Colorado Medicaid
Community Mental Health Services Program

FY 2008–2009 Site Review Report

for

Foothills Behavioral Health, LLC

May 2009

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

HSAG Health Services Advisory Group

1600 East Northern Avenue, Suite 100 ◆ Phoenix, AZ 85020
Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

1. Executive Summary 1-1
Overview of FY 2008–2009 Compliance Monitoring Activities 1-1
Objective of the Site Review 1-2
Summary of Results 1-2

2. Component 1––Member Information 2-1
Methodology 2-1
Summary of Findings and Opportunities for Improvement 2-1
Summary of Strengths 2-1
Summary of Required Actions 2-1

3. Component 2––Notices of Action 3-1
Methodology 3-1
Summary of Findings and Opportunities for Improvement 3-1
Summary of Strengths 3-2
Summary of Required Actions 3-2

4. Component 3––Appeals 4-1
Methodology 4-1
Summary of Findings and Opportunities for Improvement 4-1
Summary of Strengths 4-2
Summary of Required Actions 4-2

5. Component 4––Underutilization 5-1
Methodology 5-1
Summary of Findings and Opportunities for Improvement 5-1
Summary of Required Actions 5-1

6. Follow-up on FY 2007–2008 Corrective Action Plan 6-1
Methodology 6-1
Summary of FY 2007–2008 Required Actions 6-1
Summary of Findings 6-1
Summary of Required Actions 6-1

Appendix A. Compliance Monitoring Tool ..... A-i
Appendix B. Notice of Action Record Review ..... B-i
Appendix C. Appeals Record Review ..... C-i
Appendix D. Site Review Participants D-1
Appendix E. Corrective Action Plan Process for FY 2008–2009 ..... E-1
Appendix F. Compliance Monitoring Review Activities F-1

Overview of FY 2008–2009 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct an annual evaluation of their managed care organizations and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements, and the State's quality strategy. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for the Colorado behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the fifth year that HSAG has performed compliance monitoring reviews of the BHOs. For the fiscal year (FY) 2008–2009 site review process, the Department requested a focused review of four areas of performance.[1-1] HSAG developed a review strategy consisting of four components for review, which corresponded with the four performance areas identified by the Department. These were: Member Information (Component 1), Notices of Action (Component 2), Appeals (Component 3), and Underutilization (Component 4). Compliance with federal regulations and contract requirements was evaluated through review of the four components. This report documents results of the FY 2008–2009 site review activities for the review period of July 1, 2007, through June 30 2008. Details of the site review methodology and summaries of the findings, strengths, opportunities for improvement, and required actions for each component are contained within the section of the report that addresses each component. Completed data collection tools for each component are found in the appendices. In addition, HSAG has included an overview of **Foothills Behavioral Health, LLC** (**FBH**) follow-up activities and status regarding the corrective actions that were required as a result of the FY 2007–2008 compliance site review.

In developing the data collection tools and in reviewing the four components, HSAG used the BHOs' contract requirements and regulations specified by the BBA with revisions that were issued on June 14, 2002, and effective on August 13, 2002. The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)* (see Appendix F).

[1-1] The Department developed these performance areas through surveys of participants from the Medicaid Mental Health Advisory Committee (MHAC) and the Medicaid Mental Health Planning and Advisory Council (MHPAC). The Department developed the MHAC to exchange information and identify, evaluate, and communicate issues related to the Colorado Medicaid Community Mental Health Services Program. MHPAC was created as a result of federal laws passed in 1986 and 1992, which require states and territories to perform mental health planning in order to receive federal Mental Health Block Grant funds (Sections 1911–1920 of the Public Health Service [PHS] Act [42 USC 300x-1 through 300x-9] and Sections 1941–1956 of the PHS Act [42 USC 300x-51 through 300x-66]).

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements in the four areas of review.
- The quality and timeliness of, and access to, mental health care furnished by the BHO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality the BHO's service related to the area reviewed.
- Activities to sustain and enhance performance processes.

Summary of Results

HSAG assigned each element within the components in the Compliance Monitoring Tool a score of *Met, Partially Met, Not Met, Not Applicable,* or *Not Scored*. *Not Scored* was used when materials had been previously reviewed and approved by the Department as meeting requirements, but minor revisions would enhance the clarity or compliance of the materials. HSAG assigned each element within the record review tools a score of *Met, Partially Met, Not Met,* or *Not Applicable.* Based on the results from the Compliance Monitoring Tool, the record review scores, and conclusions drawn from the review activities, HSAG assigned each component of the review an overall score of *In Compliance*, *In Partial Compliance,* or *Not In Compliance.* HSAG assigned required actions to any individual element within the Compliance Monitoring Tool or the record reviews receiving a score of *Partially Met* or *Not Met.* HSAG also identified opportunities for improvement with associated recommendations for enhancement for some components, regardless of the score. While HSAG provided recommendations for enhancement of BHO processes based on these identified opportunities for improvement, they do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **FBH** for each of the components. Details of the findings for each component follow in subsequent sections of this report.

Table 1-1—Summary of Scores for the Components

Component #	Description of Component	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable or Not Scored*	Score (% of *Met* Elements)
1	Member Information	25	24	24	0	0	1	100%
2	Notices of Action	9	9	5	4	0	0	56%
	Notices of Action Record Review	50	39	32	0	7	11	82%
3	Appeals	23	22	18	4	0	1	82%
	Appeals Record Review	28	28	27	0	1	0	96%
4	Underutilization	4	4	4	0	0	0	100%
	Totals	**139**	**126**	**110**	**8**	**8**	**13**	**87%**

Table 1-2 presents the overall score for **FBH** for each of the components.

Table 1-2—Results	
Component	**Overall Score**
Component 1—Member Information	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*
Component 2—Notices of Action	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*
Component 3—Appeals	☐ *In Compliance* ☒ *In Partial Compliance* ☐ *Not In Compliance*
Component 4—Underutilization	☒ *In Compliance* ☐ *In Partial Compliance* ☐ *Not In Compliance*

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and all member informational materials and templates used by the BHO during the review period. While on-site, HSAG reviewed additional documentation and interviewed key BHO personnel. Details of the findings for Component 1 follow in Appendix A—Component 1.

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

FBH had an effective mechanism for ensuring that the required information was mailed within one month of **FBH**'s notification of enrollment. Mailings occurred monthly. **FBH**'s materials were available in Spanish, large print, and audio format. **FBH**'s community mental health centers (CMHCs) used TTY/TTDs when needed. For oral interpretation services, **FBH** used contracted interpreters, the language line, or bilingual staff members available at some of the CMHC sites. **FBH** mailed a letter annually that informed members that they may request information about **FBH** and may receive another consumer handbook. While the consumer handbook included all of the requirements, there was one area that represented an opportunity for improvement. **FBH** may consider revising member materials to specify the difference in filing requirements between filing appeals related to termination, suspension, or reduction of a previously authorized service (10 days from the date of the notice of action or before the date of the intended effective date) and the denial or limited authorization of a requested service (20 days from the date of the notice of action).

Summary of Strengths

FBH's member handbook divided the large amount of required information into small sections that made the information easier to understand. In addition, **FBH** created small, subject-specific flyers (PCP, EPSDT, etc.) that were included in the enrollment mailing. **FBH** had a mechanism to sort the initial enrollment mailing by Spanish-speaking and non-Spanish-speaking households so that Spanish-speaking households received the first enrollment mailing in Spanish rather than in English.

In addition to the grievance and appeal information contained in the member handbook, **FBH** had developed a Grievance and Appeal Guide that included more specific requirements and time frames that was sent to members with notices of action and appeal acknowledgement letters (at the entry point for members when they required the specific information about the processes).

Summary of Required Actions

There were no corrective actions required for this component.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation, interviewed key BHO personnel, and conducted a record review of documentation associated with completed notices of action.

For the record review, a sample of 10 actions with an oversample of 5 actions was selected from all Medicaid member actions sent by **FBH** during the review period. The oversample was used if 1 or more action records was deemed not applicable or was not available during the on-site review. A total of 10 records were reviewed for the timeliness and content of the documentation related to notices of action. (The entire sample was reviewed if the BHO had fewer than 10 notices of action sent during the review period.) Details of the findings for Component 2 follow in Appendix A—Component 2.

Summary of Findings and Opportunities for Improvement

Overall score: In Partial Compliance

FBH had a mechanism for appropriate utilization control, ensuring that medically necessary services were provided in an amount, duration, and scope needed to achieve the purpose for which they were provided. **FBH**'s utilization management (UM) program included a process for sending notices of action when services were denied, terminated, reduced, or authorized in an amount, duration, or scope that was less than requested. The UM policies and procedures included most of the required provisions.

The notice-of-action template letters that were used for all notices sent to members included the requirements and time frames for continuation of benefits during the appeal and State fair hearing processes and information related to House Bill (HB) 1116 processes. As a result, members for whom these processes did not apply received the above information, resulting in letters that may have been confusing for members who may have not understood those processes. **FBH** may consider customizing letters to the member's particular circumstances and removing nonapplicable language from the notices of action to improve the understandability of the notices of action.

Notice-of-Action Record Review Summary

HSAG reviewed 10 notice-of-action records at **FBH**. All 10 notices contained the content required by the BBA. Four of nine applicable records met the requirement to mail the notice of action within 10 calendar days of receiving a request for services. This element was not applicable to one record as the case was a denial of subsequent authorization of services as a result of a concurrent review.

Three of the five records that were out of compliance for timeliness of sending the notice of action were out of compliance because the letter was sent several days following the date of the decision (as reported in the notice of action). For those records, if the letter had been sent the day of the decision, **FBH** would have been in compliance with the timeliness requirement. **FBH** stated that it was aware that this had been a problem and had already taken measures necessary to correct it. Nine of 10 records included an easy-to-understand reason for the action taken.

There were two notice-of-action letters that indicated an effective date of 10 days in the future, although the type of action was either a denial or limited authorization of a requested service. A 10-calendar-day notice is only required in the case of termination, reduction, or suspension of previously authorized services. For other denials of services, the notices of action stated that the effective date was the date of the letter. For new service requests, indicating a future effective date is confusing and inaccurate as services have not yet been authorized (and are being denied in whole or in part).

Although **FBH** staff reported that it was **FBH**'s policy that decisions to deny inpatient hospitalization were made by a medical doctor, one record did not include documentation that the decision to deny inpatient hospitalization was made by a medical doctor.

In two records it was evident that **FBH** had denied the request for services as **FBH** did not have the clinical information necessary to establish medical necessity. **FBH** then processed the subsequent communication from the requesting provider, which included additional information, as a new request. While this is in compliance with the BBA, **FBH** may consider using the extension process to allow additional time for receiving the clinical information needed and avoid unnecessary actions.

Summary of Strengths

While **FBH** used templates for the notices of action, **FBH** staff also added a significant amount of non-template language to the notices that were sent to explain the situation and reasons for the action. In addition, the case-specific denial records contained ample documentation to demonstrate that **FBH**'s authorization decisions were not arbitrary and were based on medical necessity determinations and a standard set of UM criteria.

Summary of Required Actions

The definition of an action in **FBH**'s policies and member materials was incomplete. The denial in whole or in part of payment for a service was not included in the definition of an action; therefore, the policy did not address the time frame for mailing the notice of action for this type of action. In addition, **FBH**'s policy stated that a type of action was "the failure to act within the specified timeframes." The policy should specify that this type of action was "the failure to act within the time frames for resolution of grievances and appeals." **FBH** must revise its applicable policies and member materials to include an accurate and complete definition of an action, as specified in the BBA.

Based on the on-site review of the notice-of-action records, **FBH** must:

- Ensure that it mails all notices of action within 10 days of receiving a request for services.
- Ensure that each notice of action includes the reason for the action in an easy-to-understand format.
- Ensure that notice-of-action records contain documentation that decisions to deny, terminate, or authorize services in a limited amount, duration, or scope are made by individuals with the appropriate clinical expertise as described in **FBH** policies.
- Discontinue the use of an effective date (10 days in the future) for actions related to the denial or limited authorization of a newly requested service.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation, interviewed key BHO personnel, and conducted a record review of documentation associated with Medicaid member appeals.

For the record review, a sample of 10 appeals with an oversample of 5 appeals was requested. **FBH** provided four **FBH**-level appeal records. HSAG reviewed the records for timeliness and content related to the appeals. (The entire sample was reviewed since the BHO had fewer than 10 appeals during the review period.) Details of the findings for Component 3 follow in Appendix A—Component 3.

Summary of Findings and Opportunities for Improvement

Overall Score: In Partial Compliance

FBH had an established process that allowed members access to the **FBH** appeal process and the State fair hearing process. **FBH**'s policies, member materials, and provider materials indicated that members and authorized representatives may file orally or in writing. The materials, however, did not clarify that oral requests must be followed by a written request. **FBH** should await the Department's clarification regarding this requirement and ensure that materials reflect the appropriate information. **FBH** policies included most of the required information.

Appeal Record Review Summary

Although **FBH** submitted a list of six records for review, two of these were Administrative Law Judge (ALJ) hearings only. An **FBH**-level appeal was not requested; therefore, four **FBH**-level appeal records were reviewed on-site. Each of the four records contained descriptive documentation of the assistance provided to members during the appeal process. All acknowledgment letters were sent within two days of receiving the appeal. All records contained evidence that the individual who made the decision on the appeal was not involved in a previous level of review and had the clinical expertise required to make the decision. Three of the four resolution letters were sent within 10 working days of the request for the appeal.

While the resolution letters contained all of the required information, the templates used contained information not applicable to all cases. For example, all resolution letters contained information about continuation of benefits during the State fair hearing process (which would not apply unless the action was related to the termination of previously authorized services), and resolution letters in favor of the member contained State fair hearing rights. **FBH** may consider customizing resolution

letters to the specific cases and/or developing a template for use when the decision is favorable to the member, so as not to offer rights to members for whom those rights do not apply.

Summary of Strengths

Members were well informed about their rights to access the appeal and State fair hearing processes. The Grievance and Appeal Guide was very comprehensive and understandable and was provided to members with notices of action and with appeal acknowledgment letters (at the time members would need more detailed information). The Grievance and Appeal Guide encouraged members to pursue the State fair hearing process while undergoing the **FBH** appeal process due to the limited time frame for requesting a State fair hearing.

Appeal resolution letters contained a large amount of non-template language that explained fully the process of investigation, the resolution, and the reason for the decision in an easy-to-understand way.

The case-specific records contained summaries that described the case, the process, and the results, as well as documentation of the assistance provided by **FBH** Office of Consumer and Family Affairs (OCFA) staff to the member in completing the appeal process.

Summary of Required Actions

Based on the on-site review of appeal records, **FBH** must ensure that appeals are resolved and notification sent within the required time frame (10 working days).

While **FBH** staff did use the extension process when it was in the interest of the member for standard appeals (as evidenced by the record review), **FBH** policies did not include an extension provision for appeals that were initially filed as expedited appeals. **FBH** must revise applicable policies and other applicable materials to include a process for extending the time frames for resolution of expedited appeals when the member requests the extension, or when **FBH** shows that the extension would be in the interest of the member.

FBH did have an expedited review process described in its policies and member materials; however, the process did not include the procedure for notifying members in writing if the request for expedited review is denied, or the procedure for **FBH** to determine that an expedited review process is needed. **FBH** must clarify its applicable policies and other materials to describe all the required processes related to the expedited review process for processing appeals.

The Grievance and Appeals policy, while it addressed all of the requirements, was incorrect regarding the time frame for filing an appeal and requesting continuation of benefits. **FBH** must revise applicable policies and other materials to accurately reflect the required time frames (10 days) for filing appeals and continuing benefits when the appeal is related to the termination, suspension, or reduction of previously authorized services.

Methodology

HSAG reviewed materials submitted by the BHO prior to the site visit. These materials included policies and procedures, staff training materials, minutes of key committee meetings, and member and provider informational materials. While on-site, HSAG reviewed additional documentation and interviewed key BHO personnel. Details of the findings for Component 4 follow in Appendix A—Component 4.

Summary of Findings and Opportunities for Improvement

Overall Score: In Compliance

FBH had a variety of routine reports that analyzed and trended utilization data and were designed to identify over- and underutilization. These reports included emergency room (ER) visits per 1,000, outpatient visits, hospital admissions per 1,000, follow-up after hospitalization, and hospital recidivism. The reports trended data by provider in the external provider network and compared the CHMCs (as single, organizational providers).

Summary of Strengths

Since all services except emergency services were authorized by **FBH** or its UM delegates, **FBH**'s data included both authorized and nonauthorized services. **FBH** described the process of transitioning between the FlexServ system of authorizing services, used during the review period, to the LOCUS/CALOCUS system, in current use. Using data from the LOCUS/CALOCUS system, **FBH** anticipates the ability to trend data using additional measures, including what percentage of members account for 50 percent or more of service utilization, level of care per diagnosis, follow-up after missed appointments, and penetration rate per age-related population.

Summary of Required Actions

There were no corrective actions required for this component.

6. Follow-up on FY 2007–2008 Corrective Action Plan

for Foothills Behavioral Health, LLC

Methodology

As a follow-up to the FY 2007–2008 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all components for which it received a score of *In Partial Compliance* or *Not In Compliance*. The plan was to include interventions to achieve compliance and the timeline associated with those activities. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with the BHO until HSAG and the Department determined that the BHO completed each of the required actions from the FY 2007–2008 compliance monitoring site review, or until the time of the on-site portion of the BHO's FY 2008–2009 site review.

Summary of FY 2007–2008 Required Actions

As a result of the FY 2007–2008 site review, **FBH** was required to review its access policies and procedures and evaluate how the **FBH** network CMHCs' staff members have been implementing those policies regarding services for Medicaid members who reside in nursing facilities. **FBH** must clarify Medicaid managed care regulations regarding access to services with the CMHCs and ensure that when CMHCs respond to requests from nursing facilities, they do not require processes that delay access to services for members residing in nursing facilities.

Summary of Findings

The **FBH** Access to Mental Services in Nursing Home and Assisted Living Facilities policy described the specific procedures used for scheduling residents of nursing facilities (NFs) or assisted care facilities (ACFs) for routine services. The Access to Services policy included the required time frames for routine, urgent, and emergent services. **FBH** staff clarified that the Access to Services policy and the time frames within the policy were applicable to all members. Letters from both of **FBH**'s in-network CMHCs indicated that CMHC staff had been trained pertaining to access/intake procedures for NF or ACF residents and that the seven-day access requirement for routine care had been reiterated during the training. **FBH**'s list of interview questions and the results of **FBH**'s interviews (monitoring the CMHCs) indicated that **FBH** had monitored the CMHCs' processes for scheduling intake appointments for members residing in NFs or ACFs, and that there were no barriers to accessing services identified during the monitoring process.

Summary of Required Actions

FBH successfully completed the FY 2007–2008 required actions. There were no required actions continued from FY 2007–2008.

The completed compliance monitoring tool follows this cover page.

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(3) Contract: II.G.d.g & II.G.d.h	1. The Contractor provides all members the required information (see below) within a reasonable time after the BHO receives notice of enrollment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The FBH Member Rights and Responsibilities Operating Policies and Procedures document stated that the member handbook and provider directory will be mailed to all new Medicaid enrollees within three weeks of the Department's electronic notification of new enrollees. FBH staff described the process for ensuring that members receive the information. FBH staff stated that the enrollment data was sent to InNet (FBH's delegate for data processing), which forwarded the data to FBH and its contracted printing company. The printing company then mailed the handbook and directory directly to new members. FBH staff reported FBH reviewed invoices to track and ensure that mailings were complete. Staff reported that the enrollment mailing included the member handbook, the provider directory, the ombudsman flyer and three small flyers with specific content (how to obtain and use a primary care provider [PCP], use of emergency services, and Early and Periodic Screening, Diagnosis, and Treatment [EPSDT] services).	
	Required Actions: None	
Contract: II.G.d.b	2. The Contractor has a mechanism to help members and potential members understand the requirements and benefits of the plan.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Member Rights and Responsibilities policy stated that it is the responsibility of OCFA to help enrollees and potential enrollees understand the requirements and benefits of the plan. The member handbook instructed members to call OCFA for help with any problems or questions and listed several telephone numbers that could be called to contact OCFA representatives. The member handbook also included a list of services as well as a brief description of each service. FBH staff reported that each CMHC had an OCFA representative employed by FBH, and that clinicians were able to refer members to the on-site OCFA representative as needed. In addition to easy accessibility on-site at the CMHCs, FBH staff reported that OCFA representatives regularly attended community-based National Alliance on Mental Illness (NAMI) and Federation for the Family meetings and provided presentations at area schools.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(b)(1)&(3) 42CFR438.10(d) Contract: II.G.d.a; II.G.d.c; & II.G.d.d	3. The Contractor provides all enrollment notices, informational materials (handbooks, newsletters, directories), and instructional materials (health education, grievance system notices) in a manner and format that may be easily understood: ◆ In the prevalent non-English language. ◆ In alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The Member Rights and Responsibilities Member Information policy stated that FBH uses the Centers for Medicare & Medicaid Services Writing and Designing Print Materials for Medicaid Beneficiaries—A Guide for State Medicaid Agencies to help ensure all written materials are written in a manner and format that is easy to understand. FBH staff stated that FBH also makes arrangements to provide materials in formats that will accommodate members who are visually or hearing impaired. Member materials written in English included a statement written in Spanish informing members that written materials are available in Spanish and how to obtain them. FBH's policy indicated that it sorted monthly enrollment lists obtained from the Department so that Spanish speakers received new enrollment materials in Spanish and did not need to call FBH for the Spanish version. During the on-site interview, FBH staff confirmed this process. FBH provided several examples of member materials written in Spanish.	
	Required Actions: None	
42CFR438.10(c)(4)&(5) Contract: II.G.d.c; II.G.d.e; & II.G.d.f	4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: FBH's Member Information policy and procedure stated that FBH arranges for oral interpretation of all member materials through the AT&T Language Line or interpreters. Members were informed of this right via the member handbook. The cover page of the member handbook stated that oral interpretation services are available free of charge and gave instruction on how to obtain those services. This information was also included in the section of the member handbook titled, "What if you need help understanding this handbook or talking with your provider?" The availability of interpreter services was repeated in the list of Medicaid rights and responsibilities, which was also included in the member handbook and posted on the CMHCs' and FBH's Web sites. Providers were informed about oral interpretation services via the member handbook that was reprinted in the provider manual and also available to providers (from the CMHCs and the independent provider network [IPN]) for distribution to members at intake.	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.10(c)(5) Contract: II.G.d.f	5. The Contractor notifies members that written information is available for prevalent non-English languages and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The cover of the member handbook gave members the telephone numbers to call to get a Spanish version of the handbook.	
	Required Actions: None	
42CFR438.10(d)(2) Contract: II.G.d.f	6. The Contractor notifies members that written information is available in alternative formats and how to access the materials.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook stated that information in the member handbook is available to members in a variety of formats, including large print and audio. The handbook also offered sign language and oral translation services and informed members of how to obtain these services.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(2) Contract: II.G.d.k	7. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information (42CFR438.10), upon request.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: FBH mailed members an annual letter in January 2008. This letter reminded members of their right to request and obtain the member handbook and described the content (in bullet form) and type of information available in the member handbook.	
	Required Actions: None	
42CFR438.10(f)(4) Contract: II.G.d.i	8. The Contractor gives written notice of any significant change in information to members at least 30 days before the intended effective date of the change.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The FBH Member Information policy stated that it is the responsibility of OCFA to ensure that members are given written notice of any significant change in services at least 30 days before the intended effective date of the change. Service agreements between FBH and the CMHCs required the CMHCs to notify FBH "promptly" of any situation that will materially interfere with the CMHCs' performance of its duties and obligations under the agreement. The IPN service agreements required providers to notify FBH of any situation that will materially interfere with the CMHCs' performance of their duties and obligations under the agreement. The member handbook informed members that they would be given written notification of any major change at least 30 days before the date of the change. During the on-site interview, FBH staff reported no significant changes during the review period.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f)(5) Contract: II.G.d.j	9. The Contractor makes a good-faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice to each member who is receiving or has received in the last six months his or her primary mental health care from, or was seen on a regular basis by, the terminated provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook included the statement that FBH would try to give members a 15-day notice if their provider leaves the program. FBH provided an example of a letter that was sent as a result of a provider choosing to leave the network. The example letter reviewed demonstrated compliance.	
	Required Actions: None	
42CFR438.10(f) Contract: II.G.d.g.	10. Member information materials include: ◆ Names, locations, and telephone numbers of, and non-English languages spoken by, current contracted providers, including identification of providers who are not accepting new patients. ◆ Any restrictions on freedom of choice among network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The FBH provider directory included the names, locations, telephone numbers, and languages spoken for each provider and indicated which providers were accepting new patients. The member handbook informed members that they may choose their provider and may request that a provider join the network. The member handbook also informed providers that members may receive services from community providers outside of the CMHCs.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(f) Contract: II.G.d.g	11. Member information materials include: ◆ Member rights as specified in 42CFR438.100. ◆ Additional member rights that include the right to: ▪ Have an independent advocate. ▪ Request that a specific provider be considered for inclusion in the network. ▪ Receive a second opinion. ▪ Receive culturally appropriate and competent services from participating providers. ▪ Receive interpreter services for members with communication difficulties or for non-English-speaking members. ▪ Prompt notification of termination or changes in services or providers. ▪ Express an opinion about the Contractor's services to regulatory agencies, legislative bodies, or the media without the Contractor causing any adverse effects upon the provision of covered services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The FBH member handbook included member rights, as required by the BBA. Members were reminded of these rights in the annual letter, mailed in January 2008. In addition to the member handbook and annual letter, FBH's CMHCs listed member rights on the consent-to-treat form and disclosure form, and included the document, "What Are Your Rights and Responsibilities?" in the intake packet members received when presenting for the first appointment (with either an IPN or CMHC provider). The CMHCs also posted the document, "What Are Your Rights and Responsibilities?" at the CMHCs.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	12. Member information regarding the grievance, appeal, and fair hearing procedures have been approved by the Department and include: ◆ The right to file grievances. ◆ The right to file appeals. ◆ The right to a State fair hearing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: Member information distributed by FBH included the right to file grievances and appeals, and the right to a State fair hearing. FBH provided an e-mail from the Department dated December 2005 approving FBH's member materials. During the on-site interview, FBH staff reported that any changes to the member handbook since 2005 were either as a result of clarification by the Department or nonsubstantive changes. Staff also reported that the additional flyers included in the enrollment mailing were individually approved by the appropriate Department representative prior to inclusion.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	13. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The requirements and time frames for filing grievances and appeals. ◆ The method for obtaining a State fair hearing. ◆ The rules that govern representation at a State fair hearing.	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The member handbook included information regarding grievances, appeals, and State fair hearings and explained the requirements and time frames for each process and how to obtain a State fair hearing. The time frame for filing an appeal and requesting that benefits continue, however, was stated as 20 days. The member handbook also informed members that more detailed information regarding grievances, appeals, and State fair hearings could be found in the Grievance and Appeals Guide, distributed with every notice of action and appeal acknowledgment letter, and upon request. The rules that govern representation at a State fair hearing were included in the guide. FBH may consider revising member materials to specify the difference between filing appeals related to termination, suspension, or reduction of a previously authorized service (10 days from the date of the notice of action or before the date of the intended effective date) and the denial or limited authorization of a requested service (20 days from the date of the notice of action).	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10(g) Contract: II.G.d.g	14. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook and the Grievance and Appeal Guide included toll-free numbers members could use to file a grievance or an appeal by phone. These documents also mentioned the availability of assistance.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	15. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for State fair hearing is filed within the timeframes specified for filing ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending, if the final decision is adverse to the member	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: Both the member handbook and the Grievance and Appeal Guide included information about how a member may request that services continue and the circumstances under which a member may be required to pay for those services. The information in the Grievance and Appeal Guide was considerably more comprehensive, describing the details of the process for members.	
	Required Actions: None	
42CFR438.10(g) Contract: II.G.d.g	16. Member information regarding the grievance, appeal, and fair hearing procedures include: ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook stated that a designated client representative (DCR) can be anyone a member chooses to speak for him or her. The Grievance and Appeal Guide specified that a physician can be a DCR.	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.10(f)(6) Contract: II.G.d.g	17. Information provided to members includes: ◆ The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. ◆ Procedures for obtaining benefits, including authorization requirements. ◆ The extent to which and how members may obtain benefits from out-of-network providers. ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract, including any cost-sharing and how transportation is provided.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The FBH member handbook included comprehensive information regarding benefits and how to obtain them, including services that are available out of network and under the State plan, but not offered by FBH. FBH used the annual letter to remind members that this information is available and how to obtain it.	
	Required Actions: None	
42CFR438.10(f)(6) Contract: II.G.d.g	18. Information provided to members includes: ◆ The extent to which and how after-hours and emergency coverage are provided, including: ▪ What constitutes an emergency medical condition, emergency services, and poststabilization services with reference to the definitions in 42 CFR 438.114(a). ▪ The fact that prior authorization is not required for emergency services. ▪ The process and procedures for obtaining emergency and poststabilization services, including the use of the 911 telephone system or its local equivalent. ▪ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and poststabilization services. ▪ The fact that the member has the right to use any hospital or other setting for emergency care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The FBH member handbook included comprehensive information regarding emergency and poststabilization services.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 Contract: II.G.d.g	19. Information provided to members includes policies on referral for specialty care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The FBH member handbook informed members that specialty care would be arranged by the care coordinator. Members were invited to call OCFA for help. The annual letter, mailed in January 2008, informed members that they had the right to receive rules on referrals for specialty care upon request.	
	Required Actions: None	
42CFR438.10 42CFR438.6(I)(2) 42CFR422.128 Contract: II.G.d.g	20. Member information regarding advance directives for adult members includes: ◆ The member's right to formulate advance directives. ◆ The member's rights under the State law to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the appropriate State agency. ◆ The Contractor's policies regarding implementation of advance directives, which must include: ▪ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. ▪ The difference between institution-wide conscientious objections and those raised by individual physicians. ▪ Identification of the State legal authority permitting such objection. ▪ Description of the range of medical conditions or procedures affected by the conscientious objection. ▪ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and is unable to receive information. ▪ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
	▪ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ▪ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. ▪ Provisions for ensuring compliance with State laws regarding advance directives. ▪ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ▪ Provisions for the education of staff concerning its policies and procedures on advance directives. ▪ Provisions for community education regarding advance directives that includes: • What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. • A description of applicable state law concerning advance directives.	
	Findings: The member handbook provided information about advance directives—what they are, how to formulate them, and the laws regarding what types of advance directives are recognized in Colorado. The handbook also provided information about what to do if a member felt that his or her advance directives were not being followed. The member handbook informed members that if they wanted more information about advance directives, they may receive FBH's policy on advance directives or contact their PCP. The member handbook also informed members that FBH would document in the medical record whether the member has an advance directive. FBH's Advance Directives policy included the provision that care would not be conditioned on whether or not the member had an advance directive, provisions for informing members of changes in State law within 90 days following the change, and provisions for training staff regarding requirements related to advance directives.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
Contract: II.G.d.h	21. Information provided to members includes: ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members. ◆ Notice that the member has been enrolled in the Community Mental Health Services Program operated by the Contractor, and that enrollment is mandatory. ◆ The Contractor's hours of operation. ◆ That assistance is available through the Medicaid Managed Care Ombudsman Program and how to access ombudsman services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The FBH member handbook informed members that enrollment is required based on the county of residence and that services are free. The handbook included hours of operation and contact information for FBH, JCMH, and MHCBBC. Members were given information about the availability of assistance through and contact information for the Medicaid Managed Care Ombudsman Program in the member handbook, and through use of ombudsman fliers, which were included in the enrollment mailing and the intake packets, and were posted at the CMHC sites (as reported during the on-site interview).	
	Required Actions: None	
Contract: II.G.d.h	22. Information provided to members includes: ◆ Appointment standards for routine, urgent, and emergency situations. ◆ Procedures for requesting a second opinion. ◆ Procedures for requesting accommodations for special needs, including written materials in alternative formats. ◆ Procedures for arranging transportation.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The member handbook included appointment standards; instructions for requesting accommodations for special needs, including written materials in alternative formats and transportation; and procedures for requesting second opinions.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 Contract: II.G.d.h	23. Information provided to members includes: ◆ Information on how members will be notified of any changes in services or service delivery sites. ◆ Procedures for requesting information about the Contractor's Quality Improvement Program. ◆ Information on any member and/or family advisory boards the Contractor may have in place.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The FBH member handbook included a brief overview of the quality improvement program and offered members a free copy of the quality improvement plan. The member handbook stated that members would be given written notice of any changes in services and that information would also be available at the CMHCs. The OCFA brochure provided information about the Consumer and Family Advisory Board and encouraged members to join.	
	Required Actions: None	
42CFR438.10 Contract: II.G.d.g	24. Additional information that is available upon request: ◆ Physician incentive plans	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: During the on-site interview, FBH staff reported that FBH had no physician incentive plans. Both the member handbook and the annual member letter informed members that they may receive information on the structure and operation of FBH upon request.	
	Required Actions: None	

Component 1—Full Review of Standard V—Member Information		
References	**Requirement**	**Score**
42CFR438.10 Contract: II.G.d.g	25. Information that must be made available annually and upon request: ◆ Information on the structure and operation of the Contractor ◆ The Contractor's service area ◆ The benefits covered under the contract ◆ The fact that no fees may be assessed for covered mental health services provided to enrolled members ◆ To the extent available, quality and performance indicators, including enrollee satisfaction	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A ☐ Not Scored
	Findings: The annual member letter informed members that they may request information about the structure and operation of FBH, and that they may receive another copy of the member handbook upon request. The letter also summarizes what information can be found in the member handbook. The member handbook included information about FBH's service area, benefits available through FBH, the fact that no fees may be charged for mental health services, and the option that a member may request information about the quality improvement program.	
	Required Actions: None	

Results for Member Information							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	1	X	N/A	=	N/A
Total Applicable		=	24	**Total Score**		=	24

Total Score ÷ Total Applicable	=	100%

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.400(b) Contract: Exhibit G—8.209.2	1. The Contractor defines action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The definition of action in FBH's policies (Action Recommendation—Routine, Notice of Action—Routine, and Notice of Action—Expedited) was incomplete. The denial, in whole or in part, of payment for a service was missing from all policies. The policies included "the failure to act within required time frames" but did not specify that the time frames are related to the resolution of grievances and appeals. Provider and member materials contained the same definition that was in the policies.	
	Required Actions: FBH must revise policies and other applicable documents to include a complete definition of action.	
42CFR438.404(a) Contract: Exhibit G—8.209.4.A.1	2. Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The template Notice of Action provided direction for UM staff to insert easy-to-understand information into the section for the reason for the decision. The on-site record review indicated that the language inserted was easy to understand and often said that the reason was that the treatment was not medically necessary. FBH staff stated that they recognized that stating lack of medically necessary was minimally compliant with the regulation. During the current FY, FBH began including additional language to help the member understand why medical necessity could not be established. There were some examples of this in the record review. There were two notice-of-action letters in the record review that indicated an effective date of 10 days in the future, even though the type of action was either a denial or limited authorization of a requested service. This made the letter difficult to understand as a future effective date was not applicable and apparently not related to an actual date that the action was effective. During the on-site interview, FBH staff reported that during the review period, the staff member processing denials had misunderstood the requirement and was applying the requirement for termination of previously authorized services to actions that were a denial or limited authorization of a newly requested service. FBH staff reported that FBH had recently implemented a procedure whereby the OCFA director reviews all notices to ensure understandability.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
	Required Actions: FBH must ensure that notices of action have correct information regarding timelines and types of action taken.	
42CFR438.404(b) Contract: Exhibit G—8.209.4.A.2	3. Notices of action must contain: ◆ The action the Contractor has taken or intends to take. ◆ The reasons for the action. ◆ The member's (and provider's on behalf of the member) right to file an appeal and how to do so. ◆ The member's right to request a State fair hearing and how to do so. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that. ◆ The circumstances under which the member may have to pay for the costs of services if continued benefits are requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: All notice-of-action letters used template language, which included each of the requirements. As a result, all notices of action included the requirements and time frames for continuation of benefits (services) during the appeal or State fair hearing processes. Members who receive a notice of action for the denial of an initial request for services would not have the right to request continuation of benefits. The language regarding continuing benefits in the letter—while not out of compliance—could be confusing for members. In addition, letters containing information about the HB 1116 process were sent to members to whom the HB 1116 process was not applicable. FBH may consider customizing letters to the member's particular needs and removing nonapplicable language from the notices of action to improve the understandability of the letters.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.3	4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within 10 calendar days, on the date the time frames expire ◆ For expedited service authorization decisions, within three days	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notices of Action—Routine and Notices of Action—Expedited policies described each of the applicable time frames except for the time frame for sending a notice related to the denial of payment. FBH provided audit reports to demonstrate that FBH had a mechanism to ensure that time frames were met. The UM committee meeting minutes demonstrated that the committee reviewed the audit reports and developed responses (such as corrective action) as needed. The on-site record review indicated that five of the records for which this element was applicable were out of compliance with the required time frame for sending notices of action. Three of the records were out of compliance because the letter was sent several days following the date of the decision (as reported in the letter). For those records, if the letter had been sent the day of the decision, FBH's score for this element would have significantly improved.	
	Required Actions: FBH must ensure that notices of action are sent within the required time frames. FBH must also revise any applicable policies to include the time frame for sending the notice of action related to a denial (in whole or in part) of payment for services.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.404(c) Contract: Exhibit G—8.209.4.A.4	5. If the Contractor extends the time frame for authorization decisions (see Standard I) it provides the member: ◆ Written notice of the reason for the decision to extend the time frame. ◆ The right to file a grievance if the member disagrees with the decision. ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notice of Action—Routine and Notice of Action—Expedited included the process for extending time frames. FBH staff reported that FBH typically did not extend the authorization decision time frames. There were cases in the records of a second request for a service accompanied by additional information. FBH had denied the original request due to lack of clinical information needed to make the determination. FBH may consider using the extension process to avoid issuing a denial and allow the provider additional time to submit the required information.	
	Required Actions: None	
42CFR438.210(a)(3)(ii) Contract: II.J.a..d.2	6. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Determination Criteria policy described the use of FBH's UM criteria. During the review period, the UM criteria used was the FBH-developed FlexServ criteria. During the current FY, FBH is transitioning to the LOCUS/CALOCUS criteria for UM determinations. The criteria were defined in the UM program description. The on-site record review demonstrated that decisions to deny or limit services were not based solely on diagnosis or condition (i.e., developmental disability). Instead, the decisions were based on lack of a covered diagnosis, a request for noncovered services, or lack of medical necessity. FBH staff reported that the executive director had received no direct calls related to denials of service to developmentally disabled individuals and that any complaints regarding that issue would be processed using the grievance system processes.	
	Required Actions: None	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(a)(3)(iii) Contract: II.J.a.d.3	7. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Utilization Determination Criteria policy described the process of utilization review for the purpose of utilization control and the use of medical necessity review to ensure that services provided are consistent with clinical practice guidelines.	
	Required Actions: None	
42CFR438.210(b)(3) Contract: II.J.a.f	8. The Contractor's written policies and procedures include the provision 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 be 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 Notice of Action letters reviewed on-site provided the member the name of the person who had made the decision. Most of the decisions for the cases reviewed were made by a physician. One notice of action reviewed indicated that an LCSW had made the decision to deny inpatient hospitalization. FBH staff reported that it is FBH's policy that only physicians may deny inpatient services and that typically the UM coordinator would consult with the medical director. The record did not reflect that the medical director had been consulted; however, 9 of 10 records in the on-site review did.	
	Required Actions: FBH must ensure 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 be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.	

Component 2—Notices of Action: Partial Review of Standard I—Authorizations and Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.210(c) Contract: II.J.a.h	9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. (Notice to the provider does not need to be in writing.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Notice of Action—Routine policy described the process for notifying both the member and the provider in writing. The on-site record review demonstrated that notices of action were copied to the requesting provider.	
	Required Actions: None	

Results for Notices of Action							
Total	Met	=	5	X	1.00	=	5
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	0	X	N/A	=	N/A
Total Applicable		=	9	**Total Score**		=	5

Total Score ÷ Total Applicable	=	56%

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(a) Contract: Exhibit G—8.209.1	1. The Contractor has a system in place that includes an appeal process and access to the State fair hearing process.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance System: Grievances and Appeals policy described FBH's policies and process pertaining to appeals and the State fair hearing process. Members were informed about the processes in the member handbook. Providers were informed via the provider manual. The on-site record review of member appeals demonstrated that members had access to the appeals and State fair hearing processes.	
	Required Actions: None	
42CFR438.400(b) Contract: Exhibit G—8.209.2	2. The Contractor defines an appeal as a request for review of an action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance System policy, the grievance information in the provider manual and the member handbook, and the Medicaid Grievance and Appeal Guide included the BBA-compliant definition.	
	Required Actions: None	
42CFR438.402(b)(1) Contract: Exhibit G—8.209.1	3. The Contractor has provisions for who may file: ◆ A member may file a PIHP-level appeal and may request a State fair hearing. ◆ A provider, acting on behalf of a member and with the member's written consent, may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member. (The State permits the provider to act as the member's authorized representative.)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance System policy indicated that members and any person a member asks to represent him or her has access to the grievance system process. The Medicaid Grievance and Appeal Guide informed members and providers that a DCR may be a provider and that members and providers may file appeals and request a State fair hearing.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
	Required Actions: None	
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.F	4. The member may file an appeal either orally or in writing and must follow an oral request with a written request (unless the request is for expedited resolution).	☐ Met ☐ Partially Met ☐ Not Met ☐ N/A ☒ Not Scored
	Findings: The Grievance System policy stated that members may file an appeal in writing, by phone, or in person, as does the Medicaid Grievance and Appeal Guide. None of FBH's policies specifically addressed the requirement to follow oral requests with written requests. The BBA requires oral requests for an appeal to be followed by a written request. The Department will send a clarification to the BHOs regarding this requirement.	
	Required Actions: None	
42CFR438.402(b)(2) Contract: Exhibit G—8.209.4.B	5. An appeal may be filed 20 calendar days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance System policy and Medicaid Grievance and Appeals Guide both included the 20-calendar-day filing time frame. The time frame was also included in the member handbook.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.402(b)(3) Contract: Exhibit G—8.209.4.N	6. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing 20 days from the date of the notice of action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The member handbook and the Grievance System policy each stated that members may pursue the FBH appeal and State fair hearing processes concurrently. The Medicaid Grievance and Appeal Guide included information that the two processes may be pursued concurrently and encouraged members to request a State fair hearing at the same time they request an FBH appeal due to the 20-day time frame to request the State fair hearing.	
	Required Actions: None	
42CFR438.406(a) Contract: Exhibit G—8.209.4.C	7. In handling appeals, the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance System policy included the process for providing assistance or interpretation services during the appeal process. Both the member handbook and the Medicaid Grievance and Appeal Guide informed members that assistance is available. The appeals records reviewed on-site contained documentation of assistance provided to members during the appeal process.	
	Required Actions: None	
42CFR438.406(a) Contract: Exhibit G—8.209.4.D	8. The Contractor acknowledges each appeal in writing within two working days of receipt, unless expedited resolution is requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance System policy included the process for acknowledging appeals within two working days of receiving the appeal. The Grievance and Appeal Guide informed members that they would receive an appeal acknowledgment within two working days. The on-site review of appeal records demonstrated that in all four records reviewed, the acknowledgment letter was sent within two working days of the receipt of the appeal.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.406(a) Contract: Exhibit G—8.209.4.E	9. The Contractor ensures that the individuals who make decisions on appeals are individuals who: ◆ Were not involved in any previous level of review or decision making. ◆ Have the appropriate clinical expertise in treating the member's condition or disease if they are deciding an appeal of a denial based on lack of medical necessity or an appeal of a denial that involves any clinical issues.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The provision was in the Grievance System policy and members were informed in the Grievance and Appeal Guide. The on-site record review of appeals demonstrated that FBH had an effective system for ensuring that individuals who made decisions on appeals were individuals who were not involved in any previous level of review or decision making, and had the appropriate clinical expertise in treating the member's condition or disease. The resolution letters were written by the individual making the decision and specifically informed members that he or she had not been previously involved in the case.	
	Required Actions: None	
42CFR438.406(b) Contract: Exhibit G—8.209.4.G—I	10. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution. ◆ The member a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records and any other documents considered during the appeals process. ◆ That either of the following individuals are included as parties to the appeal: ▪ The member and his or her representative ▪ The legal representative of a deceased member's estate	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: Members were informed in the member handbook and the Grievance and Appeal Guide that they or their representative may present evidence or information in writing or in person and may review the case file. The on-site review of appeal records demonstrated that	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
	the date of the oral inquiry was used as the appeal filing date and that members and their representatives were provided the opportunity to present evidence and to review the case file.	
	Required Actions: None	
42CFR438.408(b)&(d) Contract: Exhibit G—8.209.4.J	11. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, 10 working days from the day the Contractor receives the appeal ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: Time frames were included in the Grievance System policy and the Grievance and Appeals Guide. Four appeal records were reviewed on-site. Three of the four records met the required time frame for resolution and notice to the member.	
	Required Actions: FBH must ensure that it meets required time frames for resolution of appeals and notification to the member.	
42CFR438.408(c) Contract: Exhibit G—8.209.4.K & 8.209.5.E	12. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if either: ◆ The member requests the extension. ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance and Appeal Guide included a process for extending the time frame for resolution of standard appeals, but not for extending the time frame for resolution of expedited appeals. Similarly, the Grievance System policy only included the process for extending the time frame for resolution of standard appeals, not the process for extending the timeframe for resolution of expedited appeals. The on-site record review indicated that FBH did use the extension process when it was determined to be in the member's best interest. There were no expedited appeals in the record review sample.	
	Required Actions: FBH must revise applicable policies and member materials to include a process for extending the time frames for resolution of expedited appeals when the member requests the extension or when FBH shows the need for additional information and that the extension would be in the member's interest.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.408(b)(3) Contract: Exhibit G—8.209.4.K & 8.209.5.E	13. If the Contractor extends the time frames, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the Grievance System policy and the Grievance and Appeal Guide. In two cases reviewed during the on-site review of appeal records the time frames for resolution were extended. In both cases, FBH provided written notice to the member.	
	Required Actions: None	
42CFR438.408(d) Contract: Exhibit G—8.209.4.L	14. For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the Grievance System policy and the Grievance and Appeal Guide. There were no examples of expedited appeals in the on-site record review.	
	Required Actions: None	
42CFR438.408(e) Contract: Exhibit G—8.209.4.M	15. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: ▪ The right to request a State fair hearing and how to do so. ▪ The right to request that benefits continue while the hearing is pending and how to make the request. ▪ That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the Grievance System policy and the Grievance and Appeal Guide. The resolution notices sent to	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
	members that were reviewed on-site included all of the required information. All template letters included all of the required information. FBH may consider developing a template for decisions in favor of the member to not include State fair hearing rights. In addition, template resolution letters used for each of the records reviewed included information about the HB 1116 process. FBH may consider customizing letters so as not to include information that is not pertinent to the member's case.	
	Required Actions: None	
42CFR438.410 Contract: Exhibit G—8.209.4.P—R	16. 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 regain maximum function. The Contractor's expedited review process includes the following: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: ▪ Transfer the appeal to the time frame for standard resolution. ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two calendar days.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievance and Appeal policy, the member handbook, and the Grievance and Appeal Guide described the process if a member requests an expedited resolution of an appeal. None of the documents described the process for FBH to determine that an expedited resolution is needed, nor did they included the procedure for notifying a member in writing if the member's request to expedite the resolution is denied.	
	Required Actions: FBH must clarify applicable policies and member materials to describe all required processes related to the expedited review process for appeals.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.414 Contract: Exhibit G—8.209.3.B	17. The Contractor must provide the information about the grievance system specified in 42CFR438.10 to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The right to file grievances. ◆ The right to file appeals. ◆ The right to a State fair hearing. ◆ The requirements and time frames for filing grievances and appeals. ◆ The method for obtaining a State fair hearing. ◆ The rules that govern representation at the State fair hearing. ◆ The availability of assistance filing a grievance, an appeal, or requesting a State fair hearing. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone. ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for a State fair hearing is filed within the time frames specified for filing. ◆ The fact that, if benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal is pending if the final decision is adverse to the member. ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The CMHC service agreement bound the CMHCs to the provisions in the provider manual and the member handbook and specified the information on the grievance system. The FBH provider agreement bound IPN providers to the provider manual, which included the member handbook. The Grievance and Appeal Guide included all required information regarding grievances and appeals.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.416 Contract: Exhibit G—8.209.3.C	18. The Contractor maintains records of all appeals and submits quarterly reports to the Department.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: FBH's quarterly grievance and appeal reports, appeal logs, and case-specific appeal records reviewed on-site demonstrated compliance.	
	Required Actions: None	
42CFR438.420(b) Contract: Exhibit G—8.209.2 & 8.209.4.S	19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action ▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievances and Appeals policy included all of the above provisions; however, the policy did not define the timely filing of an appeal related to the termination of services as filing within 10 days of the notice of action or the date of the intended action. A notice of action that was sent to a member (as evidenced by a record review on-site) stated that benefits would continue if the member filed an appeal within 20 calendar days of the notice of action.	
	Required Actions: FBH must revise applicable policies and other materials to accurately reflect the required time frames for filing appeals and continuing benefits when a notice of action is related to the termination, suspension, or reduction of previously authorized services.	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.420(c) Contract: Exhibit G—8.209.4.T	20. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal ◆ Ten days pass after the Contractor mails the notice providing the resolution of the appeal against the member, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached ◆ A State fair hearing officer issues a hearing decision adverse to the member ◆ The time period or service limits of a previously authorized service has been met	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Grievances and Appeals policy included the time frames for continuation of benefits during the appeal or State fair hearing processes. Members were notified in the Grievance and Appeal Guide. FBH may consider including the information in the appropriate notices of action and appeal resolution letters.	
	Required Actions: None	
42CFR438.420(d) Contract: Exhibit G—8.209.4.U	21. If the final resolution of the appeal is adverse to the member—that is, it upholds the Contractor's action—the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this rule.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the template letter, the Grievances and Appeals policy, and the Grievance and Appeal Guide.	
	Required Actions: None	

Component 3—Appeals: Partial Review of Standard VI—Grievance System		
References	**Requirement**	**Score**
42CFR438.424 Contract: Exhibit G—8.209.4.V	22. If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the template letter, the Grievances and Appeals policy, and the Grievance and Appeal Guide.	
	Required Actions: None	
42CFR438.424 Contract: Exhibit G—8.209.4.W	23. If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: This provision was included in the template letter, the Grievances and Appeals policy, and the Grievance and Appeal Guide.	
	Required Actions: None	

Results for Appeals							
Total	Met	=	18	X	1.00	=	18
	Partially Met	=	4	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	1	X	N/A	=	N/A
Total Applicable		=	22	**Total Score**		=	18

Total Score ÷ Total Applicable	=	82%

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
42CFR438.240(b)(3) Contract: II.I.e	1. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: The Quality Improvement Program Evaluation and the Utilization Management Program Evaluation described FBH's performance indicators and utilization measures. Examples were ER visits per 1,000, outpatient visits, hospital admissions per 1,000, follow-up after hospitalization, and hospital recidivism. The data included services provided by the IPN as well as the CMHCs.	
	Required Actions: None	
UM Criteria – Section IV	2. The Contractor has policies and procedures outlining the activities undertaken to specifically identify and address underutilization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: In addition to analyzing follow-up after discharge from inpatient care and comparing this measure to recidivism and ER visit measures, during the review period, FBH tracked the number of visits used compared to the number of visits authorized. This measure was based on FBH's FlexServ UM criteria. Since the review period, FBH had transitioned to using the LOCUS/CALOCUS UM system. Measures in development at the time of the site review using the LOCUS/CALOCUS system included level-of-care (LOC) authorizations by diagnosis and provider type. FBH also planned to analyze data, including the penetration rate by age group. FBH reported that it had procedures for missed appointments, which included requirements for follow-up by a therapist. Staff also indicated that in the future FBH will develop an indicator and the ability to track data regarding follow-up after missed appointments.	
	Required Actions: None	

Component 4 —Underutilization: Partial Review of Standard X—Quality Assessment and Performance Improvement		
References	**Requirement**	**Score**
UM Criteria – Section IV	3. The Contractor's policies and procedures include the mechanism for routine trending and analysis of data by levels of care and by provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: FBH had data capability to trend by level of care, type of service, and provider group. The UM reports compared data by IPN providers and the CMHCs (as single, organizational providers).	
	Required Actions: None	
UM Criteria – Section IV	4. Trending includes services prior authorized and not prior authorized.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
	Findings: FBH staff reported that all services except emergency services, including any outpatient services provided by the CMHCs, required authorization. Therefore, data trending included authorized and nonauthorized services.	
	Required Actions: None	

Results for Underutilization							
Total	Met	=	4	X	1.00	=	4
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable or Not Scored	=	0	X	N/A	=	N/A
Total Applicable		=	4	**Total Score**		=	4

Total Score ÷ Total Applicable	=	100%

The completed notice of action record review tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Foothills Behavioral Health, LLC

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	March 2, 2009
Reviewer:	Rachel Henrichs, Barbara McConnell
Participating BHO Staff Member:	Jodie Collins, Donald Bechtold, Barbara Smith

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons Were Easy to Understand	Decision Made by Qualified Clinician	Notice Included all Required Content
1	XXXXX	7/10/07	7/23/07	13	M ☐ N ☒ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The request was for day treatment services. The decision to deny services, based on lack of medical necessity, was made by a medical doctor. The record indicated that FBH mailed the notice of action four days after it made the decision. If FBH had mailed the notice of action the day it made its decision, the notice would have been sent within the required time frame.										
2	XXXXX	8/9/07	8/21/07	12	M ☐ N ☒ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The request for 20 days in an intensive outpatient program was approved in an amount less than requested (8 days instead of 20). This decision was made by a medical doctor.										
3	XXXXX	9/26/07	10/2/07	6	M ☒ N ☐ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The request for services was approved in an amount less than what was requested. A portion of the request was denied because it was for a noncovered service. The request was for 13 family therapy sessions and 24 sessions of services from a behavioral specialist. The family therapy was approved, and the therapy from a behavioral specialist was denied as being a noncovered service. The decision was made by a medical doctor. Although this was a request for new service, the letter listed an effective date of October 12, 2007.										
4	XXXXX	10/31/07	11/7/07	7	M ☒ N ☐ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The date of the request was not specified in the letter; however, FBH staff members were able to review other documentation to determine the request date. The denial for day treatment services was based on lack of clinical documentation needed to establish medical necessity. The decision was made by a medical doctor.										
5	XXXXX				M ☐ N ☐ N/A ☐		M ☐ N ☐ N/A ☐	M ☐ N ☐	M ☐ N ☐	M ☐ N ☐
Comments: Removed from the sample because FBH was a secondary payer.										
6	XXXXX	NA	11/14/07	NA	M ☐ N ☐ N/A ☒	11/14/07	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☐ N ☒	M ☒ N ☐
Comments: This denial was the result of concurrent review. The record indicated that the concurrent review was initiated on November 6, 2007, with a decision on November 9, 2007, to deny another authorization (following earlier authorizations for inpatient hospitalization). The notice was sent on November 14, 2007. The record indicated that the decision was made by a licensed clinical social worker (LCSW). Although it is FBH's policy that medical doctors must make decisions to deny inpatient hospitalization, the record did not contain documentation that the decision was made by a medical doctor. The template section of the letter indicated that this was a request for new service; however, because the letter included an effective date of November 24, 2007, the reviewer was lead to believe it was a reduction of a previously authorized service.										

Appendix B. Colorado Behavioral Health Organization (BHO) Actions Record Review Tool *for* Foothills Behavioral Health, LLC

1	2	3	4	5	6	7	8	9	10	11
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for all Notices		
File #	Member ID	Date of Initial Request	Date Notice Sent	Number of Days for Decision	Notice Sent Within Time Frame	Date Notice Sent	Notice Sent Within Time Frame	Reasons Were Easy to Understand	Decision Made by Qualified Clinician	Notice Included all Required Content
7	XXXXX	11/26/07	11/29/07	3	M ☒ N ☐ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The request was for residential services for a child. The request was denied by an LCSW and a medical doctor based on lack of medical necessity. A variety of alternative services were recommended to the family.										
8	XXXXX	12/3/07	12/14/07	11	M ☐ N ☒ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The request for day treatment services was denied based on lack of medical necessity. The decision was made by a medical doctor. The record indicated that FBH mailed the notice of action eight days after it made the decision. If FBH had mailed the notice of action the day it made its decision, the notice would have been sent within the required time frame.										
9	XXXXX	12/5/07	12/17/07	12	M ☐ N ☒ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The request for substance abuse treatment was denied based on it being a noncovered benefit. The record indicated that FBH mailed the notice of action seven days after it made the decision. If FBH had mailed the notice of action the day it made its decision, the notice would have been sent within the required time frame.										
10	XXXXX	12/28/07	1/14/08	17	M ☐ N ☒ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☐ N ☒	M ☒ N ☐	M ☒ N ☐
Comments: The request was for continued day treatment. The reason for the denial was not included in the notice of action. The medical director, after reviewing the file, determined that the reason was based on lack of medical necessity.										
11	XXXXX	1/15/08	1/23/08	8	M ☒ N ☐ N/A ☐	NA	M ☐ N ☐ N/A ☒	M ☒ N ☐	M ☒ N ☐	M ☒ N ☐
Comments: The member was evaluated for day treatment. This request was denied based on lack of medical necessity. FBH recommended several alternative services. The denial was made by a medical doctor.										
# Applicable Elements					9		0	10	10	10
# Compliant Elements					4		NA	9	9	10
Percent Compliant										

Legend:
M = Met
N = Not met
N/A = Not applicable

Total Applicable Elements:	**39**
Total # Compliant Elements:	**32**
Total Percent Compliant:	**82%**

Appendix C. Appeals Record Review Tool for Foothills Behavioral Health, LLC

The completed appeals record review worksheet follows this cover page.

Appendix C. Colorado Behavioral Health Organization (BHO) Appeals Record Review Tool *for* Foothills Behavioral Health, LLC

Review Period:	July 1, 2007–June 30, 2008
Date of Review:	March 2, 2009
Reviewer:	Barbara McConnell
Participating BHO Staff Member:	Hazel Bond

1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	**Member ID**	**Date Appeal Received**	**Evidence of Reasonable Assistance**	**Date of Acknow-ledgment Letter**	**Acknow-ledgment Within 2 Working Days**	**Decision-maker—Previous Level**	**Decision-maker—Clinical Expertise**	**Expedited**	**Time Frame Extended**	**Date Resolution Letter Sent**	**Resolved in Time Frame**	**Resolution Notice Included Required Content**	**Resolution Notice Was Easy to Understand**
1	XXXXX	3/31/2008	M☒ N☐ U☐	4/2/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	4/22/08	M☐ N☒	M☒ N☐	M☒ N☐
Comments: The denial was for a request for day treatment at the Children's Hospital. The services were for a rare genetic disorder (Smith-Magenis Syndrome), which FBH determined not to be a covered service under the Medicaid capitation program. FBH determined that services for this diagnosis may be covered under FFS Medicaid and informed the member and the provider. The appeal was received March 31, 2008. The resolution was due April 14, 2008. The appeal was not completed by April 14, 2008. An extension letter was sent April 16, 2008, requesting an extension of 14 days. The letter indicated a new resolution due date of April 30, 2008. This was an incorrect calculation and should have indicated a due date of April 28. While the final resolution and notification was sent within this time frame, the timeliness requirement was not met as the extension letter was due by April 14, 2008. The resolution letter specifically informed the member that the reviewer was not involved in any previous level of review. The reason for the decision was very detailed and member-specific rather than using only template language.													
2	XXXXX	3/26/08	M☒ N☐ U☐	3/27/08	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	4/23/08	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The original request was for continued day treatment at Community Reach Center. FBH had been approving services at the out-of-network facility for continuity-of-care purposes. The denial was issued based on an assessment that the child's mental illness had stabilized and the child no longer needed day treatment services. The appeal was filed March 26, 2008; therefore, a resolution was due April 9, 2008. An extension letter was sent April 9, 2008. The letter indicated that the new due date for resolution was April 24, 2008. This was an incorrect calculation and should have indicated that the due date was now April 23, 2008. The resolution letter was sent April 23, 2008, and, therefore, was sent within the required time frame.													
3	XXXXX		M☐ N☐ U☐		M☐ N☐	M☐ N☐ U☐	M☐ N☐ U☐	Y☐ N☐	Y☐ N☐		M☐ N☐	M☐ N☐	M☐ N☐
Comments: This record indicated that only an administrative law judge (ALJ) hearing was requested. There was no FBH-level appeal.													
4	XXXXX		M☐ N☐ U☐		M☐ N☐	M☐ N☐ U☐	M☐ N☐ U☐	Y☐ N☐	Y☐ N☐		M☐ N☐	M☐ N☐	M☐ N☐
Comments: This record indicated that only an ALJ hearing was requested. There was no FBH-level appeal. A Department representative had contacted FBH indicating that the client wished to file an appeal; however, the member never contacted FBH to file the appeal. An ALJ hearing was requested and subsequently withdrawn.													
5	XXXXX		M☐ N☐ U☐		M☐ N☐	M☐ N☐ U☐	M☐ N☐ U☐	Y☐ N☐	Y☐ N☐		M☐ N☐	M☐ N☐	M☐ N☐
Comments: This record indicated that only an ALJ hearing was requested. There was no FBH-level appeal.													
6	XXXXX	7/30/07	M☒ N☐ U☐	8/1/07	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	8/10/07	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The resolution was due August 13, 2007, and was sent August 10, 2007.													

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix C. Colorado Behavioral Health Organization (BHO) Appeals Record Review Tool *for* Foothills Behavioral Health, LLC

1	2	3	4	5	6	7	8	9	10	11	12	13	14
File #	Member ID	Date Appeal Received	Evidence of Reasonable Assistance	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame	Resolution Notice Included Required Content	Resolution Notice Was Easy to Understand
7	XXXXX	7/26/07	M☒ N☐ U☐	7/27/07	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	8/9/07	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The member requested several changes to her treatment, which were denied due to lack of medical necessity. The resolution was due August 9, 2007, and was sent August 9, 2007.													
# Applicable Elements			4		4	4	4				4	4	4
# Compliant Elements			4		4	4	4				3	4	4
Percent Compliant													

Legend:
M = Met
N = Not met or No
U = Unable to determine
Y = Yes

Total # Applicable Elements	**28**
Total # Compliant Elements	**27**
Total Percent Compliant	**96%**

Table D-1 lists the participants in the FY 2008–2009 site review of **FBH**.

Table D-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
Rachel Henrichs	Project Coordinator
FBH Participants	**Title**
Don Bechtold	Medical Director
Kiara Marienau	Postdoctoral fellow—Quality Improvement
Barbara Smith	Director, Quality Assessment and Performance Improvement
Deanna Ryerson	Quality Improvement and Research Coordinator
Donald Rohner	Executive Director
Michael Smithson	Business and Data Analyst
Mel Conley	Data Analyst
Linda Runyon	Community Liaison
Hazel Bond	Director, Office of Consumer and Family Affairs
Jodie Collins	Utilization Management
Nancy Bensik	Utilization Management
Marilyn Gaipa	Utilization Management
Dennis Armstrong	Director, Provider Network
Department Observers	**Title**
Jerry Ware	Quality Compliance Specialist
Marceil Case	Behavioral Health Specialist

Appendix E. Corrective Action Plan Process for FY 2008–2009 for Foothills Behavioral Health, LLC

FBH is required to submit to the Department a CAP for all elements within each component scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each element that requires correction, the health plan should identify the planned interventions to achieve compliance with the requirement(s) and the timeline for completion. Supporting documents should not be submitted and will not be considered until the plan has been approved by the Department. Following Department approval, the BHO must submit documents per the timeline that was approved.

Table E-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 via e-mail or the file transfer protocol (FTP) site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must address the planned intervention(s) to complete the required actions, and the timeline(s) for the intervention(s).
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, the BHO must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	The Department will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan, or ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the plan, the BHO should implement all the planned interventions and submit evidence of such intervention to HSAG via e-mail or the FTP site with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table E-1—Corrective Action Plan Process	
Step 6	**Documentation substantiating implementation of the plans is reviewed and approved**
	Following a review of the CAP and all supporting documentation, the Department will inform the BHO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the BHO must submit additional documentation. The Department 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.

The template for the CAP follows.

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
2. Notices of Action 1. The Contractor defines action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals. **Findings:** The definition of action in FBH's policies (Action Recommendation—Routine,	FBH must revise policies and other applicable documents to include a complete definition of action.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
Notice of Action—Routine, and Notice of Action—Expedited) was incomplete. The denial, in whole or in part, of payment for a service was missing from all policies. The policies included "the failure to act within required time frames" but did not specify that the time frames are related to the resolution of grievances and appeals. Provider and member materials contained the same definition that was in the policies.				
2. Notices of action must meet the language and format requirements of 42CFR438.10 and ensure ease of understanding. **Findings:** There were two notice-of-action letters in the record review that indicated an effective date of 10 days in the future, even though the type of action was either a denial or limited authorization of a requested service. This made the letter difficult to	FBH must ensure that notices of action have correct information regarding timelines and types of action taken.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
understand as a future effective date was not applicable and apparently not related to an actual date that the action was effective.				
4. The notice of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized, Medicaid-covered services, at least 10 days before the date of action (unless extenuating circumstances exist—found in Exhibit G) ◆ For denial of payment, at the time of any action affecting the claim ◆ For standard service authorization decisions that deny or limit service, within 10 calendar days ◆ For service authorization decisions not reached within 10	FBH must ensure that notices of action are sent within the required time frames. FBH must also revise any applicable policies to include the time frame for sending the notice of action related to a denial (in whole or in part) of payment for services.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
calendar days, on the date the time frames expire ◆ For expedited service authorization decisions, within three days **Findings:** The Notices of Action—Routine and Notices of Action—Expedited policies described each of the applicable time frames except for the time frame for sending a notice related to the denial of payment The on-site record review indicated that five of the records for which this element was applicable were out of compliance with the required time frame for sending notices of action.				
8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is	FBH must ensure 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 be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
less than requested be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. **Findings:** One notice of action reviewed indicated that an LCSW had made the decision to deny inpatient hospitalization.				
3. Appeals 11. The Contractor must resolve each appeal and provide written notice of the disposition as expeditiously as the member's health condition requires: ◆ For standard resolution of appeals, 10 working days from the day the Contractor receives the appeal ◆ For expedited resolution of an appeal and notice to affected parties, three working	FBH must ensure that it meets required time frames for resolution of appeals and notification to the member.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
days after the Contractor receives the appeal Only three of the four records reviewed onsite met the required time frame for resolution and notice to the member.				
12. The Contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if either: ◆ The member requests the extension. ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest. **Findings:** The Grievance and Appeal Guide included a process for extending the time frame for resolution of standard appeals, but not for extending the time	FBH must revise applicable policies and member materials to include a process for extending the time frames for resolution of expedited appeals when the member requests the extension or when FBH shows the need for additional information and that the extension would be in the member's interest.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
frame for resolution of expedited appeals. Similarly, the Grievance System policy only included the process for extending the time frame for resolution of standard appeals, not the process for extending the timeframe for resolution of expedited appeals.				
16. 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 regain maximum function. The Contractor's expedited review process includes the following: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal ◆ If the Contractor denies a request for	FBH must clarify applicable policies and member materials to describe all required processes related to the expedited review process for appeals.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
expedited resolution of an appeal, it must: ▪ Transfer the appeal to the time frame for standard resolution. ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two calendar days. **Findings:** None of the documents described the process for FBH to determine that an expedited resolution is needed, nor did they included the procedure for notifying a member in writing if the member's request to expedite the resolution is denied.				

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
19. The Contractor continues the member benefits if: ◆ The member or the provider files timely—defined as on or before the later of the following: ▪ Within 10 days of the Contractor mailing the notice of action ▪ The intended effective date of the proposed action ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits.	FBH must revise applicable policies and other materials to accurately reflect the required time frames for filing appeals and continuing benefits when a notice of action is related to the termination, suspension, or reduction of previously authorized services.			

Table E-2—FY 2008–2009 Corrective Action Plan *for* FBH				
Site Review Component	**Required Actions**	**Planned Intervention**	**Date Completed**	**Documents Submitted as Evidence of Completion**
Findings: The Grievances and Appeals policy did not define the timely filing of an appeal related to the termination of services as filing within 10 days of the notice of action or the date of the intended action.				

Appendix F. Compliance Monitoring Review Activities for Foothills Behavioral Health, LLC

The following table describes the activities performed throughout the compliance monitoring process. The activities listed below are consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*, February 11, 2003.

Table F-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
Activity 1:	**Planned for Monitoring Activities**
	Before the compliance monitoring review: ◆ HSAG and the Department held teleconferences to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff provided an orientation on October 3, 2008, for the BHO and the Department to preview the FY 2008–2009 compliance monitoring review process and to allow the BHOs to ask questions about the process. HSAG reviewed the processes related to the request for information, CMS' protocol for monitoring compliance, the components of the review, and the schedule of review activities. ◆ HSAG assigned staff to the review team. ◆ HSAG provided a presentation to the Department and the BHOs on January 27, 2009, titled "Developing and Implementing Corrective Action Plans." In this presentation, HSAG reviewed the timeline and requirements for the corrective action plan process. ◆ Prior to the review, HSAG representatives responded to questions from the BHO related to the process and federal managed care regulations to ensure that the BHO was prepared for the compliance monitoring review. HSAG maintained contact with the BHO as needed throughout the process and provided information to the BHO's key management staff members about review activities. Through this telephone and/or e-mail contact, HSAG responded to the BHO's questions about the request for documentation for the desk audit and about the on-site review process.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the BHO's contract, dated March 1, 2007, to develop the monitoring tool, desk audit request, on-site agenda, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval.
Activity 3:	**Reviewed Documents**
	◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the desk audit request and sent a documentation request form and an on-site agenda. The BHO had 30 days to provide all documentation for the desk audit. The desk audit request included instructions for organizing and preparing the documents related to the review of the four components. ◆ Documents requested included applicable policies and procedures, minutes of key BHO committee or other group meetings, reports, logs, and other documentation.

Table F-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG…**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected additional documents. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature.) ◆ HSAG requested and reviewed additional documents needed that HSAG identified during its desk audit. ◆ HSAG requested and reviewed additional documents needed that HSAG identified during the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with BHO staff to provide an overview of preliminary findings of the review. ◆ HSAG used the FY 2008–2009 Site Review Report to compile the findings and incorporate information from the pre-on-site and on-site review activities. ◆ HSAG analyzed the findings and assigned scores. ◆ HSAG determined opportunities for improvement based on the review findings. ◆ HSAG determined actions required of the BHO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2008–2009 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG coordinated with the Department to incorporate the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG coordinated with the Department to incorporate the BHO's comments and finalize the report. ◆ HSAG distributed the final report to the BHO and the Department.