State of Colorado

Department of Health Care Policy and Financing

Colorado Medicaid
Community Mental Health Services Program

FY 06–07 Site Review Report

for

Foothills Behavioral Health, LLC

April 2007

HSAG Health Services Advisory Group

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This is the third year that Health Services Advisory Group, Inc. (HSAG) has performed site reviews of the Colorado behavioral health organizations (BHOs). Compliance with federal regulations and contract requirements was evaluated in 10 areas (i.e., delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing). Individual records were reviewed in the areas of grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services to evaluate implementation of select requirements related to the standards. Details of the site review methodology are contained in Appendix D of this report.

This report documents results of the fiscal year (FY) 06–07 site review for **Foothills Behavioral Health, LLC** (**FBH**) related to compliance with requirements in the 10 standard areas and the elements of the record reviews evaluated as part of the site review.

2. Summary of Follow-Up on Prior Year Review

for Foothills Behavioral Health, LLC

As a follow-up to the FY 05–06 site review report, **FBH** was required to submit a corrective action plan (CAP) to the Colorado Department of Health Care Policy & Financing (the Department) addressing all elements for which **FBH** received a score of *Partially Met* or *Not Met*. The plan included interventions to achieve compliance and the timeline. The Department reviewed the CAP and associated documentation, requesting revisions where necessary. **FBH** completed all corrective actions for FY 05–06.

The findings for the FY 06–07 site review were determined from a desk review of the documents submitted by **FBH** to HSAG prior to the on-site portion of the review, interviews with key **FBH** staff members, and a review of records conducted during the site review.

For the review of the 10 standards, the individual elements (i.e., contract requirements) reviewed for each standard were assigned a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable (N/A)*. A summary score was then determined by calculating the percentage of applicable elements found compliant (i.e., *Met*).

Table 3–1 presents the number of elements for each of the 10 standards, the number of applicable elements for each standard, the number of elements assigned each score (*Met*, *Partially Met*, *Not Met*, or *N/A*), the overall compliance score for each standard, and the overall compliance score for the review of standards. Details of the review of the 10 standards can be found in Appendix A.

Table 3–1—Summary of Scores for the Standards

Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I	Delegation	13	12	11	1	0	1	92%
II	Provider Issues	26	25	24	1	0	1	96%
III	Practice Guidelines	5	5	5	0	0	0	100%
IV	Member Rights and Responsibilities	18	18	17	1	0	0	94%
V	Access and Availability	20	20	20	0	0	0	100%
VI	Utilization Management	8	8	7	1	0	0	88%
VII	Continuity-of-Care System	15	15	15	0	0	0	100%
VIII	Quality Assessment and Performance Improvement Program	12	12	12	0	0	0	100%
IX	Grievances, Appeals, and Fair Hearings	11	11	11	0	0	0	100%
X	Credentialing	32	32	31	1	0	0	97%
	Totals	160	158	153	5	0	2	97%

For the review of records for documentation of services, denials, and grievances, elements in each record reviewed were assigned a score of Yes (compliant), No (not compliant), or Not Applicable (N/A). For each of the scored record reviews, a summary score was then determined by calculating the percentage of applicable elements found compliant.

Table 3–2 presents the number of records reviewed, the number of applicable elements, and the number of compliant elements. It also provides an overall compliance score for each record review as well as a combined record review compliance score. Details of each record review can be found in Appendix B. The coordination-of-care record review was not scored. A narrative summary of each record review can be found in Section 4.

Table 3–2—Summary of Scores for the Review of Records

Associated Standard #	Description of Record Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
II	Documentation of Services	**10**	**21**	**15**	**71%**
VI	Denials	**10**	**27**	**23**	**85%**
VII	Coordination of Care—Children Transitioning From Inpatient to Outpatient Services	**10**	**Not Scored**	**Not Scored**	**Not Scored**
IX	Grievances	**10**	**41**	**41**	**100%**
	Totals	**40**	**89**	**79**	**89%**

Table 3–3 presents the overall scores (percentage of compliance) for the review of the standards, for the review of records, and for the review of the standards and records combined.

Table 3–3—Overall Compliance Scores

Review of the Standards—Percentage Compliant	**97%**
Review of Records—Percentage Compliant	**89%**
Overall Percentage Compliant	**94%**

This section of the report describes **FBH**'s strengths and required actions related to each of the standards and types of records reviewed. Details of the scores related to the review of the standards can be found in Appendix A and details of the scores related to the review of records can be found in Appendix B.

Standard I—Delegation

Strengths

FBH had delegation agreements with each of its delegates that contained all of the required language. **FBH** provided ample evidence of both formal and ongoing monitoring of quality and data, requiring corrective action when necessary, and following up on required corrective actions.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard II—Provider Issues

Strengths

FBH had an effective tracking mechanism in place to ensure that it had current agreements with each individual and organizational provider. The provider agreements contained all of the required content. **FBH** had a comprehensive corporate compliance program that met all the requirements and an active corporate compliance committee. **FBH** provided sufficient evidence that it monitored for both quality and appropriateness of care, and for consumer outcomes for both network community mental health centers (CMHCs) and independent network providers.

Review of Documentation of Services

A sample of 10 consumer service records was reviewed to assess **FBH**'s compliance with contract requirements related to documentation of services for submitted encounters. **FBH** was compliant with 14 of 21 applicable elements for a record review score of 71 percent. Nine of 10 records contained documentation on the same day for which the encounter was submitted. The 10th record contained only monthly summaries, even though weekly therapy occurred. Six records contained documentation that described a session that matched the procedure code submitted. Four records had documentation indicating that either the wrong procedure code was submitted or that an encounter was submitted for an inappropriate activity.

FBH staff members reported that upon discovering (during the audit of 411 encounter records) that the encounter submission to the State included incorrect codes, inappropriate codes, and encounters not supported by documentation or supported by inadequate documentation, they developed corrective actions with the providers and resubmitted the encounter file. The revised encounter file included corrected encounters, as appropriate, and **FBH** deleted encounters with inadequate or missing supporting documentation.

Required Actions

FBH must continue to take measures to review encounter data for inappropriate or inaccurate coding and continue to follow up on existing corrective action plans.

FBH must have a process for notifying the Department in writing of its decision to terminate any existing provider agreement, where such termination would cause service to be inadequate in a given area.

Standard III—Practice Guidelines

Strengths

FBH researched, adopted, and periodically reviewed clinical practice guidelines that were based on valid and reliable clinical evidence and a consensus of local and regional health care experts in the field. The BHO actively considered feedback from consumers and family members in developing the guidelines, including seeking input at meetings of the Consumer and Family Advisory Board (CFAB), and working closely with consumers and families in writing consumer tips. **FBH** made copies of the practice guidelines, medication algorithms, and consumer tips available on the **FBH** Web site and provided copies of the guidelines, including consumer tips, to providers, consumers, and family members upon request.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard IV—Member Rights and Responsibilities

Strengths

FBH had policies, procedures, and practices in place regarding consumer rights and responsibilities, and provided evidence of oversight and monitoring of staff and providers to ensure rights were taken into account during service provision.

The BHO had a well-staffed Office of Consumer and Family Affairs (OCFA), whose roles and responsibilities included advocacy, processing of grievances and appeals, and developing and distributing consumer information. The organizational structure of OCFA provided for local presence at the BHO administrative office as well as at the network CMHCs.

In response to corrective actions in the prior year, the advance directives procedures had been revised to include documentation of whether consumers had executed advance directives, and specific forms and data elements were used to document in the network CMHC electronic medical records.

Required Actions

The independent provider network (IPN) treatment summary form was vague in its documentation of advance directives information for those consumers receiving services from the IPN. Therefore, the BHO must develop a mechanism to ensure the IPN providers document whether a consumer has executed an advance directive.

Standard V—Access and Availability

Strengths

The BHO had policies, procedures, and documented evidence of the provision of services in nursing facilities and to dually eligible consumers.

Staff members and providers were made aware of expectations for timely access to services, and the BHO had sound methodology in place to track, monitor, and report timeliness of service provision by both the network CMHCs and the IPN. Improvements in access to care measures over the past year were noted.

The adequacy of the provider network was ensured through **FBH**'s evaluation procedures, and the BHO demonstrated its capacity for service provision, including CMHCs, independent providers, numerous single-case agreements, and contracts with federally qualified health centers (FQHCs), hospitals, organizational providers, and schools.

The BHO's commitment to the recovery model was particularly noteworthy, with an approach that included unique and creative—as well as more traditional—initiatives. **FBH** expressed a goal of developing a service delivery system that instills hope for recovery and resiliency, and had defined specific organizational (administrative and clinical) indicators to measure and ensure a culture change in its staff and providers.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard VI—Utilization Management

Strengths

FBH had an active utilization management program in place to monitor the access to and appropriate utilization of covered services. The BHO used information from multiple data sources, including claims and encounter data, and FlexServ* data to predict consumer service needs, assess patterns of service utilization, and measure compliance with access to care standards. **FBH** delegated various utilization management functions to its network CMHCs and to InNET. The BHO used several tools, including standardized level of care criteria, training, interrater reliability studies, and other oversight activities to ensure consistency in practice across the delegated entities.

Review of Denial Records

A sample of nine enrollee service denial records was reviewed to assess **FBH**'s compliance with contract requirements related to the presence and content of required documentation, as well as the timeliness of decisions and documentation. **FBH** was compliant with 23 of the 27 total applicable elements reviewed, for an overall score of 85 percent. **FBH** was fully compliant with the requirement to include the reason for the denial in notices. Notice of Action letters for two cases reviewed were not sent in a timely manner to the consumer and provider following a utilization review (UR) denial, as required in Exhibit G of the BHO's contract with the Department. In two cases, a certified alcohol counselor made the decision to deny services because the consumer did not have a covered diagnosis.

Required Actions

Because not all denial files reviewed met the timeliness standard for issuing a notice of action, **FBH** must ensure that a Notice of Action is sent in a timely manner to the consumer and provider following a UR denial decision and request extensions when necessary or appropriate to do so. In addition, since **FBH**'s policies require that denial decisions be made by licensed behavioral health professionals, **FBH** must ensure that it follows its policies and procedures regarding decisions to deny requests for authorization of services.

* FlexServ is a standardized approach to determining the type and number of authorized services based on the member's clinical presentation and identified level-of-impairment (LOI) needs, while at the same time providing the member choice in the design of his or her service plan.

Standard VII—Continuity-of-Care System

Strengths

FBH had comprehensive policies and procedures that described the role of the care coordinator in linking consumers to medical, substance abuse, and social services within the community. The BHO participated in numerous collaborative projects with community stakeholders, including schools, juvenile and adult corrections, child welfare, and DD community centered boards. **FBH** also sponsored multiple projects to improve coordination with medical providers, including providing colocated services at pediatrician offices, PCP offices, and FQHCs.

Review of Coordination of Care—Children Transitioning from Inpatient to Outpatient Services

Ten records were reviewed for evidence of care coordination and of outpatient follow-up for children after discharge from an inpatient facility. There were two cases for which **FBH** records indicated that the dates of the sample encounter were not hospital stays, but rather residential treatment center (RTC) admissions. There were several denied claims in the sample, two cases for which **FBH** was a secondary payer only, and two cases of retroactive eligibility. In each case that **FBH** was the payer for inpatient services (excluding retroactive eligibility cases), there was evidence of communication between the inpatient facility and either **FBH** or its contracted providers, even when the discharge plan was for services funded by the Department of Human Services (DHS). In one case of the ten **FBH** was responsible for services following discharge, and there was documentation of the follow-up appointment having taken place on the day of discharge.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard VIII—Quality Assessment and Performance Improvement Program

Strengths

FBH had a comprehensive quality assessment and performance improvement (QAPI) program in place that used data from multiple sources, including performance improvement projects (PIPs), consumer satisfaction surveys, clinical chart audits, and outcome measures to assess the quality of care provided to consumers. The program was supported by a health information system capable of collecting, analyzing, and reporting data. **FBH** actively solicited feedback from consumers and family members regarding quality management initiatives and developed, implemented, and monitored performance improvement plans to address any problems in performance identified through the quality improvement process.

Required Actions

No corrective action for this standard is being required at this time because the BHO was found to be in compliance with all the requirements.

Standard IX—Grievances, Appeals, and Fair Hearings

Strengths

FBH had a grievance system that included policies, procedures, standardized forms, and a reporting structure that met the requirements of the BBA and the State's contract for processing grievances and appeals. There was evidence of information and assistance to consumers for the grievance and appeal procedures.

Review of Grievance Records

Ten records of clinical- and access-to-care grievances were reviewed for timeliness of acknowledgement, extension, and decision/resolution letters; appropriate level of expertise for decision-making; and responsiveness to the grievance issue. Records were complete, orderly, and well-documented. All 10 records met standards in all areas of review, for an overall score of 100 percent.

Required Actions

No corrective action for this standard is required because the BHO was found to be in compliance with all the requirements.

Standard X—Credentialing

Strengths

FBH had a comprehensive credentialing program with policies and procedures that included the majority of requirements. Organizational provider site quality assessments were completed and included all the requirements. A review of individual and organizational provider files provided ample evidence that **FBH** was credentialing and recredentialing individual providers, both subcontracted and those employed by the network CMHCs, and was assessing organizational providers, as required by NCQA.

Required Actions

FBH's procedures that addressed credentialing (the Credentialing Manual) did not address the procedure for ongoing monitoring of sanctions. While **FBH** was clearly using complaint data and trending adverse events within the **FBH** organization, **FBH** was not monitoring for federal or State sanction information between recredentialing cycles.

FBH must revise its policies and procedures to include the procedure for ongoing monitoring of sanctions for individual providers, and it must include in its procedures and practice the process for ongoing monitoring of federal and State sanctions.

FBH is required to submit to the Department a CAP for all elements within the standards scored as Partially Met or Not Met and for all elements within the record reviews scored as No. The CAP must be submitted within 30 days of receipt of the final version of this report. For each element that requires corrective action, the BHO must identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. After the Department has approved the CAP, **FBH** will be required to submit documents identified as evidence of compliance.

Table 5-1 describes activities required for the CAP process.

Table 5-1—Corrective Action Plan Process	
Step 1:	**Corrective action plans are submitted.**
	Each BHO will submit a CAP to the Department within 30 calendar days of receipt of the final external quality review site review report. CAPs will be submitted via HSAG's file transfer protocol (FTP) site and the BHO will e-mail notification to the Department and HSAG. For each of the elements within the standards receiving a score of *Partially Met* or *Not Met*, and for each element within the record reviews receiving a *No*, the CAP must address the planned intervention(s) to achieve compliance and the timeline(s) for the intervention(s).
Step 2:	**Plans are reviewed and approved.**
	HSAG and the Department will review the CAPs. The Department will notify each BHO as to the adequacy of its plan. If the Department determines that a CAP is adequate to bring the BHO into full compliance with the applicable contract requirements, the Department will notify the BHO in writing that the plan is approved. If the Department determines that a CAP is not adequate to bring the BHO into full compliance with one or more contract requirements, the Department will require the BHO to submit a revised CAP. Following the review of the revised plan, the Department will notify the BHO in writing of its decision to approve the plan or to require further revisions.
Step 3:	**Progress reports may be required.**
	Based on the nature and seriousness of the noncompliance, the Department may require the BHO to submit regular reports to the Department detailing progress made on one or more elements in the CAP.
Step 4:	**Corrective actions are implemented.**
	Each BHO is expected to implement all corrective actions and achieve full compliance with the applicable contract requirements within 60 calendar days of the Department's written notification of having approved the BHO's CAP. The Department may extend the time frame for implementation of one or more of the corrective actions if requested by a BHO in writing and with cause.

Table 5-1—Corrective Action Plan Process	
Step 5:	**Substantiating documentation is submitted.**
	When all Department-approved corrective actions have been implemented, the BHO will submit documentation to the Department substantiating the completion of all required corrective actions and compliance with the related contract requirements.
Step 6:	**Documentation substantiating implementation of the plans is reviewed and approved.**
	Following a review of the documentation, the Department will inform the BHO as to whether: (1) the documentation is adequate to demonstrate completion of all required actions and compliance with the related contract requirements, or (2) the BHO must take additional actions and/or submit additional documentation. The Department 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 contract requirements.

Table 5-2 can be used by the BHO to document its planned interventions for any required actions that are listed.

Table 5-2—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard I: Delegation				
3. Content of Agreement D. Specifies that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any responsibilities delegated to the subcontractor.	FBH must revise its contract with InNET to specify that InNET shall comply with standards in the contract between the Department and FBH related to authorization functions.			
Standard II: Provider Issues				
8. Termination of Provider Agreements The Contractor notifies the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area and provides the notice at least ninety (90) days prior to termination of the services unless the termination is based on quality or performance issues.	FBH must have a process for notifying the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area.			
13. Record Review: Documentation of Services	FBH must continue to take measures to review encounter data for inappropriate or inaccurate coding and continue to follow-up on existing corrective action plans.			

Table 5-2—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard IV: Member Rights and Responsibilities				
5. Advance Directives A. The Contractor has written policies and procedures for Advance Directives.	FBH must implement a mechanism to ensure that its providers in the IPN document in the medical record whether a consumer has executed an advance directive.			
Standard VI: Utilization Management				
4. Clinical Expertise The Contractor ensures that any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope, that is less than requested, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	FBH must ensure that it follows its policies and procedures regarding decisions to deny requests for authorization of services.			
7. Record Review: Denials	FBH must ensure that a Notice of Action is sent timely to the consumer and provider following a UR denial decision. In addition, FBH must ensure that it follows its policies and procedures regarding decisions to deny requests for authorization of services.			

Table 5-2—FY 06–07 Corrective Action Plan *for* FBH				
Evaluation Elements	**Required Actions**	**Planned Intervention**	**Due Date**	**# of Attachment With Evidence of Compliance**
Standard X: Credentialing				
3. Content of Policies and Procedures Q. The procedure for ongoing monitoring of sanctions, complaints and adverse events (for high-volume providers).	FBH must revise the Credentialing Manual or other appropriate policies to describe ongoing monitoring for both State and federal sanctions that meet NCQA guidelines, and must implement the policies, as written.			

The review of the standards follows this cover page.

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
1. Pre-delegation Assessment	Prior to entering into subcontracts, the Contractor evaluates the proposed subcontractor's ability to perform the activities to be delegated.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings The Delegation of BHO Responsibilities policy described the process to evaluate potential delegates' ability to perform the activities to be delegated. Foothills Behavioral Health (FBH) staff reported that no new delegation agreements were entered into during the review period.	
II.C.1	**Required Actions** None	
2. Written Agreements	The Contractor has a written agreement with each subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH delegated the following functions: reauthorization of inpatient hospitalization and submission of encounter and Colorado Client Assessment Record (CCAR) data to InNET, certain service authorization tasks and tasks related to denials of service to its network community mental health centers (CMHCs), and credentials verification to Value Options. FBH had a written agreement with each of these delegates.	
II.C.2	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement	The written agreement: A. Specifies the activities delegated to the subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Each agreement specified the responsibilities of the delegate.	
	Required Actions None	
	B. Specifies the reporting responsibilities delegated to the subcontractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section 3 of the Value Options agreement, Exhibit A of the InNET agreement, and the section titled Delegation of Jefferson Center for Mental Health (JCMH) and The Mental Health Center Serving Boulder and Broomfield Counties (MHCBBC) agreements, specified the reporting responsibilities of the delegates.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
3. Content of Agreement	C. Includes provisions for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article V of the JCMH and MHCBBC agreements, Article III of the InNET agreement, and Sections 10 and 11 of the Value Options agreement included provisions for revoking delegation or imposing other sanctions in case of inadequate subcontractor performance.	
	Required Actions None	
	D. Specifies that the subcontractor shall comply with the standards specified in the contract between the BHO and the Department for any responsibilities delegated to the subcontractor.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Value Options agreement included language that required the delegate to comply with the credentialing standards of the National Committee on Quality Assurance (NCQA). This requirement satisfied the credentialing requirements specified in the contract between the BHO and the Department. Exhibit A of the InNET agreement stated that data submission by InNET would occur according the contractual obligations; however, there was not clear language in the agreement specifying that InNET would comply with the agreement between the Department and FBH for authorization functions delegated to InNET. The JCMH and MHCBBC agreements stated that the contract between the Department and FBH was incorporated into the agreements by reference.	
	Required Actions FBH must revise its contract with InNET to specify that InNET shall comply with standards in the contract between the Department and FBH related to authorization functions.	
II.C.2		

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
4. Policies and Procedures II.C.4	The Contractor has written procedures for monitoring the performance of subcontracts: A. On an ongoing basis	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Monitoring of Delegates policy, the Prior Service Authorization policy, and the Expedited Notice of Action policy included procedures for monitoring delegates on an ongoing basis.	
	Required Actions None	
	B. Through formal review	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Monitoring of Delegates policy included procedures for monitoring delegates through formal review.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
5. Monitoring of Delegates	The Contractor monitors services provided through subcontracts for: A. Quality	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There were audit results, monitoring through regular reporting to FBH by the delegates, and face-to-face meetings with the delegates that contained monitoring for quality of the performance of activities by the delegates.	
	Required Actions None	
	B. Data reporting	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There were audit results, monitoring through regular reporting to FBH by the delegates, and face-to-face meetings with the delegates that contained monitoring the delegates for completeness and accuracy of data reporting.	
II.C.3	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
6. Corrective Action II.C.5	If the Contractor identifies deficiencies or areas for improvement, the Contractor and the subcontractor take corrective action.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Examples of corrective action plans included plans submitted by InNET, MHCBC, and JCMH.	
	Required Actions None	
7. Termination of Subcontracts II.C.9	The Contractor notifies the Department in writing of its decision to terminate any existing subcontract applicable to the performance of services under the Contract.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Delegation of BHO Responsibilities policy included the provision for notifying the Department in writing of FBH's decision to terminate delegation subcontracts. The policy stated that a 90-day advance notice would be provided, which exceeds the 60-day requirement. FBH stated that no delegation subcontracts had been terminated during the review period.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard I: Delegation		
8. Access to Records II.C.8	All subcontracts provide for access to all records by the Secretary of the U.S. Department of Health and Human Services, for 3 years following disposition of property or equipment. **Findings** Section 8.8 of the InNET agreement, Article VI of the network CMHC agreements, and Section 8 of the Value Options agreement provided for access to all records by the secretary of the U.S. Department of Health and Human Services for three years following disposition of property or equipment. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard I					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
11	1	0	1	12	92%

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
1. Provider Discrimination	A. The Contractor does not discriminate with respect to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The credentialing procedures in the Foothills Behavioral Health Provider Network Individual Provider Credentialing & Recredentialing & Organizational Assessment Manual (Credentialing Manual) included required statements that FBH did not discriminate against providers. The template provider agreements included a nondiscrimination clause, which included the required language. FBH staff members described consistent application of the credentialing processes regardless of practitioners' license or specialty.	
	Required Actions None	
	B. If the Contractor declines to include individual or groups of providers in its network, it gives the affected providers written notice of the reason for its decision.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual indicated that providers were notified in writing of FBH's decision to decline participation in the network. FBH provided a template letter on-site.	
	Required Actions None	
II.H.4.a		

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	A. The Contractor has a mandatory compliance plan and administrative and management arrangements or procedures that are designed to guard against fraud and abuse, and that include: 1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state requirements.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's Corporate Compliance Program included policies, procedures, and standards of conduct that articulated a commitment to comply with all applicable federal and state requirements and to guard against fraud and abuse.	
	Required Actions None	
	2. Designation of a compliance officer and compliance committee that is accountable to senior management.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Corporate Compliance Program included the designation of the compliance officer and a compliance committee. Corporate Compliance Committee meeting minutes indicated that the committee was composed of FBH senior management members and was active during the review period.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	3. Training and education for the compliance officer and the Contractor's employees.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Corporate Compliance Program and associated training outlines and agendas described the content of training for FBH's employees, and for JCMH and MHCBBC employees. The Corporate Compliance Program described training requirements for new-employee orientation and annually. In addition, provider agreements included a clause that compelled subcontractors to comply with the Corporate Compliance Program. The Independent Provider Network Newsletter included updates regarding corporate compliance information.	
	Required Actions None	
	4. Provisions for internal monitoring and auditing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Detection of Fraud and Abuse policy and the Monitoring of Encounter Record Accuracy policy described procedures for monitoring and auditing to detect fraud and abuse and determine compliance. Reports of monitoring and audits were reviewed. They demonstrated implementation of the program as written with regard to auditing and monitoring.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
2. Program Integrity	5. Provisions for prompt response to detected offenses and for development of corrective action initiatives.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Corporate Compliance Program described provisions for prompt response to detected offenses and for development of corrective action initiatives.	
	Required Actions None	
	B. The Contractor reports possible instances of Medicaid fraud to the Department within ten (10) business days of receipt of information. The Referrals include specific background information, the name of the Provider and a description of how the Contractor became knowledgeable about the occurrence.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Reporting of Fraud and Abuse policy included the provision for reporting possible instances of fraud to the Department within 10 business days of the receipt of the information, and it described the content of the report to the Department, which included the required information. The FBH staff reported that there had been no instances of possible fraud within the review period.	
	Required Actions None	
II.G.5.c.1-7 II.H.5.d		

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
3. Provider Agreements II.H.10.a.2	The Contractor has a written agreement with each provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Agreement templates reviewed were the Facility Service Agreement, the Provider Agreement, the Sub Acute Facility Agreement, the single case agreement contract, and the Network Mental Health Center Agreement. FBH had an effective tracking system to ensure that it had an agreeement with each provider. Credentialing files for individual and organizational providers contained signed agreements.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
4. Content of Agreement	The written agreement: A. Specifies the activities of the provider	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article II of each provider agreement specified the activities of the provider.	
	Required Actions None	
	B. Specifies the reporting responsibilities of the provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article III in each provider agreement specified general reporting responsibilities of the provider. Article V of the agreements used for organizational and individual providers specified reporting responsibilities related to claims submissions.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
4. Content of Agreement	C. Includes provisions for revoking the agreement or imposing other sanctions if the provider's performance is inadequate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Articles VII and IX of the Provider Agreement and Articles IV and VIII of the Facility Service Agreement, the Sub Acute Facility Agreement, and the Network Mental Health Center Agreement included provisions for revoking the agreement or imposing other sanctions if the provider's performance became inadequate.	
II.H.10.a.2	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment	The Contractor provides that its Medicaid members are not held liable for: A. The Contractor's debts in the event of the Contractor's insolvency.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article V of each provider agreement included the provision that Medicaid members may not be held liable in the case of FBH's insolvency.	
	Required Actions None	
	B. Covered services provided to the member for whom the Department does not pay the Contractor, or the Department or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referral, or other arrangement.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article V of each provider agreement included the provision that members were not held liable in the case of nonpayment by FBH.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
5. Liability for Payment II.H.11.a	C. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Article V of each provider agreement included the provision that the subcontractor may not bill, charge, collect deposits from, or seek compensation from covered persons.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	The Contractor monitors covered services provided under provider agreements for: A. Quality	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Peer Review Medical Record Audit Results report included evidence of monitoring services for quality for network CMHCs and independent providers.	
	Required Actions None	
	B. Appropriateness	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Peer Review Medical Record Audit Results report included evidence of monitoring of services for appropriateness of care for network CMHCs and independent providers.	
	Required Actions None	
	C. Member outcomes	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Quality Improvement Program quarterly reports included evidence of monitoring of services for member outcomes for network CMHCs and independent providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
6. Monitoring of Providers	D. Requirements for medical records	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Peer Review Medical Record Audit Results report included evidence of assessment for requirements for medical records for network CMHCs and independent providers.	
	Required Actions None	
	E. Requirements for data reporting	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings There were several audits performed during the review period that provided evidence of monitoring providers (CMHCs and subcontractors) for data reporting requirements.	
	Required Actions None	
II.H.10.a.3		

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
7. Policies and Procedures	The Contractor has written procedures for monitoring the performance of providers on an ongoing basis.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Corrective Action Process policy, the Detection of Fraud and Abuse policy, the Maintenance of Medical Records policy, the Monitoring of Encounter Record Accuracy policy, and the Quality of Care Concerns policy included written procedures for monitoring the performance of providers on an ongoing basis.	
II.H.10.a.4	**Required Actions** None	
8. Termination of Provider Agreements	The Contractor notifies the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area and provides the notice at least ninety (90) days prior to termination of the services unless the termination is based on quality or performance issues.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Corrective Action Process policy included the provision for notifying the Department 90 days prior to the termination of contracts for delegated functions. The requirement for notifying the Department of provider agreement terminations was not addressed in policy. All of the provider agreements except for the JCMH and the MHCBBC agreements included language describing the requirement for notification of provider terminations.	
II.H.10.d	**Required Actions** FBH must have a process for notifying the Department in writing of its decision to terminate any existing provider agreement where such termination causes the delivery of covered services to be inadequate in a given area.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
9. Prohibited Affiliations II.H.6.a	The Contractor does not knowingly have a relationship of the type described below with the following: An individual or an affiliate of an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Prohibited Relationships policy and the Credentialing Manual described processes to ensure that FBH did not have relationships with individuals or affiliates excluded from federal health care participation. Credentialing files contained evidence that FBH used the Office of Inspector General (OIG) database to determine if providers had been excluded.	
	Required Actions None	
10. Marketing II.H.8	The Contractor adheres to all contract requirements related to marketing.	☐ **Met** ☐ **Partially Met** ☐ **Not Met** ☑ **N/A**
	Findings FBH staff reported that, during the review period, FBH did not engage in marketing activities as defined in the BHO contract with the Department.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
11. Department Approved Member Handbook	The BHO's Member Handbook was submitted to and approved by the Department prior to distribution.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH staff reported that the member handbook approved by the Department in 2005 was the handbook in use at the time of the site review, and that the handbook submitted for approval in September 2006 had not yet been approved.	
II.H.8.a	**Required Actions** None	
12. Statistically Valid Sampling	The BHO reviews compliance with criteria for submission of encounter claims data each year by reviewing and documenting at least one statistically valid sample of encounter claims submitted to the Department.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH reviewed a statistically valid sample (411) of encounter records for compliance with contract criteria. The report FBH submitted indicated that FBH reviewed for accuracy and completeness of data, the presence of both paid and denied claims, and for the presence of documentation in the medical record. The report also indicated that the sample included data from each of the network CMHCs, as well as subcontracted providers, and represented the array of services provided by FBH.	
II.J.6.c.3.c	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard II: Provider Issues		
13. Record Review: Documentation of Services	Presence, timeliness, and accuracy of documentation to support encounter claims.	
	Findings A sample of 10 consumer service records was reviewed to assess FBH's compliance with contract requirements related to documentation of services for submitted encounters. FBH was compliant with 14 of 21 applicable elements for a record review score of 71 percent. Nine of 10 records contained documentation on the same day for which the encounter was submitted. The 10th record contained only monthly summaries, even though weekly therapy occurred. Six records contained documentation that described a session that matched the procedure code submitted. Four records had documentation indicating that either the wrong procedure code was submitted or that an encounter was submitted for an inappropriate activity. FBH staff reported that upon discovering (during the audit of 411 encounter records) that the encounter submission to the State included incorrect codes, inappropriate codes, and encounters not supported by documentation or supported by inadequate documentation, they developed corrective actions with the providers and resubmitted the encounter file. The revised encounter file included corrected encounters, as appropriate, and FBH deleted encounters with inadequate or missing supporting documentation.	
	Required Actions FBH must continue to take measures to review encounter data for inappropriate or inaccurate coding and continue to followup on existing corrective action plans.	

Results for Standard II					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
24	1	0	1	25	96%

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	Any practice guidelines adopted by the Contractor will: A. Be based on valid and reliable clinical evidence or a consensus of health care professionals in the field.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Clinical Practice Guidelines policy stated that clinical practice guidelines developed by the BHO were based on clinical evidence and/or the consensus of behavioral health care professionals. Information included in the FY 06-07 Desk Review Form indicated that FBH convened a Clinical Practice Guideline Subcommittee to develop and implement clinical practice guidelines. Minutes from Clinical Practice Guideline Subcommittee meetings held on February 23, 2006, and November 30, 2006, and Quality Assessment and Performance Improvement (QAPI) Program Committee meeting minutes dated February 16, 2006, documented that FBH adopted practice guidelines for attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD) and schizophrenia this review period. The ADHD guidelines were adapted from the American Academy of Child and Adolescent Psychiatry Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with ADHD. The practice guidelines and corresponding medication algorithm for schizophrenia were adapted from the American Psychiatric Association's Practice Guidelines for the Treatment of Patients with Schizophrenic Illness.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	B. Consider the needs of the members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's Clinical Practice Guidelines policy indicated that FBH developed and implemented practice guidelines based on the following priorities: disorders that are highly prevalent among FBH consumers, disorders associated with high morbidity and disability, consumer or provider request for guidance regarding a specific treatment modality (e.g., dialectical behavioral therapy), and other priorities identified by FBH providers, consumers, and families. The FY 06-07 Desk Review Form stated that all clinical practice guidelines adopted by FBH included a set of consumer tips in addition to the clinical guideline and medication algorithm specific to each diagnosis. The Clinical Practice Guidelines policy also included an expectation that consumers and family members have an opportunity to review and comment on draft practice guidelines prior to their adoption by the BHO. During the interview, FBH staff reported that consumers and family members played an active role in ensuring that the guidelines were recovery-focused and were relevant to their needs. Meeting minutes from a November 30, 2006, Clinical Practice Guidelines Subcommittee meeting indicated that FBH staff had reviewed a tip sheet and practice guideline with the Consumer and Family Advisory Board (CFAB).	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption	C. Be adopted in consultation with contracting health care professionals.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's Clinical Practice Guidelines policy stated that the FBH medical director, assistant medical director, and senior clinical staff from both the BHO's network CMHCs and IPN were active members on the Clinical Practice Guideline Subcommittee. Staff members at the BHO also stated that FBH providers as well as regional experts with specific expertise relevant to a particular practice guideline had been invited to participate in the research and development of guidelines, as appropriate. Minutes from a February 23, 2006, Clinical Practice Guidelines Subcommittee meeting documented a discussion regarding the recruitment of expert consultants to assist in the research and development of ADHD practice guidelines.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
1. Adoption II.I.2.a.1	D. Be reviewed and updated periodically as appropriate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Clinical Practice Guidelines policy stated that practice guidelines were reviewed and updated by the Clinical Practice Guideline Subcommittee at least every two years following a review of current professional literature and after seeking feedback from providers, consumers, and families. The policy indicated that final approval of any revisions to the practice guidelines, medication algorithms, or consumer tips were approved for implementation by the QAPI Committee and Utilization Management (UM) Committee. Minutes from a Clinical Practice Guidelines Subcommittee meeting on November 30, 2006, documented that revisions to both the BHO's depression practice guidelines and bipolar disorder guideline, tip sheet, and medication algorithm were reviewed and discussed. During the interview, FBH staff reported that a three-year plan for the development and periodic review of clinical practice guidelines had recently been adopted by the BHO. FBH staff also indicated that any significant change in the recommended treatment of a mental health disorder documented in the professional literature would trigger the need to review practice guidelines more frequently.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard III: Practice Guidelines		
2. Dissemination II.I.2.a.2	The Contractor disseminates practice guidelines to all affected providers and, upon request, to members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Clinical Practice Guidelines policy stated that consumers may request copies of practice guidelines from their providers or by contacting the BHO director of the Office of Consumer and Family Affairs (OCFA). Clinical practice guidelines, medication algorithms, and tip sheets were made available to providers, consumers, and family members on the FBH Web site. During the interview, FBH staff members stated that their network CMHCs also posted practice guidelines on the intranet or shared drive and that consumer tips were frequently provided to consumers and family members by providers as part of the psycho-educational process. The BHO provided an agenda for a new employee orientation at MHCBBC that included a discussion regarding practice guidelines.	
	Required Actions None	

Results for Standard III					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
5	0	0	0	5	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	The Contractor has written policies and procedures for treating members in a manner that is consistent with the member's right to: A. Receive information about his/her rights.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies, Member Information and Member Rights, contained procedures for ensuring consumers were informed of their rights, and described the role of the OCFA in the development and distribution of consumer information. The policies stated that all new Medicaid enrollees received the required information within three weeks of enrollment notification, again when the consumer presented for the first appointment with the BHO, and any time upon request. The BHO also mailed a letter annually to inform consumers of the availability of the information and annually distributed the provider directory. The provider manual described the providers' role in dissemination of consumer information, including rights information, and the Independent Provider Network Treatment Summary form included a check box for the provider to indicate that the member handbook information was given to the consumer. Network CMHC providers were expected to post the rights information, OCFA poster, grievance system information, and ombudsman flyer at each site. IPN providers were also expected to post or distribute consumer rights information provided to them by the BHO. This information included a letter to consumers with brief highlights of the information that was available and the page of the handbook where they could locate it quickly.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	B. Be treated with respect and with due consideration for his/her dignity and privacy.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies, Member Information and Member Rights, the provider manual, and the member handbook included the expectation that all consumers would be treated with respect, dignity, and consideration of privacy.	
	Required Actions None	
	C. Participate in decisions regarding his/her health care, including the right to refuse treatment except as provided by law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies, Member Information and Member Rights, the provider manual, and the member handbook included the expectation that all consumers would be included in decisions about their health care. Consumer empowerment was also addressed in the FBH mission and values statements, included in training modules for staff and providers, and described in detail in FBH's Commitment to the Recovery Model policy and procedure.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	D. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies, Member Information and Member Rights, the provider manual, and the member handbook included the expectation that all consumers would receive information about treatment options in an understandable manner. Consumer empowerment was addressed in the FBH mission and values statements, included in training modules for staff and providers, and described in detail in FBH's Commitment to the Recovery Model policy and procedure.	
	Required Actions None	
	E. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies, Member Information and Member Rights, the provider manual, and the member handbook included the requirement that all consumers would be free from restraint and seclusion as a means of discipline, coercion, or retaliation.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights	F. Request and receive a copy of his/her medical records and to request that they be amended or corrected.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies, Member Information and Member Rights, the provider manual, and the member handbook included the expectation that all consumers could request and receive a copy of their medical records and ask that they be amended.	
	Required Actions None	
	G. Be furnished health care services in accordance with 42 C.F.R. Sections 438.206 through 438.210.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies, Member Information and Member Rights, the provider manual, and the member handbook included the expectation that services would be delivered in a manner consistent with federal regulations. Several additional FBH policies and the provider manual addressed expectations for access and availability of services, coordination and continuity of care, and authorization of services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
1. Written Policy on Member Rights II.G.3	H. Be free to exercise his/her rights without it affecting the way the Contractor and its providers treat the member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies, Member Information and Member Rights, the provider manual, and the member handbook included the expectation that all consumers would be free to exercise their rights without fear of retaliation. FBH's consumer materials made references, in numerous places, to the fact that consumers could call the OCFA if they felt that the way they were treated had changed since voicing a complaint.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	A. The Contractor ensures that its staff and affiliated providers take these rights into account when furnishing services to members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policy, Member Rights, described the procedures that the BHO followed to ensure providers took rights into account when providing services. Evidence of staff and provider training about member rights and expectations for staff (new employee and annual) was reviewed. The OCFA staff members were responsible for monitoring providers' distribution of consumer materials and for educating providers on the rights of consumers. Additional mentoring by the BHO included conducting chart audits, and tracking/trending information on consumers' experience of care with FBH providers. The information used in this evaluation included member survey responses, grievances and appeals information, quality of care concern investigations, and reports of rights violations. Documented evidence of provider monitoring results was reviewed.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	B. The BHO has a process to ensure the member's right to an independent advocate.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policies on Member Rights and Grievance System: Grievances and Appeals contained information about the consumer's right to an independent advocate. Consumers were also given this information in their informational materials and when filing a grievance. The BHO's process for assisting the consumer with obtaining an independent advocate was described, and included referrals to the Ombudsman office for further assistance with referrals to advocates, as well as referrals by BHO staff to Legal Aid, National Alliance for the Mentally Ill, Federation of Families, and the Legal Center for Persons with Disabilities.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
2. Takes Rights Into Account	C. The BHO has processes to follow-up on all member complaints about a staff person or provider and to ensure that the staff/providers do not retaliate against the member for expressing a concern.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policies on investigation of quality of care concerns and on the grievance system included processes for follow-up on complaints about staff or providers, and stated that there would be no retaliation against a consumer for voicing a complaint. This was reinforced with the consumers through various notices and rights flyers that contained the information that the BHO would not tolerate retaliation. Consumers were instructed to report any concern of this nature to the OCFA. The BHO had a process to track and trend grievances by type of complaint. During the interview, the BHO staff described one occurrence of a consumer complaint of retaliation and the process the staff members used to refer the complaint to HCPF so there would be no perceived conflict of interest by the consumer during the investigation.	
	Required Actions None	
	D. The BHO furnishes to each of its Members information about the assistance available through the Medicaid Managed Care Ombudsman Program and how to access Ombudsman Program Services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH, in its Member Rights policy, described the requirement for providers to post and/or distribute the Ombudsman flyer to consumers. The policy also included procedures for monitoring the providers for compliance with this requirement. FBH OCFA staff provided oversight of the network CMHCs' posting of this information, and ensured that mailing to the IPN, including hospitals and other organizational providers occurred at least annually.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
II.G.3-4		
3. Member Responsibilities	The Contractor has written requirements for member participation and responsibilities in receiving covered services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH had a set of consumer responsibilities that was distributed to consumers and providers through the FBH member handbook and the provider manual. Rights and responsibilities information was given to all new Medicaid enrollees and to consumers upon entry into the FBH system.	
	Required Actions None	
II.G.2		

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
4. Consumer and Family Affairs II.G.5	The Contractor has an Office of Consumer and Family Affairs to work with members and families.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's OCFA consisted of a director position and a community liaison operating out of the FBH administrative office, and two advocate positions with one at each of its network CMHCs. The roles and responsibilities of this office were described in detail in policies (Member Information, Member Rights, Grievance System: Grievances and Appeals) and in the consumer handbook and provider manual. An OCFA poster was published to post this information at provider sites. Among OCFA's roles were developing and distributing consumer information, training and monitoring providers in taking rights into account when providing services, advocating for consumers and their families, assisting consumers with and processing grievances and appeals, reporting to the QAPI Committee periodic summary information on grievances and appeals, and supporting the BHO's CFAB for the adult consumers and the newly created family forum (for child consumers and their families).	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives	A. The Contractor has written policies and procedures for Advance Directives.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH had a policy, Advance Directives, that addressed how the BHO respected and implemented the member's rights (under the State law) regarding advance directives, including distribution of advance directives information, documentation of advance directives in the medical record, information that the provision of care was not conditioned on whether an individual had executed an advance directive, and information that the BHO required annual provider training on policies and procedures for advance directives. In follow-up to the required corrective action from the previous year's site review, FBH was asked to demonstrate the mechanisms for documenting in a consumer's medical record whether or not the consumer had executed an advance directive. The network CMHCs had electronic medical record-keeping systems that ensured the documentation of this requirement. The IPN advance directive documentation included a check box to indicate that the provider had inquired, but not information about whether the consumer had an advance directive.	
	Required Actions FBH must implement a mechanism to ensure that its providers in the IPN document in the medical record whether a consumer has executed an advance directive.	
	B. The Contractor provides all adult members with written information on Advance Directives policies, which includes: 1. A description of the applicable state law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The advance directive information contained in the FBH member handbook included a description of the applicable State law.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IV: Member Rights and Responsibilities		
5. Advance Directives II.H.7	2. The member's rights under the law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The advance directive information contained in the FBH member handbook included the statement that the consumer could provide written instructions about his/her wishes regarding care, get more information or copies of policies about advance directives (with resources and phone numbers provided), and complain about a provider for not following the consumer's directive.	
	Required Actions None	
	3. The fact that complaints concerning non-compliance with the Advance Directive requirements may be filed with the State Department of Public Health and Environment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Advance directive information given to consumers in the FBH member handbook included the phone number of the Colorado Department of Public Health and Environment for consumers to register complaints if a provider did not follow an advance directive.	
	Required Actions None	

Results for Standard IV					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
17	1	0	0	18	94%

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
1. On-site Nursing Facilities II.F.2-3	The Contractor: - Provides medically necessary mental health services on-site in nursing facilities for members who are residents of nursing facilities and who cannot reasonably travel to a service delivery site for their services. - Considers the ability of the resident to travel when determining the service delivery site (i.e., BHO site or nursing facility).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policy, On Site Mental Health Services in Nursing Facilities, described the requirements and procedures for provision of services, including arranging for transportation, to consumers who resided in nursing facilities. The BHO also provided evidence of the number and types of services it had provided to nursing facility residents during FY 05-06. Both the consumer handbook and the provider manual described the requirements for providing these services. The network CMHCs and a couple of older adult specialty service providers in the IPN were primarily responsible for services to individuals residing in nursing facilities.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
2. Dual Medicare/Medicaid Eligible	A. The Contractor makes an effort to identify and include providers in the Contractor's network that are capable of billing Medicare for dual Medicare and Medicaid eligible members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO policy, Dual Medicare and Medicaid Members, as well as the consumer handbook and provider manual, communicated requirements and expectations of the BHO for providers to identify and report dual eligibility of consumers, and stated that Medicare-certified providers would be identified for provision of covered services, as available. The network CMHCs were both designated as Medicare-eligible providers of services and were primarily responsible for services to individuals with dual eligibility for Medicaid and Medicare.	
	Required Actions None	
	B. If qualified Medicare providers cannot be identified, the Contractor provides the medically necessary mental health services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO policy, Dual Medicare and Medicaid Members, as well as the consumer handbook and provider manual, communicated requirements and expectations that the BHO would ensure services were provided if a Medicare-certified provider could not be identified. FBH quantified the number of services provided by the two network CMHCs to dual-eligible consumers in a report for the time period January 1, 2006, through September 30, 2006. Compared to the same period in the previous year, the BHO had increased its service provision to this population by 5 percent.	
	Required Actions None	
II.F.4		

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	A. The Contractor monitors providers to determine compliance with standards for timely access.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policy, Access to Services, described the monitoring processes of the BHO to ensure that all providers, network CMHCs and IPN, met access standards for timely provision of services. The BHO provided documented evidence of timely appointments in the IPN in an Excel spreadsheet, and quarterly access to care reports provided to the Department that included network CMHC data on access indicators. Other means of oversight and monitoring included provider site visits and information gained from consumer and family surveys. The standards for timely access were contained in the provider manual. The provider manual also instructed the provider that, in the event a provider identified an inability to meet an appointment standard, providers were to refer the consumer to the FBH IPN clinical manager for assistance in arranging an appointment with another FBH network provider. The BHO's methods for access data collection and calculation were sound and consistently applied across the network CMHCs and the IPN.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	B. The Contractor meets standards for timeliness of service including the following: 1. Emergency services are available - By phone within 15 minutes of the initial contact. - In person within one hour of contact in urban and suburban areas. - In person within two hours of contact in rural and frontier areas.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Provision of emergency mental health services by the BHO and its provider network was accomplished largely through the network CMHCs and local emergency rooms. The BHO had worked with one network CMHC to develop and implement corrective actions which, in the last reported quarter, demonstrated that significant improvement in meeting the emergency standard had been achieved (100 percent). The provider manual contained requirements for the IPN and expectations for assisting consumers with urgent or emergent service needs. Consumers and providers were instructed to use the FBH emergency service line, to call 911, or to go to any emergency room. The FBH emergency line was routed after hours to ProtoCall, a professionally staffed emergency evaluation phone service with an immediate response time to phone calls.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	2. Urgent care is available within 24 hours.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Provision of urgent mental health services by the BHO and its provider network was accomplished largely through the network CMHCs and local emergency rooms. The provider manual described requirements for the IPN and expectations for assistance to consumers with urgent or emergent service needs. Consumers and providers were instructed to use the FBH emergency service line, to call 911, or to go to any emergency room. The FBH emergency line was routed after hours to ProtoCall, a professionally staffed emergency evaluation phone service with an immediate response time to phone calls.	
	Required Actions None	
	3. Routine services are available within seven calendar days.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policy, Access to Services, described the monitoring processes of the BHO to ensure timely provision of routine appointments. The BHO provided evidence of monitoring appointment timeliness on a weekly, monthly, and quarterly basis, and the data demonstrated improvement in meeting the timeliness standard for routine appointments. The network CMHCs and IPN were instructed, through the provider manual, to refer the consumer to FBH in the event the provider could not offer a timely routine appointment. FBH's monitoring and reporting requirements were applicable to both network CMHCs and the IPN.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
3. Access to Services	C. The Contractor takes corrective action if there is a failure to comply with standards for timely access.	
	Findings This element was not reviewed or scored.	
	Required Actions	
	D. The authorization process takes into consideration other factors, such as the need for services and supports to assist a Member to gain new skills or regain lost skills that support or maintain functioning and promote recovery.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The provider manual, in the section on utilization management (UM) procedures, and the FBH UM Program Description described how the need for services and supports that assisted consumers in their recovery would be considered in the UM process. Other evidence that the BHO took these factors into account included its criteria for service authorization, practice guidelines, and provider and consumer communications about recovery. The BHO conducted medical record audits to evaluate the treatment planning process and the set of services offered. The Colorado Client Assessment Record (CCAR) was used as an evaluation tool for consumer outcomes and was tied to the FlexServ authorization system, which uses a consumer's level of impairment to determine the range and intensity of services needed.	
II.F.1.a.7 II.F.1.a.4.a-e II.F.1.a.8 Exhibit C.III.C	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	In establishing and maintaining the provider network, the Contractor considers: A. Including both Essential Community Providers and other providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policy, Assurances of Adequate Capacity of Services, addressed the BHO's processes for monitoring the network adequacy. The detailed listing of FBH contracted providers demonstrated that the BHO had included CMHCs, federally qualified health centers, hospitals, other organizational providers, as well as individual/group practitioners. The list also included schools with which the BHO had agreements to provide school-based services. The adequacy of the network was regularly evaluated and reported in the Network Adequacy Summaries and Final Reports.	
	Required Actions None	
	B. The anticipated Medicaid enrollment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policy, Assurances of Adequate Capacity of Services, addressed the BHO's processes for considering the anticipated Medicaid enrollment when establishing the network. The adequacy of the network was regularly evaluated and reported in the Network Adequacy Summaries and Final Reports.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network	C. The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the enrolled population.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policy, Assurances of Adequate Capacity of Services, addressed the BHO's processes for considering the expected utilization of services and the needs of the population when establishing the network. The adequacy of the network was regularly evaluated and reported in the Network Adequacy Summaries and Final Reports. The BHO provided an example of researching and recruiting a specialty provider (eating disorder treatment) when the need arose.	
	Required Actions None	
	D. The numbers and types (training/experience) of providers required to furnish the contracted Medicaid services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policy, Assurances of Adequate Capacity of Services, addressed the BHO's processes for considering the number and types of providers needed when establishing the network. The provider directory indicated the provider's specialty area of practice, license, and service type. The adequacy of the network was regularly evaluated and reported in the Network Adequacy Summaries and Final Reports.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
4. Provider Network II.F.1.c	E. The numbers of network providers who are not accepting new Medicaid patients. **Findings** The FBH policy, Assurances of Adequate Capacity of Services, addressed the BHO's processes for considering the number of providers who are not accepting new Medicaid patients when establishing the network. The provider directory indicated whether contracted providers were accepting new patients. The adequacy of the network was regularly evaluated and reported in the Network Adequacy Summaries and Final Reports. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
5. Out-of-Network Providers II.F.1.d	If the Contractor is unable to provide covered services to a particular member, the Contractor provides the covered services out of network at no cost to the member. **Findings** The FBH policy, Assurances of Adequate Capacity and Services, stated, "If FBH is unable to provide the medically necessary services to meet the needs of a Member, including specialty care requests within the established network, such services are purchased from an out-of-network provider at no cost to the Members." There was evidence provided of several contracts and single-case agreements both out-of-network and outside of the counties of FBH's geographic responsibility. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
6. Geographic Access II.F.1.e II.1.a.5	A. The Contractor has arrangements to ensure proximity of participating providers to the residences of members so as not to result in unreasonable barriers to access and to promote continuity of care taking into account the usual means of transportation ordinarily used by members.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Assurances of Adequate Capacity and Services, described procedures for determining the geographic proximity of providers to residences of members. On a quarterly basis, the BHO conducted geo-mapping and reported the results in its evaluation of network capacity.	
	Required Actions None	
	B. The Contractor ensures that providers are located throughout the Contractor's service area, within 30 miles or 30 minutes travel time, to the extent such services are available.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Assurances of Adequate Capacity and Services, described procedures for determining that the geographic proximity of providers to members was within 30 miles. On a quarterly basis, the BHO conducted an analysis and mapping and reported the results in its evaluation of network capacity.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
7. Selection of Providers II.F.1.f	The Contractor allows each member to choose, to the extent possible and appropriate, his or her health professional.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policy, Member Choice of Provider, contained procedures to ensure continuity of care for new consumers who had been receiving services from an out-of-network provider, and for providing choice for consumers of in- or out-of-network providers, as long as credentialing criteria were met. Evidence of over 100 consumers being served through single-case agreements demonstrated the BHO's commitment to allowing consumers to choose their providers to the extent possible.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
8. Recovery Model Exhibit C.II	The Contractor will demonstrate commitment to the recovery model.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH had several unique and creative approaches to ensure that its providers practiced according to the principles of the recovery model. In addition to consumer involvement as peers, employees, and committee/council members of the BHO, FBH had a specific policy (Commitment to the Recovery Model) that described its expectations, and a specific organizational Recovery Committee that had developed and planned to measure administrative and clinical indicators for adherence to the recovery model within FBH and its providers. FBH also had an award for a recovery champion at the network CMHCs and significant financial grants awarded to the network CMHCs in 2006 and 2007 for further development and implementation of initiatives in support of consumer recovery. Within the past year, FBH had also sponsored staff/provider trainings with nationally recognized experts in recovery and peer support programs, and developed/distributed posters and folders containing recovery-focused brochures, tips for management of certain mental disorders, and notepads containing recovery statements to instill hope.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
9. Medication Management Exhibit C.IV.I	The BHO provides or arranges for the monitoring of medications prescribed, and consultation provided to Members by a physician as necessary.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH UM Program Description, provider manual, and consumer handbook described requirements for the provision of medication monitoring services. A quarterly network adequacy summary during the review period discussed that the BHO had a minimum of one prescriber per county. FBH staff explained that several prescribers were available at each of the network CMHCs, including at least one child psychiatrist. The BHO was exploring the use of additional prescribers by contracting with advance practice nurses and was evaluating the need to change the fee schedule in order to recruit and retain more prescribers. A report of medication services provided during FY 05-06 demonstrated the number of unduplicated consumers who received at least one medication service during the time period. The network CMHCs served 2,710 consumers and the IPN served 92 consumers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard V: Access and Availability (Service Delivery)		
10. Alternative Services Exhibit K.III.A-I	The BHO has sufficient capacity to provide alternative services as described in Exhibit K of the Contract with the Department (effective 3/31/06). These services are available to serve the specified number of Members, and at the specified locations.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Available alternative services were described in the consumer handbook and the provider manual. The BHO furnished an annual report for FY 05-06, the FBH Alternative Services Capacity Report. For each service, FBH evaluated the number of consumers served and the number of providers in the time period against the projected capacity, as listed in the contract with the Department. Discussion and analysis of reasons that services exceeded, met, or were below projections were also included in the report. The BHO also reported quarterly expenditures for alternative services to the Department.	
	Required Actions None	

Results for Standard V					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
20	0	0	0	20	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	A. The Contractor has a Utilization Management (UM) Program to monitor the access to and appropriate utilization of covered services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH provided numerous policies and procedures and other documents to demonstrate that the BHO had an active UM Program in place to monitor the access to and appropriate utilization of covered services. The FBH Utilization Management Program Principles and Practices document provided an overview of the BHO's UM program, including a description of delegated UM functions, comprehensive information regarding the utilization review process, copies of admission, continued stay and discharge criteria for various levels of care, and a list of UM reports used by FBH to manage consumer care and detect under-utilization and over-utilization of services. The BHO's FY 06-07 Quality Improvement Program Description and Work Plan included several indicators related to access to care, including penetration rates, timeliness of response to emergency and urgent requests, and timeliness of hospital follow-up.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program	B. The UM program includes written policies and procedures.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH had several policies and procedures that provided guidance to staff regarding various aspects of the BHO's UM program. UM-related policies and procedures provided by FBH for review included the following: Prior Service Authorization, Utilization Determination Criteria, Referrals for Specialty Care, Provider and Employee Incentives, Notice of Action-Routine, Notice of Action-Expedited, Monitoring Impact of Benefit Limitations--Inpatient, and Monitoring Impact of Benefit Limitations--Individual Outpatient Therapy.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
1. Utilization Management Program II.J.1	C. The Contractor has a mechanism in effect to ensure consistent application of the review criteria for authorization decisions and, as applicable, consultation with the requesting provider.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings During the interview, FBH staff members stated that the responsibility for making certain utilization review decisions had been delegated to the CMHCs and to InNET. They also indicated that to ensure consistency in practice, the BHO used standardized level of care criteria and trained all staff members involved in the utilization review process on the criteria used and the UM-related policies. In addition, FBH's Utilization Determination policy and the Behavioral Health Utilization Management Principles and Practices document described the BHO's use of inter-rater reliability studies and periodic chart audits to ensure the consistent application of review criteria. The policy also included information regarding arranging for staff consultations to discuss utilization review decisions upon request by a subcontracted provider.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
2. Over-/Under-Utilization II.I.2.e	The Contractor has in effect mechanisms to detect both under-utilization and over-utilization of services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Utilization Management Program Principles and Practices document, Utilization Management Program Evaluation Fiscal Year 2005-2006 and FY 06-07 QAPI Program Description and Work Plan described numerous measures used by the BHO to detect both under- and over-utilization of services. Measures used by the BHO included penetration rates, the number of consumers exceeding inpatient and outpatient benefit limits, hospital recidivism rates, grievances and appeals data, and high- and low-utilization reports that identified the top 20 high and low utilizers each quarter. FBH also provided copies of daily census reports used by the BHO to monitor variations in the hospital census.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
3. Evaluation of UM Program II.J.I.e	The Contractor has mechanisms to evaluate the effects of the UM program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Utilization Management Program Priniciples and Practices document stated that the BHO formally evaluated its UM program annually to assess consumer satisfaction and outcomes and to identify any opportunities for improvement. The Utilization Management Program Evaluation Fiscal Year 2005-2006 contained summary data and an analysis of several UM measures, including grievances and appeals data, hospital recidivism data and consumer satisfaction data derived from the Mental Health Statistics Improvement Program (MHSIP) survey. The annual evaluation also identified opportunities for improvement and described next steps to address substandard performance.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
4. Clinical Expertise II.J.1.g	The Contractor ensures that any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope, that is less than requested, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Prior Service Authorization policy stated that only the FBH medical director or another licensed physician familiar with the standards of care in Colorado could make inpatient service authorization denials. FBH's Prior Service Authorization policy, and the Prior Service Authorization section of the FBH Utilization Management Program description stated that any decision to "deny or modify a service authorization request is made by a licensed behavioral health professional with appropriate clinical expertise in treating the consumer's mental health disorder." Furthermore, the UM section of the FBH Utilization Management Program description stated, "Staff that are not fully qualified behavioral health professionals may, under the supervision of appropriately licensed and qualified behavioral health professionals, collect data for prior service authorization and concurrent review. They may also be delegated the authority to approve (but not to deny) services for which there are specific criteria." Findings from the denial record review indicated in two cases the decision to deny services was made by a certified alcohol counselor (CAC II) based on a non-covered diagnosis (both cases). This practice was in conflict with FBH policies regarding denials of service authorization requests. While FBH provided evidence that the CAC II who made decisions to deny two service authorization requests had experience in treating the member's condition or disease, FBH policies specifically added the requirement that the behavioral health professional making the decision must be licensed.	
	Required Actions FBH must ensure that it follows its policies and procedures regarding decisions to deny requests for authorization of services.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
5. Co-occurring MI/DD II.E.1	The Contractor has written criteria for determining whether the need for mental health services for a member with co-occurring mental illness and developmental disabilities is a result of the individual's mental illness, or a result of the individual's developmental disability, or developmental delay (if the member is under age 5).	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings During the interview, FBH staff reported that the BHO played an active role with the Department in developing mental illness/developmental disablity (MI/DD) practice standards. A copy of the practice standards was included in the BHO's provider manual. FBH leadership staff also indicated that the BHO had recently funded a model program that provided both mental health and DD services to dually diagnosed consumers.	
	Required Actions None	
6. Compensation for Conducting UM Activities II.F.1.g	The Contractor does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's Provider and Employee Incentives policy stated that the BHO executive director or designee reviewed all provider contracts and all salary or compensation plans for internal BHO staff to ensure that the contract or compensation plan did not include language that would cause payments of any type to be made as an inducement to limit medically necessary services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VI: Utilization Management		
7. Record Review—Denials	Presence and timeliness of required documentation and decisions by qualified clinician.	
	Findings A sample of nine enrollee service denial records was reviewed to assess FBH's compliance with contract requirements related to the presence and content of required documentation, as well as the timeliness of decisions and documentation. FBH was compliant with 23 of 27 of the total applicable elements reviewed, for an overall score of 85 percent. FBH was fully compliant with regard to the notice including reason for denial. Notice of Action letters for two cases reviewed were not sent timely to the consumer and provider following a utilization review (UR) denial, as required in Exhibit G of the BHO's contract with the Department. In two cases a certified alcohol counselor made the decision to deny services based on "not a covered diagnosis."	
	Required Actions FBH must ensure that a Notice of Action is sent timely to the consumer and provider following a UR denial decision. In addition, FBH must ensure that it follows its policies and procedures regarding decisions to deny requests for authorization of services.	

Results for Standard VI					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
7	1	0	0	8	88%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
1. Written Policies and Procedures II.F.1.h.1	The Contractor has written policies and procedures that ensure coordination of the provision of covered services to its members, and that address expectations for timely coordination of care.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH had a Coordination and Continuity of Care policy that described the role of the care coordinator in assessing consumers' individual needs and ensuring the timely and appropriate coordination between mental health providers, physical health providers, and other community agencies and programs serving the individual. The policy addressed coordination of care activities for at-risk members, including dually diagnosed consumers with mental illness and developmental disabilities, and described the BHO's process for provider monitoring related to coordination of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	The written policies and procedures address: A. Service accessibility	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Coordination and Continuity of Care policy stated that a primary purpose for activities provided by the care coordinator was to ensure service accessibility. The policy described the role of the care coordinator in assisting consumers to access medical care through their primary care physician (PCP) as well as mental health and other community services.	
	Required Actions None	
	B. Attention to individual needs	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section I.B. of the Coordination and Continuity of Care policy described FBH's requirements regarding assessing the consumer's needs at intake and developing an individualized service plan to help support the consumer's recovery and promote continuity of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	C. Continuity of care	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section V of the Coordination and Continuity of Care policy stated that upon request the BHO attempted to establish contracts with a consumer's current provider for a minimum of 60 days following member enrollment to ensure continuity of care. The policy also addressed the process for ensuring that consumers receive ongoing mental health care without interruption in cases where there is a change in the consumer's responsible BHO.	
	Required Actions None	
	D. Maintenance of health	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section II.C. of the Coordination and Continuity of Care policy described the process for informing the PCP about the mental health plan of care, including a list of psychotropic medications prescribed, if any. The policy also included information regarding collaboration with other mental health providers and community service agencies in support of the consumer's mental health.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies	E. Independent living	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Section I.B.1.of the Coordination and Continuity of Care policy stated that services documented in the treatment plan should include efforts to coordinate with medical providers, mental health providers, or other community agencies and programs that support the consumer's ability to remain in the community. During the interview, FBH staff members stated that the BHO and its contracted providers used UM Level of Care (LOC) criteria and various independent living skills assessments to identify the most appropriate placement setting for each consumer.	
	Required Actions None	
	F. Coordination with other medical and behavioral health plans	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Coordination and Continuity of Care policy addressed the process for seeking consumer consent to allow the sharing of information with the PCP and described BHO expectations regarding the coordination of services provided to youths under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) program. The policy also described the role of the care coordinator in supporting consumer access to needed medical and mental health services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
2. Content of Policies II.F.1.h.1	G. Confidentiality and privacy consistent with 45 CFR parts 160 and 164 (HIPAA)	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH provided a Confidentiality and Security of Health Information policy and a guideline document regarding confidentiality and the security of protected health information, which was used by the BHO to provide staff training. The policy and guideline document provided staff guidance regarding the disclosure of protected health information consistent with 45 CFR parts 160 and 164 (HIPAA) and described the process for providing notice of privacy rights to consumers. The BHO also provided a copy of a confidentiality agreement used with its employees, members of governing boards, and committee members to obtain their commitment to upholding consumer confidentiality.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination	A. The Contractor provides for care coordination, which addresses the member's need for integration of mental health and other services. This includes identifying, providing, arranging for and/or coordinating with other agencies to ensure that the member receives the health care and supportive services that allow the member to remain in her/his community.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Medicaid provider manual included information regarding the care coordinator's role in collaborating with health care providers and other agency staff serving at-risk consumers, including individuals with DD/MI and adult consumers with severe and persistent mental illness (SPMI). The BHO provided a written description of an integrated program operated by Imagine!, a Community Centered Board that provided both mental health services and services to address developmental disabilities in one location. During the interview, FBH staff members stated that they were involved in various other collaborative projects with juvenile and adult corrections, child welfare, schools, substance abuse providers, and other community agencies. The BHO also provided copies of peer case file review tools used by network CMHCs and FBH to monitor provider efforts to collaborate with mental health providers, substance abuse providers, and other community agencies.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
3. Care Coordination II.F.1.h Exhibit C.III.B	B. The BHO, in consultation with the service provider, Member, family, and/or person with legal custody, shall determine the medical and/or clinical necessity of the covered service.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Utilization Management Program Principles and Practices document stated that consumers, family members, providers, and other stakeholders play an active role in the development of utilization determination criteria and clinical practice guidelines. The BHO also provided copies of peer review checklists used by the CMHCs and FBH to audit clinical records. Several of the checklists included an indicator to monitor whether service plans had been signed by the consumer or parent/guardian to document his or her active involvement in the treatment planning process.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services	A. The Contractor assists members in obtaining necessary medical treatment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Coordination and Continuity of Care policy required that care coordinators attempt to secure consumer consent to share information with all health care providers involved in the person's care as part of the intake process, and provide support and assistance to consumers in accessing medical services, as needed. The BHO provided numerous record review checklists used by the CMHCs and FBH to assess provider practice in documenting assistance to consumers in obtaining needed medical care.	
	Required Actions None	
	B. If a member is unable to arrange for supportive services to obtain medical care due to his/her mental illness, these supportive services will be arranged for by the Contractor or another person who has an existing relationship with the member whenever possible.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Medicaid provider manual emphasized that the range and intensity of supportive services required by each consumer was variable and was based upon the person's severity of illness and level of functioning. The manual noted that while some consumers required a simple reminder to keep medical appointments, other at-risk consumers required more active interventions on the part of the care coordinator or primary clinician. The BHO's Coordination and Continuity of Care policy also defined "at-risk members" and described required activities to assist consumers with special needs in accessing needed medical services.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
4. Coordination with Medical Care Services II.F.1.h	C. The Contractor coordinates with the member's medical health providers to facilitate the delivery of health care services.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Medicaid Provider Manual and Coordination and Continuity of Care policy described the BHO's requirements and procedures for coordinating with the consumer's medical health provider(s). The BHO provided numerous examples of integration projects that co-located mental health services at PCP offices, pediatrician offices, and at FQHCs.. Documentation of provider efforts to coordinate care with medical providers was also monitored by FBH through periodic chart audits.	
	Required Actions None	
5. School-Based Services Exhibit C.IV.I	Mental health services are provided to school-aged children and adolescents on site in their schools, with the cooperation of the schools.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH provided a narrative description of school-based services offered through JCMH and MHCBBC. The narrative description indicated that the BHO's two network CMHCs provided school-based services to appoximately 600 unduplicated youth throughout FY05-06. Services included day treatment; case management; and individual, group, and family counseling. At the time of the interview, FBH staff members reported that several practitioners in FBH's IPN also provided school-based services and that the BHO and its providers targeted the provision of this service to schools identified as high risk.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
6. EPSDT II.E.1	The Contractor provides services identified under the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's Coordination and Continuity of Care policy provided staff guidance regarding requests for EPSDT screening information and emphasized the importance of closely coordinating services with the consumer's PCP. The FBH Medicaid provider manual included comprehensive information regarding the EPSDT program, including the requirement that medically necessary services to treat health care needs identified through an EPSDT screening be provided even if the identified service was not included in the State's Medicaid Plan. The BHO also had policies and procedures that addressed monitoring and reporting requirements related to inpatient and outpatient benefit limitations. During the interview, FBH staff members stated that the BHO monitored utilization review denials and information included in inpatient and outpatient benefit limitation reports to help ensure that providers were not inappropriately denying medically necessary services available under the EPSDT program.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VII: Continuity of Care System (Service Delivery)		
7. Record Review—Coordination of Care: Inpatient to Outpatient Transition (children). Exhibit C.I	There is evidence of coordination of care provided for children transitioning from an inpatient facility to outpatient services. **Findings** Ten records were reviewed for evidence of care coordination and of outpatient follow-up for children following discharge from an inpatient facility. There were two cases for which FBH records indicated that the dates of the sample encounter were not hospital stays, but rather RTC admissions. There were several denied claims in the sample, two cases for which FBH was a secondary payer only, and two cases of retroactive eligibility. In each of the cases that FBH was the payer for inpatient services (excluding retroactive eligibility cases), there was evidence of communication between the inpatient facility and either FBH or its contracted providers, even when the discharge plan was for services funded by DHS. In one case of the 10, FBH was responsible for services following discharge, and there was documentation of the follow-up appointment having taken place on the day of discharge. **Required Actions**	

Results for Standard VII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
15	0	0	0	15	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
1. Internal Quality Assessment and Performance Improvement Program II.I.1	The Contractor has an internal Quality Assessment and Performance Improvement (QAPI) Program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH provided numerous documents to support that it had an active QAPI program in place. The FBH FY 06-07 Quality Improvement Program Description and Plan addressed the purpose and scope of the program, described the QAPI committee and subcommittee structures, and included information regarding access to care indicators, consumer surveys, clinical outcome data, quality studies, and utilization measures used by the BHO to assess quality. FBH also provided a Quality Assurance Program policy that described the various data sources used by the BHO to evaluate quality of care and described the process for evaluating the QAPI program on an annual basis.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program	The scope of the QAPI program includes, but is not limited to: A. A quality assessment and performance improvement plan that: 1. Delineates current and future quality assessment and performance improvement activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Quality Improvement Program Description and Plan included information regarding the BHO's current and future quality assessment and performance improvement activities. The plan included the following information for each quality initiative implemented by the BHO: a description of the quality indicator or study, performance goal and/or benchmark information as available, information regarding the BHO's monitoring and follow-up plan, and timelines for the quality improvement initiatives.	
	Required Actions None	
	2. Integrates findings and opportunities for improvement identified in studies, performance outcome measurements, member satisfaction surveys, and other monitoring and quality activities.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH FY 06-07 Quality Improvement Program Description and Plan addressed the use of various quality improvement measures including, but not limited to, the following: access to care indicators, consumer satisfaction surveys, grievance and appeal data, symptomatic and functional outcome measures, penetration rates, and hospital recidivism rates. The FBH Program Impact Analysis and Annual Report Fiscal Year 2005-2006 included graphs and a written analysis of quality improvement findings for each indicator or study, and it identified opportunities for improvement, as appropriate.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
2. Scope of QAPI Program	B. Processes for addressing quality of care concerns.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH had a Quality of Care Concern policy and Potential Quality of Care Concern Notification form. The Quality of Care Concern policy identified methods used by the BHO to detect potential quality of care concerns (QOCC) and described the QOCC reporting and investigation process. Information regarding QOCCs was also contained in the FBH Medicaid provider manual, including reporting instructions and a description of the QOCC investigation process. During the interview, FBH staff members stated that their OCFA was very active in helping consumers and family members resolve QOCCs and that QOCCs were discussed at QAPI Committee meetings.	
II.I.2	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	A. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH FY 06-07 Quality Improvement Program Description and Plan indicated that the BHO used grievance and appeal data and information from the MHSIP survey to monitor member perceptions of accessibility. The Quality Improvement Program Description and Plan also described the BHO's use of several access-to-care indicators, including timeliness of response to emergency and urgent requests, timeliness of hospital follow-up, and timeliness of first medication evaluation.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	B. The Contractor's tools to monitor member satisfaction include: 1. Member Surveys	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Quality Assurance Program policy stated that the BHO monitored member satisfaction through the use of both the MHSIP adult survey and the Youth Services Survey-Family (YSS-F). During the interview, the FBH staff also reported that a consumer survey adapted from the MHSIP had been conducted for IPN providers this review period. Findings and performance improvement activities related to survey results were included both in the BHO's Quality Improvement Program quarterly reports and in the Program Impact Analysis and Annual Report Fiscal Year 2005-2006. QAPI Committee meeting minutes dated September 21, 2006, documented that results of the MHSIP survey were reviewed and discussed. The BHO also conducted a Committee/Board Member Satisfaction Survey through the OCFA. The purpose of the survey was to assess consumer and family member satisfaction with their involvement on committees at FBH, JCMH, and MHCBBC.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction	2. Anecdotal Information	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings Minutes for FBH CFAB meetings documented that information regarding the BHO's service delivery system and quality management initiatives was shared with BHO members and that consumers and family members had an active voice in providing feedback regarding the system of care. Minutes from a CFAB meeting on April 20, 2006, indicated that consumers and family members provided feedback to the BHO about a performance improvement project (PIP) related to recovery, including input regarding a recovery brochure. During the interview, FBH staff members indicated that OCFA trended anecdotal information from consumers and family members and that additional feedback regarding member satisfaction had been solicited through family forums.	
	Required Actions None	
	3. Grievance and Appeal data	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FY 06-07 Quality Improvement Program Description and Plan stated that FBH trended and analyzed information from consumer grievances and appeals as part of the quality improvement process. Summary data for indicators related to grievance and appeals was also included in the BHO's Quality Improvement quarterly reports. QAPI Committee meeting minutes dated February 16, 2006, documented that a handout of grievance and appeal data was reviewed and discussed.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
3. Member Satisfaction II.I.2.d	C. The Contractor develops a corrective action plan when members report statistically significant levels of dissatisfaction, when a pattern of complaints is detected, or when a serious complaint is reported.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH provided evidence that it developed corrective action plans or performance improvement plans to address serious complaints and other opportunities for improvement identified through the quality improvement process. The BHO provided an example of a letter sent to one of its network CMHCs in follow-up to a complaint alleging that a utilization denial decision had been made without prior consultation with a physician. Copies of the CMHC's response, including steps planned and/or taken to address the issue, were also provided for review.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
4. Health Information System II.I.h.2	The Contractor has a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to: A. Utilization	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings At the time of the interview, FBH staff members stated that utilization-related reports were queried from data available in the InNET data warehouse. FBH collected, analyzed, integrated, and reported data for numerous utilization measures including hospital admissions, hospital length of stay, number of consumers exceeding inpatient and outpatient benefit limitations, hospital recidivism, emergency department utilization, and penetration rates. The BHO provided examples of several utilization reports that included information regarding hospital recidivism and emergency department visits per 1,000 members.	
	Required Actions None	
	B. Grievances and Appeals	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH maintained a grievance and appeal database that allowed the BHO to track the timely resolution of reported concerns as well as information regarding grievance type and resolution status. Summary grievance and appeal data queried from the database were reported in both the BHO's Quarterly QI Reports and in a Medicaid Grievance and Appeals Narrative Report produced by FBH each quarter.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard VIII: Quality Assessment and Performance Improvement Program		
5. Program Impact Analysis II.I.2.j.1	The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program. **Findings** The FBH Quality Assurance Program policy described the process used by the BHO to evaluate its QAPI program annually. The policy also stated that the Program Impact Analysis and Annual Report was made available to consumers, advocacy organizations, and providers upon request. The Program Impact Analysis and Annual Report Fiscal Year 2005-2006 included summary data and graphs for performance improvement projects implemented by the BHO and an assessment of the overall effectiveness of the QAPI program. The annual report also identified potential areas for improvement and possible next steps to improve future performance, as appropriate. **Required Actions** None	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**

Results for Standard VIII					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
12	0	0	0	12	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
1. Grievance and Appeal Records Exhibit G: 8.209.3.C	The Contractor maintains a record of grievances and appeals.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH, in its operating procedures for processing grievances and appeals, used standardized forms for recording dates and steps taken when processing grievances and appeals. These procedures allowed the BHO to monitor and meet due dates, and key aspects of this information were entered into an electronic database for monitoring and reporting purposes. The BHO tracked, trended, and reported on various aspects of the grievance system using ths information. The disparity between the number of adult (18) and the number of child/representative (4) grievances for the previous fiscal year was discussed with the BHO. FBH staff observations were that families of children were very involved in decision-making for the child with the multi-agency treatment team and that issues were generally resolved there, and that family members were more likely to "speak their mind" about their needs, as opposed to filing a grievance. In the interview, BHO staff members also described examples of capturing complaint data and treating the complaint as a grievance even when the consumer did not request to file a grievance, so that the BHO could investigate and take action as needed. This also allowed the data to be available for tracking and trending purposes.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
2. Provider Information Exhibit G: 8.209.3.B	The Contractor provides a Department approved description of the grievance, appeal, and fair hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the Contractor.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's provider information about the grievance system was part of the provider manual and was the same information that was provided to the consumers. The FBH Grievance and Appeal Guide for consumers was distributed to all providers as an appendix to the provider manual at the time of entering into a contract, and was updated as needed through e-mail or mass-mailing communications, and was available on the FBH Web site.	
	Required Actions None	
3. Reasonable Assistance Exhibit G: 8.209.4.C	The Contractor provides members with assistance in completing any forms required by the Contractor, putting oral requests for a state fair hearing into writing, and taking other procedural steps including providing interpretive services and toll-free numbers that have adequate TTY/TTD interpreter capability.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policy on grievance and appeal processing and the consumer handbook included information about assistance available to consumers wishing to file a grievance or appeal, and listed the resources and phone numbers available for assistance, including interpreters, information in alternative formats, the language line, Relay Colorado, and TTD numbers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
4. Individuals Who Make Decisions	The Contractor ensures that the individuals who make decisions on grievances and appeals are: A. Individuals who were not involved with any previous level of review or decision-making.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies and procedures on the processing of grievances and appeals required that individuals making decisions would not have been involved in a previous level of decision-making. The grievance record review provided documented evidence that the BHO used an assignment process that ensured decisions were made by uninvolved individuals.	
	Required Actions None	
	B. Individuals who have the appropriate clinical expertise in treating the member's condition or disease if deciding an appeal of a denial that is based on lack of medical necessity, a grievance regarding denial of expedited resolution of an appeal, a grievance that involves clinical issues, or an appeal that involves clinical issues.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies and procedures on the processing of grievances and appeals required that individuals making clinical grievance or appeal decisions would have the qualifications to do so. The grievance record review provided documented evidence that the BHO used an assignment process that ensured decisions were made by individuals with qualifications to do so.	
Exhibit G: 8.209.4	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
5. Accepts Grievances and Appeals Exhibit G: 8.209.4	The Contractor accepts grievances and appeals orally or in writing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The policy, Grievance System: Grievances and Appeals, the FBH operating procedures, and consumer informational materials included the requirement that grievances and appeals would be accepted in writing or verbally (phone or in person). Evidence from the grievance record review provided evidence that the BHO accepted grievances both verbally or in writing.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	A. The Contractor provides the member an opportunity to present evidence, and allegations of fact or law, in person as well as in writing, and informs the member of the limited time available in the case of expedited resolution.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Grievance and Appeal Guide for consumers stated, "FBH will give you the chance to provide more information to the reviewer. You can do this in person or in writing. OCFA will let you know about any time limits."	
	Required Actions None	
	B. The Contractor provides the member and the designated client representative opportunity, before and during the appeal process, to examine the member's case file, including medical records and any other documents and records considered during the appeal process.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH Grievance and Appeal Guide for consumers stated, "FBH will let you and your DCR see your case file. This includes medical records and any other information used in the appeal process. OCFA can help you with this."	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process	C. The Contractor includes as parties to the appeal, the member and, as applicable, the designated client representative or legal representative.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings FBH's policies and operating procedures, as well as consumer and provider informational materials about the appeal process, provided evidence that the BHO included consumers and their DCRs or legal representatives as parties to the appeal process.	
	Required Actions None	
	D. The Contractor has an expedited review process for appeals when the contractor determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The FBH policy, Grievance System: Grievances and Appeals, as well as consumer and provider informational materials about appeals, provided evidence that the BHO had an expedited appeal process available to consumers and providers when necessary.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		
6. Appeals Process Exhibit G: 8.209.4	E. The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The BHO's policy on grievance and appeal processing stated that "FBH does not take any negative action against a Provider who assists a Member with an expedited resolution request." During the interview, BHO staff members stated that this was reinforced by OCFA during the appeal process and through written communications with the consumer.	
	Required Actions None	
7. Record Review—Grievance	Presence and timeliness of required documentation, decisions by qualified clinician, and responsiveness of resolution.	
	Findings A total of 10 grievance records (quality of care and access issues) were reviewed for timeliness of acknowledgement, extension, and grievance resolution decision letters; whether the decision was made by a qualified clinician; and whether the resolution was responsive to the grievance issue. One record contained an extension notice and was processed timely. All 10 records were compliant with all requirements that were reviewed. The BHO had implemented an effective action plan to correct deficiencies noted in the previous year's review.	
	Required Actions	

Evaluation Elements	Contract Language Requirements	Scoring
Standard IX: Grievances, Appeals, and Fair Hearings		

Results for Standard IX					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
11	0	0	0	11	100%

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
1. Excluded Providers	The Contractor does not employ or contract with providers excluded from participation in federal health care programs under Title XI of the Social Security Act, Sections 1128 and 1128A.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Prohibited Relationships policy and the Credentialing Manual described processes for ensuring that FBH did not have relationships with individuals or affiliates excluded from federal health care participation. Credentialing files contained evidence that FBH used the OIG database to ensure that providers had not been excluded.	
II.H.3.e	**Required Actions** None	
2. Written Policies and Procedures	The Contractor documents the mechanism for the credentialing and recredentialing of licensed independent practitioners with whom it contracts or employs, and who render services or authorize services to members, and who fall within the Contractor's scope of authority and action.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The procedures in the Credentialing Manual described the mechanism for documenting the credentialing and recredentialing processes. A review of selected practitioner credentialing files demonstrated implementation of the procedures, as written with regard to this requirement.	
NCQA CR1	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	The written policies and procedures specify: A. The types of practitioners to credential and recredential. At a minimum, this includes all physicians and other licensed and/or certified practitioners who have an independent relationship with the BHO and who see enrollees outside the inpatient hospital setting or outside the facility-based settings.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the types of practitioners FBH credentialed and recredentialed.	
	Required Actions None	
	B. The verification sources used.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the verification sources used.	
	Required Actions None	
	C. The criteria for credentialing and recredentialing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the criteria for credentialing and recredentialing.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	D. The process for making credentialing and recredentialing decisions.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the process for making credentialing and recredentialing decisions.	
	Required Actions None	
	E. The process for managing credentialing files that meet the organization's established criteria.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the process for managing credentialing files.	
	Required Actions None	
	F. The process to delegate credentialing or recredentialing.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the process to delegate credentialing and recredentialing.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	G. The process to ensure that credentialing and recredentialing are conducted in a non-discriminatory manner, i.e., the Contractor does not make credentialing and recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the process to ensure that credentialing and recredentialing are conducted in a non-discriminatory manner.	
	Required Actions None	
	H. The process for notifying a practitioner about any information obtained during the Contractor's credentialing process that varies substantially from the information provided to the organization by the practitioner.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the process for notifying practitioners about any information obtained during the credentialing process that varied from information obtained from the applicant.	
	Required Actions None	
	I. The process to ensure that practitioners are notified of the credentialing decision within 60 calendar days of the committee's decision. Note: The organization (BHO) is not required to notify providers of recredentialing approvals.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the process to ensure that practitioners were notified of the credentialing decision within 60 calendar days of the committee's decision.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	J. The Medical Director or other designated physician's direct responsibility and participation in the credentialing program.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the role of the medical director in the credentialing program.	
	Required Actions None	
	K. The process to ensure the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the process to ensure the confidentiality of all information obtained during the credentialing process.	
	Required Actions None	
	L. The process for ensuring that listings in provider directories and other materials for enrollees are consistent with credentialing data, including education, training, certification, and specialty.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the process for ensuring that listings in provider directories and other member materials were consistent with credentialing information.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	M. The right of practitioners to review information submitted to support their credentialing application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the rights of practitioners, including the right of practitioners to review information submitted to support their credentialing application.	
	Required Actions None	
	N. The right of practitioners to correct erroneous information.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the rights of practitioners, including the right of practitioners to correct erroneous information.	
	Required Actions None	
	O. The right of practitioners, upon request, to be informed of the status of their credentialing or recredentialing application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified the rights of practitioners, including the right of practitioners to be informed of the status of their application, upon request.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	P. How the applicant is notified of these rights and of the appeal process.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specified how applicants were notified of their rights, including the right to an appeal process.	
	Required Actions None	
	Q. The procedure for ongoing monitoring of sanctions, complaints and adverse events (for high-volume providers).	☐ **Met** ☑ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Monitoring Mental Health Provider Performance policy and the Credentialing Manual included the procedures for ongoing monitoring of complaints and adverse events; however, it was unclear about the procedures for ongoing monitoring of sanctions. During the interview, FBH staff members indicated they were not monitoring for State or federal sanctions between recredentialing cycles.	
	Required Actions FBH must revise the Credentialing Manual or other appropriate policies to describe ongoing monitoring for both State and federal sanctions that meet NCQA guidelines, and must implement the policies, as written.	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
3. Content of Policies and Procedures	R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Monitoring Mental Health Provider Performance policy included the range of actions available to FBH if the provider did not meet FBH's standards of quality.	
	Required Actions None	
	S. Procedures for detection and reporting of incidents of questionable practice, in compliance with Colorado statutes and regulations, the Health Care Quality Improvement Act of 1986, and NCQA standards.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Reporting of Fraud and Abuse and the Monitoring Mental Health Provider Performance policies included procedures for detection and reporting incidents of questionable practice.	
	Required Actions None	
	T. An appeal process for instances in which the BHO chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual described the appeal process for practitioners for whom FBH altered the conditions of network participation based on issues of quality of care.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
CR1-Element A and B NCQA CR9 CR10-Element A and C II.H.3.g		
4. Credentialing Committee	The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing decisions.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of Credentialing Committee meeting minutes confirmed the use of the peer review process to make credentialing decisions.	
NCQA CR2	**Required Actions** None	
5. Provider Application	Providers are required to complete an application for inclusion in the Contractor's provider network that addresses: - The provider's health status, and reasons for any inability to perform the essential functions of the position, with or without accommodation - Lack of present illegal drug use - History of loss of license and felony convictions - History of loss or limitation of privileges or disciplinary activity - Current malpractice insurance coverage - The correctness and completeness of the application.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings During the review period, FBH used the Colorado Health Care Professional Credentials Application, which contained all of the required content. A sample of credentialing files contained the completed Colorado application.	
NCQA CR4-Element A	**Required Actions** None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
6. High Volume Practitioners NCQA CR6-Element B	The Contractor specifies the method to identify high-volume providers.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual specfied the method that FBH used to identify high-volume providers.	
	Required Actions None	
7. Evaluation of High Volume Practitioners	For high-volume providers, the Contractor conducts: A. An initial site visit	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings A review of credentialing files demonstrated that FBH conducted a site visit for high-volume providers.	
	Required Actions None	
	B. An initial evaluation of treatment record-keeping practices at each site.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The site visit form used by FBH included an evaluation of treatment record-keeping practices.	
	Required Actions None	
NCQA CR6-Element B		

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
8. Requirements for Credentialing Policies for Organizational Providers NCQA CR11	The Contractor has written policies and procedures for the initial and ongoing assessment of providers with which it intends to contract.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual had written policies and procedures for the assessment of organizational providers.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	The Contractor's written policies and procedures include: A. The Contractor confirms that the organization is in good standing with state and federal regulatory bodies.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual included the provision that FBH confirm that its organizational providers are in good standing with State and federal regulatory bodies.	
	Required Actions None	
	B. The Contractor determines whether the provider has been reviewed and approved by an accrediting body.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual included the provision that FBH determined whether the provider had been reviewed and approved by an accrediting body.	
	Required Actions None	

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		
9. Policy Content—Organizational Provider Credentialing	C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual included procedures and criteria for conducting an on-site quality assessment, and how FBH determined that the organizational provider credentialed its practitioners. A review of organizational provider files demonstrated that FBH followed its policies as written with regard to assessing organizational providers. It should be noted that FBH did not assess the JCMH or the MHCBBC as organizational providers, but rather chose to credential and recredential each individual practitioner employee of the mental health centers.	
	Required Actions None	
	D. At least every three years, the Contractor confirms that the organizational provider remains in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.	☑ **Met** ☐ **Partially Met** ☐ **Not Met** ☐ **N/A**
	Findings The Credentialing Manual included the process (confirm that the organizational provider remain in good standing with State and federal regulatory bodies, confirm the accreditation status of the provider, and perform the on-site quality assessment) for reassessing nonaccredited organizational providers every three years.	
	Required Actions None	
NCQA CR11-Element A		

Evaluation Elements	Contract Language Requirements	Scoring
Standard X: Credentialing		

Results for Standard X					
# of Elements					Score
Met	Partially Met	Not Met	Not Applicable	Applicable	% of Elements Compliant
31	1	0	0	32	97%

The review of the records follows this cover page.

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Foothills Behavioral Health, LLC

Type of Record Reviewed	**Documentation of Services**		
Review Period	**January 1, 2006 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date	**January 23, 2007**	**Participating BHO Staff Member**	**Toni Moon, Mary Spenceri, Alan Girard**

Table B-1—Documentation of Services

#	Member ID	Provider ID	Date of Encounter	Doc Date Matches Encounter Date	Service Documentation Within 7 Days of Encounter Date	Procedure Code Submitted	Description of Procedure Code	Documentation Describes Procedure Code Submitted
1	*******	4033023	4/26/2006	Y	NA	T1016	CASE MANAGEMENT EACH 15 MINS	N
The progress note indicated that the case manager received a voice mail message (duration 2 min) and coded the event as a case management contact. FBH staff reported that the provider has been informed that no activity with a duration of less than 8 minutes can be submitted as an encounter. FBH also reported that it revised the encounter file and resubmitted encounter data to the State with this encounter, and others similar to it, deleted.								
2	*******	4033015	1/19/2006	Y	NA	H0037	CMTY PSYC SUPPORTIVE TX PROGM-DIEM	Y
3	*******	4033023	3/16/2006	Y	NA	H2012	BEHAVIORAL HEALTH DAY TX PER HOUR	N
There was a clubhouse attendance note. FBH staff members reported that this was not the correct code for clubhouse activities. The clubhouse HCPC code is H2030. FBH staff members reported that they had a corrective action plan in process with the mental health center, and that they had revised the encounter file and resubmitted encounter data to the State with corrected codes.								
4	*******	4033015	3/2/2006	Y	NA	H0034	MEDICATION TRN&SUPPORT PER 15 MIN	Y
5	*******	4033023	1/27/2006	N	N	90804	PSYCHOTX OV/OP BEHV MOD 20-30 MN;	Y
There was no progress note for an individual therapy session. FBH staff members reported that during the audit of 411 encounter records they discovered that this provider was writing monthly summaries instead of progress notes for each contact, and that they had sent an amended encounter submission to the State, which excluded all encounters not documented properly.								
6	*******	11707356	5/11/2006	Y	NA	90804	PSYCHOTX OV/OP BEHV MOD 20-30 MN;	N
The code used was for a 30-minute session. The progress note described a one-hour session. FBH staff reported that this provider has been notified and trained regarding coding.								
7	*******	4033023	1/31/2006	Y	NA	90804	PSYCHOTX OV/OP BEHV MOD 20-30 MN;	N
The progress note was a physician note and described a medication management visit. FBH staff reported that Boulder physicians also provided psychotherapy; however, this note did not describe a psychotherapy session.								
8	*******	4033023	1/23/2006	Y	NA	90805	PSYCHOTX OP 20-30 MIN; W/MED E&M	Y
9	*******	4033015	1/10/2006	Y	NA	90853	GROUP PSYCHOTHERAPY	Y
10	*******	4033015	3/31/2006	Y	NA	T1016	CASE MANAGEMENT EACH 15 MINS	Y
			# Applicable Elements	**10**	**1**			**10**
			# Compliant Elements	**9**	**0**			**6**
			% Compliant Elements	**90%**	**0%**			**60%**

TOTALS	
Total # Applicable Elements	**21**
Total # Compliant Elements	**15**
Total % Compliant Elements	**71%**

Table Legend: DOS = Date of Service, Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Foothills Behavioral Health, LLC

Type of Record Reviewed	**Coordination of Care Inpatient to Outpatient Transition (Children)**		
Review Period	**October 1, 2005 - June 30, 2006**	**Reviewer**	**Barbara McConnell**
Review Date	**January 23, 2007**	**Participating BHO Staff Member**	**Mary Spenceri, Lisa Strub, Toni Moon, Brent Dice**

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)

#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
1	*******	********	SCHIZOPHRENIA NOS-UNSPEC	11/17/2005		Y	CMHI - Ft. Logan	
The Fort Logan After Care Plan indicated that the plan was for a DHS RTC placement. There was a case management progress note from MHCBBC on 10/24 indicating that the care coordinator was unable to reach Fort Logan. The progress note indicated that the care coordinator spoke with the DHS case worker and the team leader at the RTC and confirmed the discharge plan. Care coordinator notes indicated that the consumer was discharged to a DHS placement at the RTC.								
2	*******	********	REC DEPR PSYCH-PSYCHOTIC	1/4/2006		Y	Childrens Hospital	
Hospital progress notes and FBH care coordinator notes indicated that the consumer had actually been in the facility since 10/8/05, and was on the medical unit. FBH staff reported that this inpatient stay was denied and submitted to the department as a denied claim. FBH staff indicated that FBH paid for a partial hospitalization episode of care while the consumer was spending nights on the medical unit.								
3	*******	********	UNSPECIFIED EPISODIC MOOD DISORDER				Cedar Springs Behavioral Health Systems, Inc	
FBH reported that the dates of the sample were RTC dates rather than inpatient hospitalization dates, according to their records.								
4	*******	*********	BIPOLAR I DISORD MOST RECENT EP UNSPEC	5/1/2006		Y	Cedar Springs Behavioral Health Systems, Inc	
There was a JCMH clinical case management note on 4/27/06 indicating that the case manager spoke with the hospital liaison regarding the hospital team's recommendation of RTC placement. The hospital discharge note indicated that the consumer was discharged to a DHS RTC placement.								
5	*******	*********	BIPOL AFF, MIXED-UNSPEC				St. Anthony Hospital - Central	
FBH staff reported that this was a case of retroactive eligibility and that the consumer was Medicaid-ineligible at the date of services.								
6	*******	********	UNSPECIFIED EPISODIC MOOD DISORDER				CMHI - Pueblo	
FBH reported that this was a case of the State Web portal eligibility error. The State had, in error, changed the consumer's eligibility county to FBH's area, then when the error was discovered, transferred the case to the appropriate BHO. During the dates of these services the consumer was listed as eligible with FBH, but was not actually an FBH consumer, and the encounter was submitted as a denied claim.								
7	*******	*********	UNSPECIFIED EPISODIC MOOD DISORDER	4/20/2006		Y	CMHI - Ft. Logan	
There was a clinical note from JCMH on 4/10/06 stating that the JCMH clinician attempted to contact DHS. On 5/3/06 the DHS worker left a message for the clinician stating that the consumer was placed in another county with services provided by DHS.								
8	*******	*********	UNSPECIFIED EPISODIC MOOD DISORDER	3/2/2005			Centennial Peaks Hospital	
There was no request for prior authorization and FBH staff members reported that they were unaware of the hospitalization until one month later when they received a claim stating that FBH was a secondary payer. The primary payer was Kaiser. Kaiser also provided the outpatient follow-up.								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Foothills Behavioral Health, LLC

Table B-2—Coordination of Care Inpatient to Outpatient Transition (Children)								
#	Member ID	DOB	Primary Dx	D/C Date From Inpatient Facility	Date of First Follow-up	Documentation of Coordination and follow-up following an inpatient stay	In-Pt. Provider	Out-Pt. Provider
9	*******	********	UNSPECIFIED EPISODIC MOOD DISORDER	6/2/2006	6/2/2006	Y	Childrens Hospital	JCMH
There was a census tracking form completed by InNET indicating that the first appointment was scheduled for 6/13/06 with a JCMH clinician. JCMH progress notes indicated that on 6/2 a FFT (functional family therapist) clinician visited the home on the day of discharge. There was also a clinical progress note on 6/14/06 describing a case management contact with the mother arranging for a summer day program. On 6/15/06 there was a clinical progress note describing a session with the family and the consumer.								
10	*******	*********	DEPRESSIVE DISORDER NEC	4/27/2006		Y	CMHI - Ft. Logan	JCMH
There was an InNET care coordination note indicating that an appointment had been scheduled for 5/1/06. JCMH notes indicated that the consumer was a "no show" and that the therapist attempted to call the family on that day and was unable to reach them. There was a clinical progress note on 5/8/06 (JCMH) indicating that the therapist called the family to set up an appointment, but that the mother declined and said that they were moving out of state.								

Table Legend: Y=Yes, N=No

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Foothills Behavioral Health, LLC

Type of Record Reviewed	**Grievances**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Bonnie Marsh**
Review Date	**January 23, 2007**	**Participating BHO Staff Member**	**Hazel Bond**

Table B-3—Grievances Record Review

#	Case ID #	Date Grievance Received	Date of Acknowledgement Letter	Acknowledgement Sent Within 2 Working Days	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved and Notice Sent per Requirement	Appropriate Level of Expertise	Resolution Responsive to Member Grievance?
1	**	1/31/2006	2/2/2006	Y	2/21/2006	12	NA	Y	Y	Y
Grievance issue was regarding appropriateness of a medication evaluation service. The review was completed and the decision was made by the medical director.										
2	**	4/13/2006	4/17/2006	Y	4/26/2006	9	NA	Y	Y	Y
Mother of a child consumer had a complaint that she had needed an emergency appointment and wasn't given one. Medical director reviewed and determined the need was not emergent but routine. The consumer had received the next available appointment in March when the event occurred.										
3	**	4/20/2006	4/21/2006	Y	5/2/2006	8	NA	Y	Y	Y
Consumer complained about therapist and also requested a change of psychiatrist. Consumer was assisted with a referral to change psychiatrist, and the therapist's supervisor was informed of the complaints to investigate further. PhD-level clinician reviewed/decided the grievance.										
4	**	4/20/2006	4/24/2006	Y	5/2/2006	6	NA	Y	Y	Y
Consumer complained about a lack of timeliness for a requested appointment (within seven days). Consumer was dually eligible and given an appointment at a network CMHC to receive service paid for by Medicare, but in a time frame longer than seven days. OCFA staff clarified with HCPF regarding applicability of the appointment standard prior to issuing the grievance decision. Executive Director made decision based on HCPF guidance.										
5	**	6/20/2006	6/22/2006	Y	7/20/2006	21	Y	Y	Y	Y
Grievance decision extension letter was sent on 7/11/2006. Child was consumer; mother complained that medication adjustment was needed; however, had not followed through with lab monitoring appointment. Additional transportation issue was discovered, as family lived in rural area. Family was given several alternatives, including a physician second opinion and a referral to free county transportation provider. Resolved/decided by LCSW and medical director.										
6	**	7/13/2006	7/14/2006	Y	7/20/2006	4	NA	Y	Y	Y
Consumer complained about a prescription she needed that was not filled timely and available when she needed it. Documentation available stated that samples were provided in the interim. A physician was involved in the review and resolution of the grievance.										
7	**	7/14/2006	7/14/2006	Y	7/20/2006	4	NA	Y	Y	Y
Consumer complained of not feeling responded to when she left a message, and that her doctor didn't review medication side effects when the doctor changed her prescription. Upon review, it was determined that her medication had not been changed. Consumer was given phone number to call her therapist and was provided with after-hours contact information. PhD-level clinician reviewed and decided grievance.										
9	**	8/17/2006	8/21/2006	Y	9/6/2006	13	NA	Y	Y	Y
Consumer wanted a choice of providers in the FBH network but was currently an ABC client. Consumer was told to work with ABC to select new provider or to change permanent residency in the county records to receive services at JCMH. Licensed clinician reviewed/decided grievance.										
10	**	9/13/2006	9/14/2006	Y	10/2/2006	13	NA	Y	Y	Y
Consumer complained about staff being confused when she attempted to pick up her prescription after hours. She stated there was a lack of communication that the medication had been authorized. Training was provided to emergency psychiatric staff regarding better documentation needed. PhD-level reviewed/decided grievance.										

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Foothills Behavioral Health, LLC

Table B-3—Grievances Record Review										
#	Case ID #	Date Grievance Received	Date of Acknowledgement Letter	Acknowledgement Sent Within 2 Working Days	Date of Written Resolution Notification	# of Days to Resolve	Extension Notification Sent	Resolved and Notice Sent per Requirement	Appropriate Level of Expertise	Resolution Responsive to Member Grievance?
11	**	1/16/2006	1/18/2006	Y	1/30/2006	10	NA	Y	Y	Y
Consumer complained about a lack of assistance and about receiving misinformation when she needed services. PhD-level staff reviewed and decided grievance.										
			# Applicable Elements	**10**			**1**	**10**	**10**	**10**
			# Compliant Elements	**10**			**1**	**10**	**10**	**10**
			% Compliant Elements	**100%**			**100%**	**100%**	**100%**	**100%**
TOTALS										
			Total # Applicable Elements	**41**						
			Total # Compliant Elements	**41**						
			Total % Compliant Elements	**100%**						

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Foothills Behavioral Health, LLC

Type of Record Reviewed	**Denials**		
Review Period	**January 1, 2006 - September 30, 2006**	**Reviewer**	**Tom Cummins**
Review Date	**January 23, 2006**	**Participating BHO Staff Member**	**Wendy Kidd**

Table B-4—Denials Record Review

#	Member ID	Date of Initial Request	Standard/Expedited Authorization Decision			Termination, Suspension, or Reduction of Previously Authorized Services		Notice Includes Reasons	Decision Made by Qualified Clinician
			Date Notice Sent	# of Days For Decision	Notice Sent per Requirement	Date Notice Sent	Notice Sent per Requirement		
1	*******	2/23/2006	2/27/2006	4	Y			Y	Y
Request was for continued outpatient care. Consumer now lives in NBH area. Request for outpatient services was limited due to anticipated enrollment change. This case involves a prospective limitation of requested services. The reason the authorization was shortened to three months was to give the consumer an opportunity to transfer to NBH. Limitation decision made by LMFT.									
2	*******	3/8/2006	3/17/2006	9	Y			Y	Y
Retrospective request was for a psychological evaluation. Denial reason was that consumer did not meet medical necessity criteria for the service. The denial decision was made in consultation with the utilization management director and FBH medical director.									
4	*******	2/28/2006	3/6/2006	6	Y			Y	N
Youth was evaluated at a day treatment center for appropriateness of admission to the program. Request was denied due to diagnosis not being covered. The consumer's diagnosis was Pervasive Developmental Disability, Not Otherwise Specified. The consumer's presenting treatment issues were related to the developmental disability, not a mental health disorder. Decision made by a CAC II.									
7	*******	2/14/2006	3/14/2006	28	N			Y	Y
Initial request for outpatient services was received on 2/14/06 with incomplete information provided. Several attempts were made by staff from FBH to secure needed information to render a decision. Full information was not provided until 3/11. Decision was to limit authorization prospectively based on the fact that the consumer lived out-of-area. Decision was made by a LMFT.									
10	*******	3/21/2006	3/28/2006	7	Y			Y	Y
Request was for authorization for outpatient services. The BHO's decision was to limit the number of authorized sessions because documentation did not support that the consumer met medical necessity for the number of services requested. Denial made by LPC.									
12	*******	6/9/2006	6/16/2006	7	Y			Y	Y
Request was for Fetal Alcohol Syndrome testing. Service was denied since this is not a covered service. Decision was made by a LMFT.									
13	******	5/31/2006	6/12/2006	12	N			Y	N
Request for was for outpatient services. Diagnosis was initially unclear and FBH requested additional information. Request for services was denied since diagnosis was not covered. The consumer's diagnosis by history was cognitive disorder not otherwise specified and mood disorder not otherwise specified due to organic brain injury. Denial was made by a CAC-II.									
14	*******	5/9/2006	5/15/2006	6	Y			Y	Y
Request was for outpatient services. Services were authorized for a shorter period than requested since the consumer lives outside the BHO's catchment area. The denial was made by a LMFT.									
15	*******	8/18/2006	8/25/2006	7	Y			Y	Y
The request was for inpatient services. The request for services was denied since the consumer no longer met medical necessity criteria for inpatient care. The case was reviewed by a physician.									

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix B. Review of the Records
Department of Health Care Policy and Financing
Behavioral Health Organizations (BHOs)
Foothills Behavioral Health, LLC

Table B-4—Denials Record Review									
#	Member ID	Date of Initial Request	Standard/Expedited Authorization Decision			Termination, Suspension, or Reduction of Previously Authorized Services		Notice Includes Reasons	Decision Made by Qualified Clinician
			Date Notice Sent	# of Days For Decision	Notice Sent per Requirement	Date Notice Sent	Notice Sent per Requirement		
				# Applicable Elements	9			9	9
				# Compliant Elements	7			9	7
				% Compliant Elements	78%			100%	78%
TOTALS									
				Total # Applicable Elements	27				
				Total # Compliant Elements	23				
				Total % Compliant Elements	85%				

Table Legend: Y=Yes, N=No, NA=Not Applicable

Appendix C. Site Review Participants
for Foothills Behavioral Health, LLC

Review Dates

Dates for HSAG's site review for **FBH**, the period under review, and the contract term are shown in Table C–1 below.

Table C–1—Review Dates	
Dates of On-Site Review	January 23–24, 2007
Period Under Review	January 1, 2006–December 31, 2006
Contract Term	FY 06–07

Participants

Participants in the FY 06–07 site review of **FBH** are listed in Table C–2 below.

Table C–2—HSAG Reviewers and BHO Participants		
HSAG Review Team		**Title**
Team Leader	Barbara McConnell, MBA, OTR	Colorado Project Director
Reviewer	Bonnie Marsh, BSN, MA	Executive Director, EQR Services
Reviewer	Tom Cummins, LCSW	Consultant
FBH Participants		**Title**
Dennis Armstrong		Director, Provider Network
Mick Barrett		IPN Manager
Don Bechtold		Medical Director
Hazel Bond		Director Office of Consumer and Family Advocate
Erin Borgmann		Utilization Management Coordinator
Melvin Conley		Data Analyst
Brent Dice		Quality Improvement Coordinator
Alan Girard		Utilization Management Coordinator
Lucy Hausner		Consumer and Family Advocate
Peter Hine		IPN Clinical Coordinator
Wendy Kidd		Director of Utilization Management
Toni Moon		MHCBBC Liaison; Clinical QI Manager
Maritza Oralles		Credentialing Coordinator
Diane Pohlman		Senior Executive Assistant
Moira Powers		Consumer and Family Advocate
Donald Rohner		Executive Director
Linda Runyon		Community Liaison

Table C–2—HSAG Reviewers and BHO Participants	
Barbara Smith	Director, Quality Assessment and Performance Improvement
Michael Smithson	Business/Data Analyst
Mary Spenceri	Quality Improvement Coordinator
Joanna Stratton	Post-Doc Fellow
Lisa Strub	Family Services Manager, JCMH
Laura Taylor	Administrative Assistant
Department Observers	**Title**
Sue Carrizales	Behavioral Health Specialist
Nancy Jacobs	Behavioral Health Benefits Supervisor
Connie Young	Quality Improvement/Behavioral Health Specialist
CMS Observers	**Title**
Cindy Smith	CMS Region 8

Overview

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine the MCOs' and PIHPs' compliance with contract requirements and federal regulations. The Department has elected to complete this requirement by contracting with an external quality review organization (EQRO). HSAG is the EQRO for the Department. The U.S. Department of Health and Human Services' (DHHS') Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR.

The site review addressed the BHO's compliance with federal regulations and contract requirements in 10 areas: delegation; provider issues; practice guidelines; member rights and responsibilities; access and availability; utilization management; continuity-of-care system; quality assessment and performance improvement program; grievances, appeals, and fair hearings; and credentialing.

Individual records were reviewed to evaluate implementation of contract requirements for grievances, denials, coordination of care for children transitioning from inpatient to outpatient services, and documentation of services provided.

In developing the monitoring tool, HSAG used the BHO's contract requirements and the regulations specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. The site review adhered to the February 11, 2003, CMS final protocol: *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A protocol for determining compliance with Medicaid Managed Care Regulations.*

Methodology and Process

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements.
- The quality and timeliness of, and access to, mental health care furnished by the BHO.
- Interventions to improve quality.
- Activities to sustain and enhance performance processes.

To accomplish these tasks, HSAG assembled a team to:

- Collaborate with the Department to determine the review and scoring methodology, data collection methods, schedule and agenda, and other issues as requested.
- Collect and review data and documents before and during the on-site portion of the review.
- Analyze the data and information collected.
- Prepare a report of findings and required actions for each BHO.

Site Review Activities

Throughout this process, HSAG worked closely with the Department and the BHO to ensure a coordinated and supportive approach to completing the site review activities.

The following table describes the activities that were performed throughout the site review process.

Table D–1—Site Review Activities Performed

For this step,	HSAG…
Step 1:	**Established the review schedule.**
	Before the site review, HSAG coordinated with the Department and the BHO to set the site review schedule and assign staff to the site review teams.
Step 2:	**Prepared the data collection tools and submitted them to the Department for approval.**
	To ensure that all information was collected, HSAG developed monitoring tools consistent with BBA protocols. To create the monitoring tool standards, HSAG used the requirements as set forth in the contract between the Department and the BHO. HSAG also followed the guidelines specified by the BBA, including revisions that were issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tools included the NCQA 2006 Standards for the Accreditation of Behavioral Health Organizations and applicable Colorado and federal requirements.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 3:	**Prepared and submitted the Desk Review Form to the Department and the BHO.**
	After review and approval of the monitoring tools by the Department, HSAG forwarded a Desk Review Form to the BHO and requested that the BHO submit specific information and documents to HSAG within 30 days of the request. The Desk Review Form included instructions on how to organize and prepare the documents related to the review of the standards and records.
Step 4:	**Forwarded a BHO Document Request Form to the BHO.**
	HSAG forwarded a BHO Document Request Form to the BHO as an attachment to the Desk Review Form. The BHO Document Request Form contained the same standards and contract requirements as those in the tool used by HSAG to assess the BHO's compliance with contract requirements for each of the 10 standards. The Desk Review Form included instructions for completing the "BHO Information and Associated Documentation" section of this form. This step provided the opportunity for the BHO to identify, for each requirement, the specific BHO documents or other information that provided evidence of compliance, and streamlined the ability of the reviewers to identify all applicable documentation for review.
Step 5:	**Developed a site review agenda and submitted it to the BHO.**
	HSAG developed an agenda to assist BHO staff in planning for participation in the site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective site review, as well as minimizing disruption to the BHO's day-to-day operations. An agenda sets the tone and expectations for the site review so that all participants understand the process and time frames for the review.
Step 6:	**Provided orientation.**
	HSAG staff provided an orientation for the BHO and the Department to preview the site review process and respond to the BHO's and Department's questions. The orientation included identifying the similarities and differences between the FY 05-06 and the FY 06–07 review processes related to the request for information and documentation prior to the on-site portion of the site review, the schedule of review activities, and the process for the review of records.
Step 7:	**Participated in telephone conference calls with the BHO to answer questions and provide any other needed information before the site review.**
	Prior to the site review, HSAG representatives conducted a pre-site review teleconference with the BHO to exchange information, confirm the dates for the site review, and complete other planning activities to ensure that the site review was completed methodically and accurately. HSAG maintained contact with the BHO as needed to answer questions and provide information to key BHO management staff members. This teleconference and subsequent contact gave BHO representatives the opportunity to request clarification and present any questions about the request for documentation for the desk review and the site review processes.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 8:	**Received desk review documents and evaluated information before the on-site review.**
	Reviewers used the documentation received from the BHO to gain insight into the BHO's structure, enrolled population, providers, services, operations, resources, and delegated functions, if applicable, and to begin compiling the information and findings before the on-site portion of the review. During the desk review process, the reviewers: ◆ Documented findings from the review of the materials submitted by the BHO as evidence of compliance with the requirements. ◆ Identified areas and issues requiring further clarification or follow-up during the interviews. ◆ Identified information not found in the desk review documentation to be requested during the on-site portion of the review.
Step 9:	**Received record review listings and posted samples to HSAG's FTP site prepared for each BHO.**
	The Desk Review Form provided the BHO with the purpose, timelines, and instructions for submitting record review lists and for pulling sample records for HSAG's review. HSAG generated four unique record review samples based on data files supplied by the BHO or the Department. These files included the following databases: consumer grievances, consumer denials, consumers who are children and had been discharged from an inpatient facility, and encounters that had been reviewed by the BHO as part of a statically valid sample of encounters. From each of these databases, a random sample of unduplicated records was selected. For each of the record reviews, HSAG selected 10 records for the sample and five additional records for the oversample.
Step 10:	**Conducted the on-site portion of the review.**
	During the site review, BHO staff members were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. Activities completed during the site review included the following: ◆ Conducted interviews with BHO staff. Interviews were used to obtain a complete picture of the BHO's compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the BHO's performance. ◆ Reviewed information and documentation. Throughout the desk review and site review processes, reviewers used a standardized monitoring tool to guide the identification of relevant information sources and to document the findings regarding compliance with the 10 standards. This activity included a review of applicable policies and procedures, meeting minutes, quality studies, reports, records, and other documentation. ◆ Received and reviewed records. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the BHO's policies and procedures. ◆ Summarized findings at the completion of the site review. As a final step, HSAG reviewers met with BHO staff to provide a high-level summary of the preliminary findings from the site review.

Table D–1—Site Review Activities Performed	
For this step,	**HSAG…**
Step 11:	**Calculated the individual scores and determined the overall compliance score for performance.**
	All of the 10 standards in the monitoring tool were reviewed and the information analyzed to determine the BHO's performance on the individual elements within each standard. For the review of records, each element was reviewed and the BHO's documentation analyzed to determine compliance.
Step 12:	**Prepared a report of findings and required actions.**
	After completing the documentation of findings and scoring for each of the 10 standards and for the reviews of records, HSAG prepared a draft report of the site review findings, scores, and required actions for the BHO. The report was forwarded to the Department and the BHO for their review and comment. After the Department's approval of the draft, a final, individual BHO report was issued to the Department and the BHO.

Evaluation and Scoring Methodology

Standards

The BHO's performance in complying with the elements (i.e., contract requirements) related to each of the 10 standards was evaluated against evidence obtained through a review of the BHO's documents and information provided during interviews with BHO staff. A score was assigned and the review findings and related substantiating evidence were documented in the "Findings" sections of the monitoring tool. The score (*Met, Partially Met*, or *Not Met*) indicated the degree to which the BHO's performance was in compliance with the individual elements in each standard. A score of *Not Applicable* (*N/A*) was used if an individual element did not apply to the BHO. Corrective actions required by the BHO to achieve compliance with the requirements were documented in the "Required Actions" section of the monitoring tool.

Scoring Methodology (Definitions)

The BHO received a score of *Met*, *Partially Met*, *Not Met*, or *N/A* for each element of each standard. This methodology follows the CMS final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*: *A protocol for determining compliance with Medicaid Managed Care Regulations*, February 11, 2003, and is defined below.

Met indicates full compliance, defined as either of the following:

- All documentation listed under a regulatory provision, or component thereof, must be present, or
- BHO staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews, or
- Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present and staff have little or no knowledge of processes or issues addressed by the regulatory provisions, or
- For provisions with multiple components, key components of a provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for remaining components.

Not Applicable (***N/A***) signifies that the requirement does not apply, because:

- The standard or element was not applicable to the BHO.

To arrive at an overall percentage of compliance score for each standard, the total number of elements receiving a score of *Met* was divided by the total number of applicable elements.

Record Reviews

The evaluation of records to determine compliance with contract requirements was accomplished through the use of a record review tool developed for each of the applicable reviews (grievances, denials, coordination of care, and documentation of services).

Similar to the methodology followed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for determining the sample size required for confidence when evaluating compliance with elements of performance, a sample of 10 records with an oversample of five records was used for record reviews (unless there were 10 or fewer available records, in which case all available records were reviewed). The samples were selected from all applicable BHO records from January 1, 2006, through September 30, 2006 for the review of grievances and denials. For the review of documentation of services, HSAG used a random sample of 10 records with an oversample of five records selected from the 411 records submitted by each BHO for the validation of the BHO's review of a statistically valid sample of encounter data. For the coordination-of-care record review, HSAG used a sample of 10 records with an oversample of five records selected from the Department's encounter data list of children with inpatient stays and discharge dates between October 1, 2005, and June 30, 2006. Each record was reviewed for evidence of BHO compliance with the applicable elements.

For each type of record review except coordination of care, the BHO received a score of *Yes* (compliant), *No* (not compliant) or *N/A* for each of the elements evaluated. Except for the coordination-of-care record review, the BHO received an overall percentage-of-compliance score for each type of record review and for all the scored record reviews combined. The overall record review score was calculated by dividing the total number of elements scored *Yes* by the total number of applicable elements.

Determination of Overall Compliance Percentage Score

The overall compliance percentage score for each BHO was calculated by dividing the total number of elements that were compliant for the standards and the record reviews by the total number of applicable elements.

References

BBA (Balanced Budget Act). Centers for Medicare & Medicaid Services. CMS and Related Laws and Regulations. Available at: http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr438_04.html.

Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A protocol for determining compliance with Medicaid Managed Care Regulations*, Final Protocol, February 11, 2003.

National Committee for Quality Assurance (NCQA) *2006 Standards for the Accreditation of Behavioral Health Organizations (BHOs)*. Washington, DC.