_CHP-Entire Document).	
2. In establishing and maintaining the network, the Contractor considers: • The anticipated Medicaid enrollment. • The expected utilization of services, taking into consideration the characteristics and healthcare needs of specific Medicaid populations represented in the Contractor's service area. • The numbers, types, and specialties of providers required to furnish the contracted Medicaid services. • The number of network providers accepting/not accepting new Medicaid members. • The geographic location of providers in relationship to where Medicaid members live, considering	**Documents Submitted/Location within Documents:** 1. PR302 NetworkDesignAndAccessStandard_2BHO-Entire Policy 2. FY 2016 Annual Needs Assessment_052016_2BHO-Entire Document 3. CHP Provider Directory Lang Update-2016-09-14-14-59-32_CHP-Entire Document 4. Q4 FY16 NWAdequacy Report – 20160706_2BHO-Entire Document 5. Provider Manual_2BHO- page 30 *Misc 6. L604_Policy CHP LCC –Colorado CHP LCC Review Standards_FINAL_CHP-Entire Policy 7. CHP_Specific_BHONetDevPlan_FY17_CHP-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
distance, travel time, and means of transportation used by members. – Members have access to a provider within 30 miles or 30 minutes' travel time, whichever is larger, to the extent such services are available. • Physical access to locations for members with disabilities. *42 CFR 438.206(b)(1)(i) through (v)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.9.1; 2.5.9.2; 2.5.8.1.4	**Description of Process:** This element is delegated to Beacon Health Options by Colorado Health Partnerships (CHP). Beacon Health Options reviews the network adequacy for CHP regularly as per our local (L604_Policy CHP LCC –Colorado CHP LCC Review Standards_FINAL_CHP) and national (PR302 NetworkDesignAndAccessStandard_2BHO) policies to ensure Health First Colorado (Medicaid) members have a range of providers that are available to serve their needs. Our Network Development Plan (CHP_Specific_BHONetDevPlan_FY17_CHP) gives details on the specific needs CHP has in provider recruitment. Review of the network includes the number of providers, specialties, languages, locations, and accessibility. As notes in our Network Reports (FY 2016 Annual Needs Assessment_052016_2BHO and (Q4 FY16 NWAdequacy Report – 20160706_2BHO), Beacon Health Options monitors the availability of providers quarterly and annually. The monitoring completed by Beacon Health Options includes an assessment of member needs and expected utilization. Members are provided choice in providers across the CHP region (5 Provider Manual_2BHO) and (CHP Provider Directory Lang Update-2016-09-14-14-59-32_CHP) which includes an array of providers who can serve member needs based on specialty, licensure level, or level of care that is found to be medically necessary. Information is provided of member ability to choose providers that are available in the network, or the right to request a provider be added to the network in our member materials.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor provides for a second opinion from a qualified healthcare professional within the network or arranges for the member to obtain one outside the network, at no cost to the member. *42 CFR 438.206(b)(3)* Contract: Amendment 6, Exhibit A-2—2.5.8.2	**Documents Submitted/Location within Documents:** 1. Policy 257L – Request for Second Opinion_2BHO-section IA, IVA1,2 2. Second Opinion Workflow_2BHO– Entire document 3. Provider Manual_2BHO- page 13, 31 **Misc* 4. Member Handbook_CHP– Page 19 **Misc* 5. Website_StandardII_CHPSecondOpinion_ProviderChange Request_2016_CHP-Eniter Document 6. SecondOpinion_ProviderChangeRequest_2016_CHP-Entire Document **Description of Process:** This element is delegated to Beacon by Colorado Health Partnerships (CHP). In order to ensure that Members know that they have access to a second opinion, we have trained both Clinical Care Managers, Clinical Support Assistants, and OMFA Grievance Coordinator of this right. This is through team meetings, review of Policy 257L – Request for Second Opinion , and is monitored through supervision by both the Clinical Direction and OMFA Director. Policy 257L – Request for Second Opinion is Beacon's policy for requesting a second opinion. Information about requesting a second opinion is also located in the Member handbook (Member Handbook_CHP) and on the CHP website. (http://www.coloradohealthpartnerships.com/members/pdf/CHP_Member_Handbook.pdf). The number of requests that we receive each year requesting a second opinion is relatively low. In the instances a request is received, staff members follow the Second Opinion policy and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	workflow (SecondOpinionworkflow_2BHO). This can be through the Clinical Department or the Office of Member & Family Affairs. SecondOpinion_ProviderChangeRequest_2016_CHP is a form for Providers and Members alike, which were developed to help facilitate this process to ensure the reason for the second opinion is considered in finding a provider. If a network provider is not qualified to help with a second opinion (for instance in treating Members with eating disorders), we would go outside of our network at no cost to the Member. The process is further outlined in Beacon's 257LRequestforSecondOpinion _2BHO. As noted in the policy, it is necessary to determine the medical necessity and appropriateness of the mental health services that are provided to our Members; thus, allowing a need for a second consultation or opinion from a qualified mental health clinician or a Board Certified Psychiatrist. Members learn about their rights to a second opinion through the member handbook (Member Handbook_CHP) which includes the member rights and responsibilities statements. Providers are informed of the second opinion process and that there is no cost to the member through the provider handbook (Provider Handbook_2BHO).	
4. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network for as long as the Contractor is unable to provide them. *42 CFR 438.206(b)(4)* Contract: Amendment 6, Exhibit A-2—2.5.9.5	**Documents Submitted/Location within Documents:** 1. SCALetter_Practitioner_2015DEC22_PR_2BHO-Entire Document 2. SCALetter_Facilities_2015DEC22_PR_2BHO-Entire Document 3. Provider Manual_2BHO-page 30 *Misc MemberHandbook_CHP_Page 6, 8 and 21 *Misc 4. Policy 257L – Request for Second Opinion_2BHO-section IA, IVA1,2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: This element is delegated to Beacon Health Options by Colorado Health Partnerships (CHP). Beacon Health Options' policies 257LRequestforSecondOpinion_Policy_2BHO describes services not available through an in-network provider may be accessible to members through an out-of-network provider at no cost to the member and that all timeframes for authorization decisions must be upheld. Policies outline the approval process and situations in which Single Case Agreements are approved for member services outside of the provider network. Providers are sent individual contracts (SCALetter_Practitioner_2015DEC22_PR_2BHO) and (SCALetter_Facilities_2015DEC22_PR_2BHO which indicate that the Provider Manual_2BHO- page notes that members cannot be billed for behavioral health services. In the member handbook MemberHandbook_CHP), members are informed that they can ask to see a provider who may not be listed in the provider directory. Additionally stating, if the Member has a need that one of our network providers are not able to meet, Member's may call our Access to Care line and request to see an out of network provider. The provider handbook (Provider Manual_2BHO) outlines the member's rights regarding choice of providers. The Member Handbook (MemberHandbook_CHP) coincides with the Provider Handbook, in such that as part of our Member Rights, all Members have a choice of providers within our network or they may ask to have a provider added to our network.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
5. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42 CFR 438.206(b)(5)* Contract: Amendment 6, Exhibit A-2—none	**Documents Submitted/Location within Documents:** 1. SCALetter_Practitioner_2015DEC22_PR_2BHO-Entire Document 2. SCALetter_Facilities_2015DEC22_PR_2BHO-Entire Document 3. Provider Manual_2BHO- page – 53 *Misc **Description of Process:** This element is delegated to Beacon Health Options by Colorado Health Partnerships (CHP). Single Case Agreements require that out-of-network providers coordinate with Beacon Health Options with respect to payment (SCALetter_Practitioner_2015DEC22_PR_2BHO and (SCALetter_Facilities_2015DEC22_PR_2BHO). Included in the individual single case contracts is a reference to the Provider Manual (Provider Manual_2BHO). The provider manual indicates that members cannot be billed for behavioral health services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
6. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42 CFR 438.206(c)(1)(iii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.9	**Documents submitted:** 1. QM24.22CO-A_ Measurement of Access and Availability_CHP-Entire document 2. AccessToCare_Q4FY16_CHP-Entire Document 3. Provider Manual_2BHO- page-12 and 38 *Misc 4. 210L_ MemberRequestRoutine_2BHO-Page 1 Section 1 5. 211LMemberRequestUrgent_2BHO-Page 1 Section 1 A-C 6. CallM_Fail_EmergencyResponseTesting_CHP-Entire Document 7. VisnackJ_Pass_EmergencyResponseTesting_CHP-Entire Document 8. SUD Provider After Hours Availability Requirement_2BHO	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	9. eNewsletter_2016_Aug-2BHO-Page 7 10. 2015PractionerContract-2BHO-pages 13, 19, 25 and 27 11. AccessAllQuestions_CHP-Entire Document 12. Minutes_CAUMC-QISCMeetingMinutes_2015NOV06-CHP_Page 3 13. Grievance and Appeals Analysis _StRpt_Q4FY16_CHP-Entire Document 14. Grievance and Appeals State Report_Q4FY16_CHP-Grievance tab rows 26-40 15. Grievance_Survey_CHP-Entire Document 16. SurveyQ1Q2Q3FY16_CHP-Entire Document **Description of Process:** In order to ensure that covered services are available 24 hours a day, 7 days a week when medically necessary Colorado Health Partnerships (CHP) maintains policies which establishes standards to ensure that, "contract-required services are available 24 hours a day, seven days a week, when medically necessary" (QM24.22CO-A_ Measurement of Access and Availability_CHP, 210L_ MemberRequestRoutine_2BHO and 211LMemberRequestUrgent_2BHO). 2015PractionerContract-2BHO also states that the provider will, "make available to MCD Members those Medically Necessary Covered Services provided by Provider within the scope of his/her/its professional license, registration and or certification twenty-four (24) hours a day, seven (7) days a week. In addition, CHP ensures that providers are meeting the standards set forth in the contract by conducting regular monitoring. AccessToCare_Q4FY16_CHP demonstrates quarterly monitoring	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	surrounding access standards. The details of this report are shared at the CAUMC/QISC committee on a regular basis. Furthermore, the emergency responsiveness of the IPN provider network is monitored regularly through ongoing testing (CallM_Fail_EmergencyResponseTesting_CHP, VisnackJ_Pass_EmergencyResponseTesting_CHP, SUD Provider After Hours Availability Requirement_2BHO, and eNewsletter_2016_Aug-2BHO). During the test calls the IPN providers are phoned to assess the validity of their emergency instructions contained within their voicemail and to test their responsiveness in returning calls within the 15 minute requirement. Likewise, CHP also monitors the perceptions surrounding access to care of the members we serve through the semiannual Fact Finders report (AccessAllQuestions_CHP-Entire Document). The responses to the Fact Finders questions are tabulated and trended and reviewed at CAUMC/QISC (Minutes_CAUMC-QISCDraftMeetingMinutes_2015NOV06_CHP). The Provider Manual_2BHO- page also provides detail on standards for coverage of service. In addition, CHP monitors and reports grievances surrounding member's perceptions of access to care. The Grievance and Appeals Analysis _StRpt_Q4FY16_CHP and the Grievance and Appeals State Report_Q4FY16_CHP are submitted to the State quarterly with a final report submitted annually.	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	In addition to quarterly reports, the Office of Member and Family Affairs reviews Member Surveys Grievance Survey_CHP, after a grievance has been completed. The surveys relay information about the outcome of the grievances, Member's may provide written feedback and their overall satisfaction or dissatisfaction of the Grievance Process. SurveyQ1Q2Q3FY16_CHP reflects the success of the process.	
7. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members or Medicaid fee-for-service if the provider serves only Medicaid members. • Minimum hours of provider operation shall include service coverage from 8 a.m. to 5 p.m. Mountain Time, Monday through Friday. • Extended hours of operation and service coverage shall be provided at least 2 days per week at clinic treatment sites, which may include additional morning, evening, or weekend hours. • Emergency coverage 24 hours a day, 7 days a week. *42 CFR 438.206(c)(1)(ii)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.2, 2.5.8.1.3	**Documents Submitted/Location within Documents:** 1. Provider Manual_2BHO-pages 11-12 *Misc 2. 2016_Contract Compliance Tool_CHP-Page 1 (Access to Services Section) 3. QM24.22CO-A_ Measurement of Access and Availability-CHP-Entire document **Description of Process:** This element is delegated to Beacon Health Options by Colorado Health Partnerships (CHP). Beacon Health Options' policies (QM24.22CO-A_ Measurement of Access and Availability-CHP) describe provider availability and members' access to care requirements. The Provider Manual (Provider Manual_2BHO) is incorporated into each providers' contract as a participating Beacon Health Options/BHO provider. Providers are required to offer hours of operation that are not less than that offered to any other client/member that has other coverage including self-pay. Contract compliance audits are conducted to evaluate several elements including access standards 2016_Contract Compliance Tool_CHP.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services, taking into account the urgency of the need for services: • Emergency services are available: – By phone, including TTY accessibility, within 15 minutes of initial contact. – In person within 1 hour of contact in urban and suburban areas. – In person within 2 hours of contact in rural and frontier areas. • Urgently needed services are provided within 24 hours of the initial identification of need. • Routine services are available upon initial request within 7 business days. (Routine services include but are not limited to an initial individual intake and assessment appointment. Placing members on waiting lists for initial routine service requests is not acceptable.) • Routine outpatient appointments following intake/initial assessment shall occur at least 3 times within 45 days. • Outpatient follow-up appointments shall occur within 7 business days after discharge from an inpatient psychiatric hospitalization or residential facility.	**Documents submitted:** 1. QM24.22CO-A_ Measurement of Access and Availability-2BHO-Entire document 2. AccessToCare_Q4FY16_CHP-Entire Document 3. 2016_Contract Compliance Tool_CHP-Items 1-3 4. IPN_EmergencyAccessToCare_Q4FY16_CHP-Entire Document 5. CallM_Fail_EmergencyResponseTesting_CHP-Entire Document 6. VisnackJ_Pass_EmergencyResponseTesting_CHP-Entire Document 7. SUD Provider After Hours Availability Requirement_2BHO-Entire Document 8. eNewsletter_2016_Aug-2BHO-Entire Document 9. Provider Manual_2BHO- page-10,11 and 49 *Misc 10. CMHC_prov monitoring_CHP-Entire Document 11. IPAuditTool_final_2BHO-Instructions tab,cell 59C 12. swffile_summary_CHP-number 9 13. swffile_SUDScreenshot_2BHO-Entire Document 14. CAUMCQISC_2016SEP09_QM_Minutes_CHP-Pages 2 and 3 15. SUD Committee MeeetingMinutes_2016APR27-2BHO-Item VII 16. 2015PractionerContract-2BHO-pages 13, 19, 25 and 27 17. PerformanceMeasure_AmbFU_7Day-2BHO-Entire Document 18. Q4 FY16 NW Adequacy Report - 20160706_2BHO-Entire Document 19. BHO_ProviderTrainingCY16_2BHO-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
• Ongoing mental health and substance use disorder services shall be scheduled and continually provided for within 2 weeks from an initial assessment or intake appointment. (Ongoing services include but are not limited to assignment to a therapist and individual/group outpatient therapy.) *42 CFR 438.206(c)(1)(i)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.1—2.5.8.1.11.6	**Description of Process:** In order to ensure that standards for timely access to care and services are met by the contractor and its providers, Beacon Health Options maintains policies and procedures which establishes standards for timely access (QM24.22CO-A_ Measurement of Access and Availability_CHP). Furthermore, the emergency responsiveness of the IPN provider network is monitored regularly through ongoing testing (CallM_Fail_EmergencyResponseTesting_CHP, VisnackJ_Pass_EmergencyResponseTesting_CHP, SUD Provider After Hours Availability Requirement_2BHO, eNewsletter_2016_Aug-2BHO and IPN_EmergencyAccessToCare_Q4FY16_CHP). During the test calls the IPN providers are phoned to assess the validity of their emergency instructions contained within their voicemail and to test their responsiveness in returning calls within the 15 minute requirement. Beacon Health Options conducts various monitoring activities to ensure compliance with contractual language and standards 2015PractionerContract-2BHO). In order to monitor access to services Beacon regularly monitors access to care standards quarterly (AccessToCare_Q4FY16_CHP and 2016_Contract Compliance Tool_CHP). Results are shared with providers through the use of CMHC_prov monitoring_CHP CAUMCQISC_2016SEP09_QM_Minutes_CHP)	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	The SUD initiation and engaging measures were also shared with the SUD subcommittee (SUD Committee MeeetingMinutes_2016APR27-2BHO). Finally, regular monitoring of outpatient follow-up appointments (which need to occur within 7 business days after discharge from an inpatient psychiatric hospitalization or residential facility) are conducted regularly through the PerformanceMeasure_AmbFU_7Day-2BHO, swffile_summary_CHP and the swffile_SUDScreenshot_2BHO. These documents depict the average 7 day ambulatory follow up rate of CHP and its partners. Furthermore, Beacon Heath Options conducts regular IP audits (IPAuditTool_final_2BHO) which examines if a post-hospital follow-up appointment is clearly documented within 7 days of discharge from an IP facility. The BHO maintains other network reports that monitor the number and mix of the providers included in the network to serve member needs based on expected utilization and population (Q4 FY16 NWAdequacy Report – 20160706_2BHO BHO_ProviderTrainingCY16_2BHO is an example of the comprehensive provider education and training infrastructure that has been established to assure that providers are both continuously informed of programs and services as well as offering the opportunity to provide meaningful feedback.	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42 CFR 438.206(c)(1)(iv) through (vi)* Contract: Amendment 6, Exhibit A-2—2.5.8.1.11.8	**Documents submitted:** 1. AccessToCare_Q4FY16_CHP-Entire Document 2. TRENDINGREPORT_Q3FY16_CHP-Pages 1-4 3. PerformanceMeasures_BenchmarkReport_Q3FY16_CHP-Entire Document 4. CMHC_prov monitoring_CHP-Entire Document 5. CAUMCQISC_2016SEP09_QM_Minutes_CHP-Page 3 6. QM24.22CO-A_ Measurement of Access and Availability_CHP-Entire document 7. 2016_Contract Compliance Tool_CHP-Items 1-3 **Description of Process:** Beacon Health Options maintains mechanisms in order to ensure compliance with timely access. As seen in policy QM24.22CO-A_ Measurement of Access and Availability, Beacon details the standards for timely access, monitoring activities as well as to, "develop and implement corrective actions when performance is out of compliance with the established standards." AccessToCare_Q4FY16_CHP, TRENDINGREPORT_Q3FY16_CHP, PerformanceMeasures_BenchmarkReport_Q3FY16_CHP and 2016_Contract Compliance Tool_CHP all demonstrate various access monitoring activities which occur through the year. Furthermore, on an annual basis Beacon Health Options conducts formal monitoring with its providers (CMHC_prov monitoring_CHP and CAUMCQISC_2016SEP09_QM_Minutes). The formal monitoring is a comprehensive review of key area of performance. The review covers results of the quarterly access to care results, the annual 411 audit for CMHC's, mental health	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	engagement, a review of complaints and grievances and contract compliance scores.	
10. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. (Includes a written cultural competency plan, policies, and training) *42 CFR 438.206(c)(2)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.12.1—2.5.12.3	**Documents Submitted/Location within Documents:** 1. QM 33F Cultural Competency – Colorado Springs_2016OCT26 – Entire Policy 2. QMUM Program Description_pg 44, 57-62 3. Cultural Competence Plan _CHP - entire document 4. CulturalCompetenceTrainingSlideDeck_2BHO – entire document 5. Achieve Solutions_How Culturally Competent are you_CHP-found at: https://www.achievesolutions.net/achievesolutions/en/chp/Content.do?contentId=34540 6. Referral_Connect_ _2BHO – Entire Document 7. Provider Manual_2BHO –*Misc. 8. Member Handbook Spanish_CHP pg2, 7, 13, 22 – *Misc. 9. Member Handbook_CHP – Pages 2 and 21*Misc. 10. ProviderDirectory_2BHO-Entire Document 11. Beacon's Substance Use Disorder Peer Specialist training, Chapter 15, page 94-98 12. FactFinders_CHP-pg 6, 8 13. Screenshot Grievance Database CHP-Entire Document 14. Minutes_Advocates_CHP-Page 2 15. 311L Handling Calls for Limited English Speaking Members_2BHO-Entire Document 16. 306L_Member Materials Policy-Entire Document 17. Poverty and Cultural Competency_2BHO slide deck, pages 10-12, 22, 29	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: This element is delegated to Beacon by Colorado Health Partnerships (CHP). CHP and Beacon do not discriminate against any members in the provision of services based on race, religion, gender, disability, or ethnicity. CHP has adapted/modified Beacon's cultural competency policy, (QM 33F Cultural Competency – Colorado Springs_2016OCT26) to align with Colorado requirements. This policy provides direction to staff and providers about being sensitive to the needs of all people and cultures and to the communities that CHP serves. This policy explains that we are committed to breaking down barriers to behavioral health access and utilization faced by minorities. Providers are required to uphold member rights and provide culturally competent services; treatment record documentation audits evaluate cultural factors relevant to member treatment. A population analysis for CHP is included as part of the Quality/Clinical/UM Program Description (QM/UM) Program Description, (Appendix A). This population analysis also includes risk factors of members residing in our region. This analysis is used to develop the BHO's Cultural Competence Plan, Cultural Competency Trainings (see Beacon's Substance Use Disorder Peer Specialist training, Chapter 15, page 94-98 and Poverty and Cultural Competency_2BHO slide deck). Spanish is the most prevalent non-English language spoken by CHP's membership and member materials are available in both English and Spanish. See Member Handbook Spanish_CHP And Member Handbook_CHP.	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	Beacon conducts a demographic analysis for CHP using census data to determine the ethnic, linguistic, educational and economic characteristics of its membership. This is used to assess changes in demographics as well as demographic composition of the regions we serve. This analysis is used in the development of our yearly Cultural Competency plan. See Cultural Competence Plan _CHP. Members can find the cultural competency plan on the CHP website. There are also cultural comptency resources on Achieve Solutions. FactFinders_CHP pg. 6, 8 are also used to assist in the evaluation of the member's view of the availability of culturally competent services. This information is considered in the development of a provider network that includes providers who speak languages other than English and/or have expertise in the cultural needs of Medicaid members. All CHP Members then have access to Referral Connect, allowing a refined search based on ethnicity, language and sex. We make every effort to ensure that our materials and practices are culturally competent. To ensure that this is occuring, we have distributed surveys to our members (Fact Finders_CHP). Most members believe that their cultural, religious and language needs were met 95.5% over this past fiscal year according to this survey. 87.2% felt that the counselor was just right for their needs. We also monitor member perceptions of culturally competent services through the grievance process (Screenshot Grievance Database_CHP). Although there isn't a specific category related to culturally competency in the grievance data base, we review	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	grievances for rights violations and discrimination. See Screenshot Grievance Database_CHP for examples of how member can file a grievance based on Discrimination or Reasonable Accommodation. Both of these categories can give us information about member's perception of cultural competence. CHP is continually monitoring quality improvement for cultural competency. During an Advocates forum, it was identified that there were some complaints regarding Lesbian, Gay, Bisexual and Transgender (LGBT) concerns. During this Advocates meeting (Minutes_Advocates_CHP), the OMFA director took time to address these concerns and provided guidelines from the APA to address questions and answers about LGBT. We recognized the need to incorporate LGBT issues into our Cultural_Competency_TrainingSlideDeck_CHP. We are making a recommendation that all incoming staff take the cultural comptency training that is available to staff members through Beacon's Achieve Solution. https://www.achievesolutions.net/achievesolutions/en/chp/Content.do?contentId=34540 The provider directory includes languages spoken by each of the providers listed. ReferralConnect, which is available on our website, can be used to find providers with language or cultural expertise. The user can select a provider using several fields in the data base, including languages spoken or specialty. Providers are required to include cultural and social factors when doing their initial assessment, per Section 17 in the provider handbook.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Assessing cultural factors is a component of the clinical assessment and is incorporated into the service plan when appropriate. The provider handbook explains the requirements for medical record documentation (pages 85-87). As part of the initial assessment, providers should assess social and cultural factors that may be important to the member/family. CHP provides access to interpreter services free of charge. Members are informed of this right in the member handbook, pg 2, 7, 13 and various others; providers are also made aware of this in the provider handbook (Provider Handbook_2BHO). All required materials are available in English and Spanish. When distributing information through the mail, we identify members who speak Spanish, as noted on their eligibility application form, and send them information in Spanish so that they don't have to call to request the information. When telephonic oral interpretation is requested by a member who speaks a language other than English or Spanish, we use the Voiance® language line, which is accessed by following 311L Handling Calls for Limited English Speaking Members. If a provider is needed in a face to face interaction, we select interpreters from professional language service providers, or use the interpreters authorized to provider interpretation for the court system. ASL and sign language interpreters we use are certified. We do not use family or friends, unless a member requests we do. All member materials are written at a 6th grade reading level and are available in English or Spanish. Materials are tested using internet available tools such as the Fleisch-Kinkaid test. Materials are also submitted to the Department for approval prior to	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	distribution. Policy 306LMemberMaterials_Policy_CHP (I.Policy a-e) and explains the cultural factors that should be considered when developing member materials. Culturally specific information that should be considered includes language (limited English proficiency) and disability (visual or auditory impairments, disabilities that impact communication). Beacon hosted a Substance Use Disorder Peer Specialist 2 day training on March 29, 2016 and March 30, 2016. Within this two day training, they covered Cultural Comptency. See Beacon's Substance Use Disorder Peer Specialist training, Chapter 15, page 94-98. There were approximately 40 Peer Specialists at this training. In May, 2016, we hosted a Poverty and Mental Health training for internal staff. See Poverty and Cultural Competency_2BHO slide deck. In this training the culture of poverty, diversity of members in poverty and the stereotypes that can come for someone living in poverty.	

Results for Standard II—Access and Availability							
Total	Met	=	10	X	1.00	=	10
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	10	**Total Score**		=	10

Total Score ÷ Total Applicable	=	100%

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Contractor must comply with the following requirements based on 42 CFR 441.50 to 441.62 effective October 1, 2015, and Code of Colorado Regulations 10 CCR 2505-10 8.280 effective April 30, 2016. References Contract: Amendment 6, Exhibit A-2—2.5.13.5 The Contractor shall comply with all federal (441.50 to 441.62) and state (10 CCR 2505-10 8.280) EPSDT regulations. Contract: Amendment 6, Exhibit A-2—2.2.1 The Contractor shall provide or arrange for the provision of all medically necessary covered services and diagnoses and procedures, including *services* identified under the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, 42 CFR Sections 441.50 to 441.62. (Includes informing, screening, diagnosis, treatment, discretionary services, referral/care coordination, and transportation and scheduling assistance.) Additional Resources State Medicaid Manual/Section 5 offers further detailed instructions and guidance regarding the various components of the EPSDT Program.		
1. The Contractor must have written policies and procedures for providing EPSDT services to members age 20 and under. • The definition of EPSDT services includes informing, screening (assessment), diagnosis, treatment, discretionary services (e.g. medically necessary wrap-around services), referral and care coordination, and transportation and scheduling assistance. 10 CCR 2505-10 8.280.2 and 8.280.8A	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy **Description of Process:** The BHO delegates utilization management functions to Beacon Health Options. Beacon has established a comprehensive EPSDT policy and a variety of other resources to support members and providers in understanding and accessing this benefit. Policy **248L_EPSDT_2BHO-Entire Policy** is the foundational document for this standard. It is relevant in its entirety, but the "Definitions" section II.A (pp. 1-2) includes the specific language identified in this element. Although the EPSDT screenings and most medical services may be delivered typically in primary care settings, the BHO and its	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	contracted behavioral health providers are responsible for coordinating with primary care providers and assisting members to access the recommended services, regardless of whether the service is covered by the BHO. For example, the EPSDT screening completed by the primary care physician may indicate a need for developmental disability services. The BHO and/or its behavioral health provider is then responsible for referring the member/family to the community centered board (CCB) or other resource for identification and provision of the necessary services.	
2. The Contractor must notify members age 20 and under of the benefits and options for children and adolescents under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and is responsible for ensuring that children and their families are able to access the services appropriately. The Contractor must— • Provide a combination of written and oral methods to inform all eligible members (or their families) about the EPSDT program within 60 days of enrollment and annually thereafter. – Member communications must effectively inform those individuals who are blind or deaf or who cannot read or understand the English language. • Using clear and nontechnical language, provide information about the following— – The benefits of preventive healthcare.	**Documents submitted:** 1. Member_Handbook_CHP-EPSDT Section-Page 32-33 *MISC 2. CO-HF-Handbook_2BHO-Entire Document **Description of Process:** The BHO uses a variety of mechanisms to communicate with its members about the EPSDT program and how to access services. Members are informed about the EPSDT program through the Health First Colorado Member Handbook, which is mailed to all new members upon enrollment and annually thereafter. Please see CO-HF-Handbook_2BHO—pp 16-20. This handbook also is available to members on the Health First Colorado website. The BHO's member handbook, Member Handbook CHP-EPSDT Section_ (pp. 32-33), contains detailed information about the EPSDT benefit. It uses non-technical language to describe the purposes of the EPSDT program and who is eligible. This section also explains the purpose of well-child check-ups (i.e., preventive healthcare), and the recommended schedule for these visits. This section also explains how to access a Family Health Coordinator	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– The services available under the EPSDT program and where and how to obtain those services; (includes physical, mental, oral and substance abuse, as well as services that may have limits or services not covered in the state plan). – That the services under the EPSDT program are provided without cost to members 20 and under. – That necessary transportation and scheduling assistance for EPSDT services is available to members upon request, and the process to make a request. *42 CFR 441.56 (a)(1)—(4)* *(Requirement to be updated 7/2018—see appendix)* Contract: Amendment 6, Exhibit A-2—2.5.9.1; 2.5.9.2; 2.5.8.1.4	and how to locate additional information about the program on the state EPSDT website. The "Family Health Coordinators" sub-section notes that they can provide options for transportation assistance, if necessary. Members are encouraged to call the BHO's Office of Member and Family Affairs (OMFA) or the Access to Care Line to get additional assistance or to have their questions answered about EPSDT. The Member Handbook is available to all members on the BHO's website: http://www.coloradohealthpartnerships.com/services/pdf/EPSDT.pdf. Members who need EPSDT information in oral form or in a language other than English can obtain the information by contacting the OMFA office or the BHO's Access to Care Line to arrange translation or interpretation services (see p. 11 of the Member Handbook for details). For members who do not speak English, we will find a provider who speaks the member's native language, or we will provide an interpreter. If the member is deaf or hard of hearing, we will find a provider who signs or will arrange for an interpreter. The Member Handbook is available in Spanish upon request. There is no fee for any of these services. We use Relay Colorado or a TTY line to communicate effectively with deaf members and use Voiance Language Line telephone interpreters, if we do not have a staff person who speaks the member's language.	

Findings:
Both the CHP Member Handbook and the Health First Colorado (HFC) Member Handbook included sections informing members of EPSDT services. During on-site interviews, staff members confirmed that CHP distributed its handbook to members at the time of enrollment, January through June 2016, and that the Department distributed the HFC Member Handbook to members beginning July 2016. CHP continues to maintain the CHP Member Handbook on its website. Staff members also stated that CHP expected CMHC providers to have direct communication with individual members in treatment regarding EPSDT services. CHP's CMHC site review audit tool required review of examples of written and oral methods of informing all

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
eligible members (and their families) about the EPSDT program. However, neither the provider manual nor provider training materials addressed the provider's responsibilities for communicating EPSDT benefits—with components outlined in this requirement—to members. In addition, CHP could not provide examples of ongoing or periodic BHO or CMHC member communications—e.g., member newsletters, flyers, member mailings—to inform members of the EPSDT benefits and how to access them.		
Recommendations: HSAG recommends that CHP enhance its communications to members to demonstrate that the BHO has implemented a variety of mechanisms (as stated in the "Description of Process" preceding) to communicate with members about the EPSDT program, including services available and how to access those services.		
3. The Contractor must reasonably ensure the provision of all applicable components of periodic health screens (assessments) to EPSDT beneficiaries who are receiving BHO services or referred to a BHO provider. *42 CFR 441.56 (b), 441.59 (b)* 10 CCR 2505-10 8.280.8.C; 8.280.4.A.3 (d) and (h), and 8.280.4.A (4) Contract: Amendment 6, Exhibit A-2—2.5.13.2.1	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy **Description of Process:** The BHO makes every effort to reasonably ensure the provision of all applicable components of periodic health screens to EPSDT beneficiaries who are receiving BHO services or are referred to a BHO contracted provider. Please see 248L_EPSDT_2BHO-Entire Policy for details. Section IV, "Procedures" (all subsections), specifically outlines what is expected when a BHO member has a primary care physician, and when they do not. If a member does not have a primary care physician or pediatrician, Beacon call center staff can assist the member in identifying a health care provider through the State's enrollment broker. This referral also can be completed by the behavioral health provider, if the client/family has directly accessed behavioral health services with a treatment provider. Once the member becomes established with the primary care physician, the behavioral health provider must coordinate with the PCP to complete any applicable health screenings and arrange for or provide the identified services.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	For members who already have an established PCP, the behavioral health provider must coordinate care with that physician and assist the member in accessing any recommended services. If the EPSDT assessment reveals that the member needs a BHO-covered service that cannot be provided by the initial behavioral health provider (e.g., a neuropsychological assessment), the behavioral health provider must contact the BHO to help coordinate this service.	
Findings: During on-site interviews, staff members confirmed that BHO providers are primarily responsible for implementing this requirement. Policies and procedures, the provider manual, and provider training described the behavioral health provider's responsibilities as including: determining if the member is getting EPSDT screenings, assisting the member as needed with obtaining a PCP, communicating with the member's PCP regarding results of screenings, and providing any behavioral health screenings indicated as a result of PCP screenings and referral. Provider training did not include information to educate providers on the components of EPSDT periodic health screens. In addition, CHP had limited procedures or mechanisms to "ensure the provision of all applicable components of periodic health screens (assessments) to EPSDT beneficiaries who are receiving BHO services" and it was unclear how actively the provider or BHO would assist members in obtaining necessary EPSDT screenings.		
Recommendations: HSAG recommends that CHP enhance procedures, provider communications, and training to clarify expectations and mechanisms for assisting EPSDT-eligible members who are receiving BHO services in obtaining all applicable components of periodic health screens.		
4. Results of screenings (assessments) and examinations for members receiving BHO services shall be recorded in the child's medical record. Documentation shall include, at a minimum, identified problem and negative findings and further diagnostic studies and/or treatments needed and the date ordered. 10 CCR 8.280.4.A (5)	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. EPSDT_Provider_Training_2BHO—Slide 5 3. Provider_Manual_2BHO—Section 7 *Misc. 4. CMHC_Contract_Compliance_Audit_Tool_CHP—Section XI (pp. 9-15; Section XI, items #1-9). **Description of Process:** The BHO's contracted behavioral health providers are responsible for documenting the results of all screenings, assessments and examinations for members receiving BHO services. This	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	requirement is stated in the 248L_EPSDT_2BHO-Entire Policy, specifically in section IV. J: "The behavioral health provider must record the results of all screenings and examinations in the child's medical record. Documentation shall include, at a minimum, identified problem(s) and negative findings and further diagnostic studies and/or treatments needed, and the date(s) ordered." Providers are instructed about this requirement in their onboarding training, which includes specific information about EPSDT. See EPSDT_Provider_Training_2BHO—Slide 5. The BHO's Provider Manual also contains information about the EPSDT program and its documentation requirements. Please see Provider_Manual_EPSDT_2BHO—Section 7. Providers' compliance with this requirement is assessed through the BHO's audit mechanisms, including the CMHC_Contract_Compliance_Audit_Tool_CHP—Section XI (pp. 9-15; Section XI, items #1-9).	
5. The Contractor must ensure the delivery of EPSDT Contractor-covered services. 10 CCR 2505-10 8.280.8A	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy 2. QM_UM_Program_Description_CHP—pp. 29-45 *Misc **Description of Process:** The BHO is responsible for authorizing and ensuring the delivery of all contract-covered services identified as medically necessary for EPSDT-eligible members. See 248L_EPSDT_2BHO-Entire Policy (Section IV.M, p. 6).	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	The BHO has existing UM processes for meeting this requirement. The operation of the CHP UM program is outlined in the QM_UM_Program_Description_CHP—pp. 29-45. Contracted behavioral health providers can deliver many outpatient services, such as individual or family therapy, without obtaining prior authorization and without any limit to the number of units. Other services, such as psychological evaluations or higher levels of care (e.g., residential or inpatient), may require prior authorization and ongoing reviews to determine continued medical necessity. Out-of-network providers can obtain authorizations through a robust Single Case Agreement process. Providers can request authorization for any covered service. Traditional outpatient services, such as individual and family therapy, are typically authorized for a period of six months at a time. Other services may be authorized for a defined purpose (e.g., psychological evaluation) with a specified number of units, or for a defined episode of care. If the authorized units are exhausted or the specified time period expires, the provider can request additional units or time. A member or his/her family or designated client representative also can request covered services directly by contacting the BHO or by making their request known to the BHO's community behavioral health center partner. For example, if residential treatment is being recommended by the EPSDT assessor, the member may contact the CBHC partner's RTC Liaison to arrange a mental health needs assessment. The CMHC's RTC Liaison will then coordinate the review of that assessment by the BHO and authorization of services, if appropriate.	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Beacon Health Options (Beacon) EPSDT policy stated that the BHO contracted treatment provider would provide necessary mental health services through EPSDT screening information obtained from or referrals received from the primary care provider. The policy also stated that CHP would authorize any identified diagnostic or treatment services, including substance abuse needs, that meet the definition of "medical necessity" and criteria for authorization specific to EPSDT. The policy accurately outlined the EPSDT definition of "medical necessity" and criteria for authorization—as specified in Requirement #8 of this compliance monitoring tool. However, CHP's Quality Management/Utilization Management Program Description included no information specific to authorization of EPSDT-related services (e.g., the EPSDT definition of "medical necessity," clinical guidelines specific to EPSDT, or reference to the Beacon EPSDT policy). CHP could not provide evidence of development or implementation of UM procedures to operationalize the EPSDT policy.		
Recommendations: HSAG recommends that CHP modify or develop policies and procedures which ensure that EPSDT-related services are authorized by UM staff using criteria and definitions of "medical necessity" specific to EPSDT services. CHP should more clearly align organizational UM procedures with the definition of "medical necessity" and authorization criteria outlined in the Beacon EPSDT policy.		
6. The Contractor must ensure that BHO providers provide diagnostic services in addition to treatment of all mental illnesses or conditions (includes substance abuse) discovered by any screening and diagnostic procedure—even if the services are not covered in the plan. *42 CFR 441.56 (c)* 10 CCR 2505-10 8.280.4.A (3) (e); 8.280.4.C (3) Contract: Amendment 6, Exhibit A-2—2.5.13.2.5	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy **Description of Process:** The BHO is responsible for ensuring that all diagnostic services in addition to treatment of all mental illnesses or conditions (including substance use disorders) discovered by any screening and diagnostic procedure, even if the services are not covered by the BHO's benefit plan. See 248L_EPSDT_2BHO-Entire Policy (Section IV.O, pp. 6-7). As noted in #5 above, a provider or member can request authorization for any BHO covered service that is medically necessary, according to the EPSDT medical necessity definition. If the necessary service is covered, but cannot be delivered by the primary behavioral health provider because of training or licensure limitations, the provider must coordinate with the BHO to refer the member to an appropriate provider for this service. If the necessary service is not covered by the BHO	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	benefit, the primary behavioral health provider is responsible for coordinating a referral to a provider who can deliver the service. For example, if a member is identified as needing autism-specific services (e.g., a functional behavioral assessment for applied behavioral analysis), which would be uncovered by the BHO, the provider must assist the member in obtaining services through the community-centered board or another qualified provider.	
Findings: Staff members described (in "Description of Process" preceding) that if the necessary diagnostic service or treatment is not covered by the BHO benefit, the behavioral health provider is responsible for coordinating a referral to a provider who can deliver the service. However, CHP did not have written procedures, provider training, or other information to provide evidence that behavioral health providers had the resources to successfully assist members with obtaining non-covered services. In addition, CHP did not have procedures or communications to provide evidence that BHO care coordinators would assist providers in making such referrals. The Quality Management/Utilization Management Program Description also does not address the responsibility of UM care managers to assist with referrals for services not covered by the BHO. CHP did not appear to have a well-defined, coordinated process for ensuring provision of EPSDT diagnostic services and treatment of all mental illnesses or conditions that "are not covered in the plan."		
Recommendations: HSAG recommends that CHP define a more detailed approach and cohesive mechanism for ensuring that treatment of mental health conditions related to EPSDT but not covered under the BHO contract are adequately addressed.		
7. If the provider is not licensed or equipped to render necessary treatment or further diagnosis, the provider shall refer the individual to an appropriate practitioner or facility or to the Outreach and Case Management Office (Healthy Communities) for assistance in finding a provider. 10 CCR 2505-10 8.280.4.C.2 Contract: Amendment 6, Exhibit A-2—2.5.13.1.1	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy **Description of Process:** This requirement is specifically defined in 248L_EPSDT_2BHO-Entire Policy [section IV.N]. If the primary therapist or other provider is not able to render the EPSDT identified services, they shall refer the member to a provider who is able to provide that screening, diagnosis or treatment. The behavioral health provider can obtain referral assistance from the BHO by calling the Access to Care Line or by contacting the Healthy Communities office in their area.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Findings: The Beacon EPSDT policy defined this requirement as the responsibility of the primary therapist, who may outreach to the BHO care managers or Healthy Communities to obtain assistance with referrals. However, this policy statement is absent from the provider manual and provider training documents, and no procedures are listed to instruct providers or other staff on mechanisms or accountabilities for completing the referral process. During on-site interviews, staff members stated that CHP has had extensive discussions with providers concerning the EPSDT policy but had not yet developed specific written procedures regarding implementation of the various components of the policy.		
Recommendations: HSAG recommends that CHP develop procedures and/or enhance provider communications to clearly specify provider responsibilities for making referrals to appropriate practitioners or Healthy Communities and define mechanisms for effectively doing so.		
8. The Contractor defines "Medical Necessity for EPSDT Services" as: • A service that is found to be equally effective treatment among other less conservative or more costly treatment options; • Meets one of the following criteria: – The service is expected to prevent or diagnose the onset of an illness, condition, or disability. – The service is expected to cure, correct, or reduce the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. – The service is expected to reduce or ameliorate the pain and suffering caused by an illness, injury, or disability. – The service is expected to assist the individual to achieve or maintain maximum functional capacity in performing activities of daily living.	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy **Description of Process:** The BHO has defined medical necessity for EPSDT services in its EPSDT policy, 248L_EPSDT_2BHO. Please see Section II. D (pp. 3-4) for this medical necessity definition, and see Sections IV.M through IV.O (pp. 6-7) for the UM processes related to the authorization of covered versus non-covered medically necessary services.	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
• May be a course of treatment that includes observation or no treatment at all. – The Contractor's UM process provides for approval of healthcare services if the need for services is identified and meets the following requirements: o The service is medically necessary. o The service is in accordance with generally accepted standards of medical practice. o The service is clinically appropriate in terms of type, frequency, extent, and duration. o The service provides a safe environment or situation for the child. o The service is not for the convenience of the caregiver. o The service is not experimental and is generally accepted by the medical community for the purpose stated. *42 CFR 441.57* 10 CCR 2505-10 8.280.1, 8.280.4.D and E		

Findings:
The Beacon EPSDT policy included the definition of "medical necessity" and the criteria for approval of authorization requests as outlined in the requirement. However, CHP should note that the definition of "medical necessity" outlined in the State Medicaid Plan—10 CCR 2505-10 8.076.1.8 (effective August 30, 2016)—includes the EPSDT-specific criteria per 8.280.4.E. HSAG strongly recommends that the Beacon EPSDT policy incorporate the definition of "medical necessity" as outlined in the Findings section of Standard I, element 4, of this tool. The Quality/Clinical/Utilization Management Program Description/Plan (applicable to all members) included no EPSDT-specific authorization procedures, no EPSDT medical necessity criteria, and no

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
EPSDT-related review criteria or clinical guidelines. During on-site interviews, staff members confirmed that no additional UM policies and procedures exist specific to processing requests for services for members ages 20 and under. It appeared that CHP had neither incorporated the expanded "medical necessity" definition related to EPSDT services into its UM policies and procedures nor operationalized it.		
Recommendations: HSAG recommends that CHP establish a link between the EPSDT "medical necessity" definition and criteria for authorization described in the EPSDT policy and UM operational practices.		
9. The Contractor must provide referral assistance to members receiving BHO services for treatment not covered by the plan but found to be needed as a result of conditions disclosed during screening (assessment) and diagnosis. • The Contractor must coordinate with other programs that may provide EPSDT-related services: State health agencies, State vocational rehabilitation agencies, and Title V grantees (Maternal and Child Health/Health Care Program for Children with Special Needs), 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). – Includes Child Find, Early Intervention Colorado, and the Accountable Care Collaborative. • Contractors are encouraged to refer children and their families to the Healthy Communities program in their area for community services and medical referrals, transportation information, appointment assistance, and administrative case management.	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy [Section IV.O, p. 6]. **Description of Process** The BHO and/or its contracted behavioral health providers are responsible for coordinating services identified during the screening and diagnosis processes, even when these services are not included in the BHO's covered benefits. This requirement is detailed in 248L_EPSDT_2BHO [Section IV.O, p. 6]. For example, if the EPSDT assessment reveals that the member needs nutritional supports, the member or guardian would be referred to the Special Supplemental Food Program for Women, Infants and Children (WIC).	Information Only

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
– Contractors are encouraged to contact Healthy Communities for assistance in locating families who may have excessively missed appointments. • The Contractor must have a process to ensure that medically necessary services not covered by the Contractor are referred to the Office of Clinical Services for action. *42 CFR 441.61 and 441.62* 10 CCR 2505-10 8.280.8.D (5) Contract: Amendment 6, Exhibit A-2—2.5.13.1		

Findings:
The Beacon EPSDT policy reiterated the information outlined in this requirement and encouraged providers to contact Healthy Communities for "community services and medical referrals, transportation information, appointment assistance, and administrative case management." While the policy stated that the BHO must assist members with referrals for treatment not covered by the plan, CHP outlined no procedures for doing so. The accountabilities and procedures for implementing the Beacon EPSDT policy statements were confusing or had not been adequately addressed, as follows:

- During on-site interviews, staff members stated that contracted providers are responsible for most care coordination activities and that BHO care coordinators provide assistance with members who have more complex needs. However, neither the provider manual nor other provider communications addressed the responsibility of the BHO provider to coordinate with other programs that may provide EPSDT services. CHP also had no defined BHO care coordinator procedures related to providing referral assistance to providers or members for treatment not covered by the plan, including coordination with other programs/agencies that may provide EPSDT-related services.
- CHP provided no reference materials or other EPSDT-specific guidelines for providers or staff to coordinate with external EPSDT-related resources.
- As evidenced in the on-site denial record reviews, notices of action to members eligible for EPSDT services referred the member to the Department's customer service line to determine whether or not the denied service is covered under another Health First Colorado health plan; the letter did not include a BHO care coordinator contact or reference to Healthy Communities to assist members ages 20 and under with access to needed services. This communication does not reflect CHP's responsibility to provide referral assistance to members as outlined in the requirement.

Standard XI—Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
During the on-site interview, staff members acknowledged that CHP's processes are evolving toward more comprehensive EPSDT training, communications, procedures, and mechanisms for care coordination activities. CHP initiated a pilot program with one CMHC and the region's RCCO to implement an integrated care coordination process to increase well-child checks and delivery of EPSDT services.		
Recommendations: HSAG recommends that CHP develop procedures and clarify accountabilities for providing referral assistance to members receiving BHO services for treatment not covered by the plan, including coordinating with other programs that may provide EPSDT-related services. Procedures are recommended to address active involvement of BHO care coordinators (and/or documented responsibilities of affiliated organizations) to assist members and/or providers and to obtain all documents required for access to non-covered services. HSAG recommends that CHP modify and implement a notice of action letter for members 20 and under that tells members and providers to call BHO care coordinators—not the Department's customer service line—for assistance with access to needed EPSDT-related services or with contacting Healthy Communities.		
10. The Contractor must share PHI with the Department's EPSDT outreach and case management agencies (Healthy Communities) as allowable under HIPAA for treatment, payment and operations purposes, without requiring any special releases or other permission from the member. • The Contractor shall have either written consent from a member or a qualified service organization (QSO) agreement with a substance abuse organization to share member information regarding substance abuse disorder treatment with the Department's EPSDT outreach and case management agencies (Healthy Communities). Contract: Amendment 6, Exhibit A-2—2.5.13.3, 2.5.13.4	**Documents submitted:** 1. 248L_EPSDT_2BHO-Entire Policy [Section IV.P (p. 7)]. **Description of Process:** The BHO and its beahavioral health providers must share PHI with the Department's outreach and case management agencies (Healthy Communities). Such communication is allowable under HIPAA without additional consent from the member to release information, except in the case of SUD treatment. This information is detailed in 248L_EPSDT_2BHO [Section IV.P (p. 7)].	Information Only
Findings: CHP/Beacon incorporated into the Beacon EPSDT policy verbatim the requirement to share PHI with Healthy Communities. However, CHP provided no evidence of having incorporated the requirement into provider communications or internal operating procedures.		

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Recommendations: HSAG recommends that CHP develop mechanisms to communicate this requirement to providers and other pertinent staff members in order to fully operationalize the policy.		
11. The Contractor facilitates provision of components of periodic health screens (assessments) for members receiving BHO services through systematic communication with network providers regarding the Department's EPSDT requirements. 10 CCR 2505-10 8.280.8.D (3) and (4)		Information Only
Findings: The Beacon EPSDT policy appears to interpret "systematic communications with network providers" as the responsibility of behavioral health providers to communicate with primary care providers regarding EPSDT services for members. During the on-site interview, HSAG clarified that this requirement is related to the BHO's responsibility to communicate "systematically" with the BHO's contracted providers regarding EPSDT requirements. CHP provider communications and training materials do not educate providers on many of the specific elements of EPSDT services and requirements. Staff members stated that CHP has been engaged in extensive discussions over the last year with internal provider committees and review of the EPSDT policy with providers; however, CHP did not provide evidence of comprehensive EPSDT-focused trainings, provider communications, or tools for BHO providers that represented "systematic" communication regarding EPSDT requirements. During the on-site interview, CHP staff members articulated their understanding that it is the BHO's responsibility to clarify its policies and procedures and to enhance provider training and communications regarding EPSDT services for members.		
Recommendations: HSAG recommends that CHP enhance provider communications and develop a mechanism for systematic (i.e., regular and periodic) communication with network providers regarding comprehensive EPSDT services and responsibilities.		

Appendix B. Record Review Tool

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Colorado Health Partnership, LLC

Review Period:	January 1, 2016—November 30, 2016
Date of Review:	December 13, 2016
Reviewer:	Kathy Bartilotta and Rachel Henrichs
Participating Plan Staff Member:	Tami Ballard; Steve Coen

Requirements	File 1	File 2	File 3	File 4	File 5
Member	RB	CB	VD	AS	IP
Date of initial request	09/03/16	03/02/16	04/04/16	04/04/16	03/15/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	CL	CL	NR
Standard (S), Expedited (E), or Retrospective (R)	E	S	R	R	E
Date notice of action sent	09/06/16	03/08/16	04/29/16	04/28/16	03/17/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	3	6	25	24	2
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	C
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	NA	NA	C	C	NA
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	TBD	TBD	C
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**6**	**6**	**6**	**6**	**6**
Total Compliant Elements	**6**	**6**	**6**	**6**	**6**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**100%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2016–2017 Denials Record Review Tool
for Colorado Health Partnership, LLC

Requirements	File 6	File 7	File 8	File 9	File 10
Member	AH	TD	KC	SL	GH
Date of initial request	03/11/16	04/07/16	08/16/16	02/24/16	07/29/16
What type of denial? (Termination [T], New Request [NR], or Claim [CL])	NR	NR	NR	NR	CL
Standard (S), Expedited (E), or Retrospective (R)	S	E	E	S	R
Date notice of action sent	03/16/16	04/08/16	08/17/16	03/04/16	08/26/16
Notice sent to provider and member? (C or NC)	C	C	C	C	C
Number of days for decision/notice	5	1	1	8	28
Notice sent within required time frame? (C or NC) (S = 10 Cal days after; E = 3 Bus days after; T = 10 Cal days before)	C	C	C	C	NC
Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
If extended, extension notification sent to member? (C, NC, or NA)	NA	NA	NA	NA	NA
If extended, extension notification includes required content? (C, NC, or NA)	NA	NA	NA	NA	NA
Notice of Action includes required content? (C or NC)	C	C	C	C	C
Authorization decision made by qualified clinician? (C, NC, or NA)	C	C	C	C	C
If denied for lack of information, was the requesting provider contacted for additional information or consulted (if applicable)? (C, NC, or NA)	NA	NA	NA	NA	NA
If denied due to *not a covered service* but covered by Medicaid Fee-for-Service/wraparound service, did the notice of action include clear information about how to obtain the service? (C, NC, or N/A)	C	C	C	C	C
Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	TBD	TBD	TBD	TBD	TBD
Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	**6**	**6**	**6**	**6**	**6**
Total Compliant Elements	**6**	**6**	**6**	**6**	**5**
Score (Number Compliant / Number Applicable) = %	**100%**	**100%**	**100%**	**100%**	**83%**

C = Compliant **NC** = Not Compliant **NA** = Not Applicable **Y** = Yes **N** = No (not scored—informational only)
Cal = Calendar **Bus** = Business **TBD** = To Be Determined (scored NA, referred to Department for additional review)

Total Record Review Score	Total Applicable Elements: 60	Total Compliant Elements: 59	Total Score: 98%

Notes:
File #2—Member was 13 years old (potential EPSDT).
File #3—Retrospective review of ER claim (30 days from receipt)—decision made on April 26, 2016, with notice mailed on April 29, 2016. The claim was denied due to "not a covered diagnosis."
File #4—Retrospective review of ER claim (30 days from receipt)—decision made on April 26, 2016 with notice mailed on April 28, 2016. The claim was denied due to "not a covered diagnosis."
File #5—Request for continued stay in day treatment after current authorization expires. CHP determined that services were no longer medically necessary but approved two weeks for transition planning. The member was 13 years old (potential EPSDT).
File #6—Medicaid was the secondary payer. The claim was denied due to "not a covered diagnosis" ("primary" diagnosis determined to be autism). The member was 18 years old (potential EPSDT).
Fie #7—Denied due to "not a covered diagnosis" ("primary" diagnosis determined to be autism). The member was 13 years old (potential EPSDT).
File #8—Denied due to "not a covered diagnosis" ("primary" diagnosis determined to be dementia). Note: dementia was not listed in claims file—diagnosis retrieved from notes/history.
File # 9—Denied due to "not a covered diagnosis" ("primary" diagnosis determined to be dyslexia).
File #10—Retrospective review of ER claim (30 days from receipt). Decision made more than three days prior to sending notice. Denied due to "not a covered diagnosis" ("primary" diagnosis was of a medical nature).

Appendix C. Site Review Participants

Table C-1 lists the participants in the FY 2016–2017 site review of **CHP**.

Table C-1—HSAG Reviewers and CHP and Department Participants

HSAG Review Team	Title
Kathy Bartilotta, BSN	Senior Project Manager
Rachel Henrichs	External Quality Review (EQR) Compliance Auditor
CHP Participants	**Title**
Erica Arnold-Miller	Vice President, Quality Management
Lynne Bakalyan	Director, Office of Member and Family Affairs
Tami Ballard	Director, Utilization Management
James Bonk	Vice President, Operations
Peter Broderick	Medical Director
Steve Coen	Clinical Peer Advisor
Kendrick Lutz	Clinical Services Supervisor
Tina McCrory	Chief Operations Officer
Alyssa Rose	Director, Network Strategy
Myron Unruh	Colorado Market President
Wayne Watkins	Director, Information Technology
Jeremy White	Quality Manager
Department Observers	**Title**
Patricia Connally (telephonic)	Quality and Compliance Specialist
Michael Lott-Manier (telephonic)	Contract Manager
Troy Peck (telephonic)	Contract Manager
Gina Robinson	Program Administrator

Appendix D. Corrective Action Plan Template for FY 2016–2017

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

Table D-1—Corrective Action Plan Process

Step	Action
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 email or through the file transfer protocol (FTP) site, with an email 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, 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 email 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 email or the FTP site, with an email 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.

Step	Action
Step 6	**Documentation substantiating implementation of the plan 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 CAP template follows.

Table D-2—FY 2016–2017 Corrective Action Plan for CHP

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
12. The Contractor may extend the standard or expedited authorization decision time frame up to 14 calendar days if the member requests an extension or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR 438.210(d)(1)(2)* Contract: Amendment 6, Exhibit A-2—2.5.15.1 and 2.5.15.2.1	Policies and procedures clearly outlined CHP's ability to extend the authorization decision time frame by 14 days based on member request or the need for additional information. In addition, the policy stated that CHP may extend the time frame "due to matters justifiably beyond the control of the BHO," which staff described as an occurrence such as a natural disaster. Federal language clearly states that the Contractor may extend the authorization decision only if "there is a need for additional information and that the extension is in the member's best interest."	CHP must modify the language in its policies and procedures to remove "due to matters beyond the control of the BHO" as a reason for extending the authorization decision time frame.
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 I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
15. The notices of action must be mailed within the following time frames: • For termination, suspension, or reduction of previously authorized Medicaid-covered services, the notice of action must be mailed at least 10 days before the date of the intended action except: – In as few as 5 days prior to the date of action if the Contractor has verified information indicating probable beneficiary fraud. – No later than the date of action when: o The member has died. o The member submits a signed written statement requesting service termination. o The member submits a signed written statement including information that requires termination or reduction and indicates that the member understands that service termination or reduction will occur. o The member has been admitted to an institution in which the member is ineligible for Medicaid services. o The member's address is determined unknown based on returned mail with no forwarding address.	Staff members stated that it is CHP's policy to make a retrospective claim payment determination and send a notice of action within 30 days of receipt of the claim. The requirement is that the notice of action be mailed "at the time of any action affecting the claim." In one of three on-site reviews of retrospective claim denials the notice of action was not mailed within a reasonable time frame (within three days) after the denial decision was made.	CHP must clarify its policies and procedures and ensure that it sends members and providers a notice of action for denial of claims payment "at the time of any action affecting the claim"—interpreted by HSAG as on the date of denial or within three days of the decision.

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
○ The member is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. ○ A change in the level of medical care is prescribed by the member's physician. ○ The notice involves an adverse determination with regard to preadmission screening requirements. ○ The transfer or discharge from a facility will occur in an expedited fashion. • For denial of payment, at the time of any action affecting the claim. • For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. • For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 working days after receipt of the request for services. • For service authorization decisions not reached within the required time frames on the date time frames expire.		

Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**
• If the Contractor extends the time frame, as expeditiously as the member's health condition requires and no later than the date the extension expires. 42 CFR 438.210 (d) *42 CFR 438.404(c)* *42 CFR 431.211,431.213, and 431.214* Contract: Amendment 6, Exhibit A-2—2.6.5.5.5 10CCR2505—10, Sec 8.209.4.A (3) (a-c)		
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

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 email 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 three 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 a list of all Medicaid service and claims denials that occurred between January 1, 2016, and December 31, 2016. 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.

For this step,	HSAG completed the following activities:
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. • HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO service and claims denials and notices of action. • 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 2016–2017 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 draft 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.