

Colorado Medicaid
Community Mental Health Services Program

FY 2009–2010 SITE REVIEW REPORT
for
**Foothills Behavioral Health
Partners, LLC**

April 2010

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



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1. Executive Summary

for Foothills Behavioral Health Partners, LLC

Overview of FY 2009–2010 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 (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations, contractual requirements, and each state's quality strategy. The Colorado 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 sixth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2009–2010 site review process, the Department requested a review of seven areas of performance. For its review of **Foothills Behavioral Health Partners, LLC (FBHP)**, HSAG developed a review strategy consisting of seven standards that it had not reviewed within the previous two fiscal years. The areas chosen for review were Standard I—Emergency and Poststabilization Services (a subset of Standard I—Coverage and Authorization of Services); Standard IV—Member Rights and Protections; Standard VI—The Grievance System (Grievances Only); Standard VII—Provider Participation and Program Integrity; Standard VIII—Credentialing and Recredentialing; Standard IX—Subcontracts and Delegation; and Standard X—Quality Assessment and Performance Improvement. Compliance with federal regulations was evaluated through review of the seven standards. This report documents results of the FY 2009–2010 site review activities for the review period—July 1, 2009, through January 21–22, 2010 (the date of the on-site review). Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Appendices A and B contain details of the findings.

Methodology

In developing the data collection tools and in reviewing the seven standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions that were issued June 14, 2002, and were effective August 13, 2002. To determine compliance, HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key BHO personnel. Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. Details of the review of the seven standards are in Appendix A. Details of the on-site grievance record review are in Appendix B.

The seven standards chosen for the FY 2009–2010 site reviews represent a portion of the requirements based on Medicaid managed care requirements. The remainder of Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination of Care, Standard V—Member Information, and the remainder of Standard VI—the Grievance System, will be reviewed in subsequent years.

The site review processes were consistent with the February 11, 2003, Centers for Medicare & Medicaid Services (CMS) final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs)*. Appendix E contains a detailed description of HSAG's site review activities by activity, as outlined in the CMS final protocol.

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 seven areas of review.
- ◆ Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal health care regulations in the standard areas reviewed.
- ◆ The quality and timeliness of, and access to, 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

Based on the results from the Compliance Monitoring Tool and conclusions drawn from the review activities, HSAG assigned each element within the standards in the Compliance Monitoring Tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any individual element within the Compliance Monitoring Tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations to enhance some elements, regardless of the score. While HSAG provided recommendations for enhancement of BHO processes based on these identified opportunities for improvement, for requirements that may have been scored *Met*, these recommendations do not represent noncompliance with contract or BBA regulations at this time.

Table 1-1 presents the score for **FBHP** for each of the standards. Details of the findings for each standard are in Appendix A.

Table 1-1—Summary of Scores for the Standards								
Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
I	Emergency and Poststabilization Services	9	9	9	0	0	0	100%
IV	Member Rights and Protections	6	6	6	0	0	0	100%

Table 1-1—Summary of Scores for the Standards								
Standard #	Description of Standard	# of Elements	# of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Score (% of Met Elements)
VI	The Grievance System (Grievances Only)	13	13	10	3	0	0	77%
VII	Provider Participation and Program Integrity	8	8	8	0	0	0	100%
VIII	Credentialing and Recredentialing	39	39	39	0	0	0	100%
IX	Subcontracts and Delegation	6	6	6	0	0	0	100%
X	Quality Assessment and Performance Improvement	12	12	12	0	0	0	100%
Totals		93	93	90	3	0	0	97%

2. Summary of Performance Strengths and Required Actions *for Foothills Behavioral Health Partners, LLC*

Overall Summary of Performance

FBHP received an overall percentage-of-compliance score of 97 percent. HSAG identified three areas within the Grievance System (grievances only) standard that required follow-up corrective action, reflected by a score of 77 percent. However, for all six of the remaining standards HSAG reviewed, **FBHP** received overall scores of 100 percent, which indicates a comprehensive understanding of the managed care requirements set forth in the BBA. **FBHP**'s policies and procedures were comprehensive, easily understood, and presented in an organized manner. During the on-site interviews, **FBHP** staff members were able to clearly articulate procedures followed, which corroborated the policies and procedures.

Standard I—Emergency and Poststabilization Services

Summary of Findings and Opportunities for Improvement

FBHP delegated utilization management, including the authorization and adjudication of emergency and poststabilization services, to ValueOptions (VO). VO had clear and concise policies and procedures that were consistent with BBA requirements. **FBHP** demonstrated that it had effective processes in place to ensure that emergency services were provided without prior authorization and that members were not held liable for payment for emergency behavioral health care. **FBHP** included information regarding the availability of emergency and poststabilization services, including the fact that members were not to receive a bill for crisis services, in the **FBHP** Member Handbook.

Summary of Strengths

VO (as **FBHP**'s delegate) had comprehensive policies in place to provide staff guidance regarding the provision of emergency and poststabilization services. VO took steps to monitor closely the appropriateness of any denied emergency claims. One strategy used by **FBHP**, for example, was to conduct a second-level physician review of denied emergency claims to ensure that claims were approved for any member with a psychiatric diagnosis. In addition, **FBHP** made user-friendly information regarding how to access crisis care available to members as part of the **FBHP** Member Handbook.

Summary of Required Actions

There were no corrective actions required for this component.

Standard IV—Member Rights and Protections

Summary of Findings and Opportunities for Improvement

FBHP addressed member rights, including all those required by the Code of Federal Regulations (CFR) at 42 CFR 438, in **FBHP**'s Member Rights and Privacy of Protected Health Information policies. Information regarding member rights and protections was also communicated to members through the **FBHP** Member Handbook, posters, and a flyer provided to new enrollees. The Office of Member and Family Affairs (OMFA) was responsible for overseeing staff training on member rights and for monitoring any violation of federal or state rights, including the protection of member confidentiality or the handling of protected health information (PHI). **FBHP** monitored provider performance in the area of member rights and protections through the use of chart reviews, member satisfaction surveys, and a review of any trends in grievances and appeals related to member rights.

Summary of Strengths

FBHP communicated information regarding member rights and protections in easy-to-understand language in the **FBHP** Member Handbook, flyers, and posters. The Director of OMFA coordinated closely with the quality improvement director and medical director regarding any grievances and appeals related to member rights as part of the quality improvement process. **FBHP** had a comprehensive member rights training program in place for staff at its partner mental health centers.

Summary of Required Actions

There were no corrective actions required for this component.

Standard VI—The Grievance System (Grievances Only)

Summary of Findings and Opportunities for Improvement

The **FBHP** grievance policies and procedures clearly defined the BHO's process by which the member or his or her designated representative may file grievances orally and in writing. The **FBHP** Member Handbook and **FBHP** Provider Handbook demonstrated **FBHP**'s communication of the grievance process, required time frames for filing grievances, methods by which members may file grievances, and members' rights as they pertain to grievances and State fair hearings to members and providers.

The grievance file review provided evidence that: **FBHP** provided written acknowledgment of a grievance to the member within two working days of receipt of the grievance for 9 of the 10 files reviewed, **FBHP** staff who processed the grievance were not involved in any previous level of the review, **FBHP** provided written disposition of a grievance to the member within 15 working days from the date the grievance was received for 9 of the 10 files reviewed, and when staff required additional time to collect information for a grievance, which was in the member's best interest, **FBHP** staff notified the member in writing to extend the timeline to resolve the grievance. The notice of extension also contained the reason for the delay.

Of the 10 grievance files reviewed, 5 of the grievances involved a clinical issue. However, 2 of the 5 grievances that involved a clinical issue did not provide evidence that a decision was rendered by a staff person with the appropriate clinical expertise to make a decision on the grievance. All 10 files contained a notice of resolution. However, 1 grievance notice did not describe the results of the grievance process or investigation and, therefore, did not contain the required content.

Summary of Strengths

FBHP had comprehensive written policies and procedures that accurately addressed the BBA requirements related to grievances. **FBHP** had processes in place to ensure that the BHO communicated its policies and procedures related to grievances to its providers, subcontractors, and members. The grievance acknowledgment letters were written in a clear and understandable format and included all of the required content.

Summary of Required Actions

FBHP should ensure that it acknowledges all grievances within two working days of their receipt and that the individuals who make decisions on grievances involving clinical issues have the appropriate level of expertise in treating the member's condition. **FBHP** should ensure that it investigates and resolves all grievances, that the BHO provides notice of disposition to the member within 15 working days of receiving a grievance, and that all grievance notices include the results of the disposition/resolution process.

Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

FBHP received an overall score of 100 percent compliance with provider participation and program integrity standards. The **FBHP** Provider Network Delegation policy detailed the delegation of provider networking and contracting from **FBHP** to VO. The provider agreements, contract amendments, and policies contained the required provisions that the BHO would not prohibit or otherwise restrict a health care professional acting within the scope of his or her practice from advising or advocating on behalf members, that members may not be held liable for payments to providers, and that the BHO did not contract with providers excluded from participation in federal health care programs. The **FBHP** Member Handbook contained the provision that **FBHP** did not deny services based on moral or religious grounds.

The **FBHP** Corporate Compliance Plan and related policies demonstrated **FBHP**'s administrative procedures, which were designed to guard against fraud and abuse. The **FBHP** Corporate Compliance Plan and policies contained all of the required provisions for designating a compliance officer, training the compliance officer, compliance training for staff, internal monitoring and reporting, and responding to detected offenses.

Summary of Strengths

FBHP's description of chart audits to detect fraud and abuse and its use of corrective action when provider billing discrepancies were detected provided a comprehensive overview of the types of actions **FBHP** took to ensure compliance by the BHO and its providers with State and federal regulations.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard VIII—Credentialing and Recredentialing

Summary of Findings and Opportunities for Improvement

FBHP received an overall score of 100 percent compliance with credentialing and recredentialing standards. The **FBHP** Credentialing Manual detailed **FBHP**'s credentialing and recredentialing process, which included delegation of most of the credentialing and recredentialing activities to **FBHP**'s delegate, VO. The **FBHP** Credentialing Manual and the VO Credentialing and Recredentialing policies and procedures contained the necessary provisions for a comprehensive credentialing and recredentialing program. The committee descriptions for the Colorado Local Credentialing Committee (CLCC) and the National Credentialing Committee (NCC) described the roles and responsibilities for each of the committees to make recommendations for approving or denying credentialing or recredentialing of providers based on a comprehensive primary source verification of information provided by practitioners at the time of application.

The **FBHP** Credentialing Manual described the process whereby all partner mental health center (PMHC) staff/providers followed the same credentialing and recredentialing process used by VO, except for the final decision step, which was made by a combined committee of PMHC and **FBHP** staff, with final approval by the **FBHP** medical director. The **FBHP** Credentialing and Recredentialing Delegation policy described **FBHP**'s oversight of VO's credentialing and recredentialing program, which included verifying that VO maintained a well-defined process for credentialing, recredentialing, and contracting with licensed practitioners to provide services to members.

The BHO's credentialing and recredentialing policies described the process for evaluating and selecting providers to participate in the network and notifying providers of credentialing decisions within the required time frames. The credentialing and recredentialing process included the use of an application, completed by the practitioner, attestation from the practitioner, primary source verification, and recommendations to the medical director to approve credentialing or recredentialing of practitioners who completed the credentialing or recredentialing process and whose files were considered "clean," without any information that would lead to a denial of credentialing or recredentialing.

The BHO's credentialing and recredentialing policies listed providers' rights related to the credentialing and recredentialing process. The provider credentialing application form also provided evidence that providers were notified of their rights at the time they completed the application for credentialing or recredentialing.

Summary of Strengths

The Provider Data Sheet, which was generated from the VO NetworkConnect online provider credentialing and recredentialing database, demonstrated the BHO's clear and concise organization of provider credentialing and recredentialing information. This information came from primary source verification, verification of providers' responses on the credentialing and recredentialing

application, and recommendations to the CLCC and NCC based on information collected during the credentialing or recredentialing process.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

FBHP delegated several managed care functions to VO, including claims, clinical and utilization management services, credentialing, health information systems, provider network management, and data reporting. The BHO had a fully executed Delegation Agreement in place with VO that included a description of all delegated functions and detailed reporting requirements. The written Delegation Agreement included all elements required by the BBA and the National Committee for Quality Assurance (NCQA). To help ensure compliance with the agreement, **FBHP** conducted a predelegation assessment of VO's ability to perform all delegated functions. Also, the BHO monitored VO's performance through several activities, including data reports submitted by VO as deliverables.

Summary of Strengths

FBHP demonstrated that it closely monitored VO's performance under the Delegation Agreement through data reports, formal site reviews, and weekly meetings to address any challenges related to program implementation. The BHO also provided evidence that it actively followed up on deficiencies in delegate performance. For example, **FBHP** discussed problems related to VO's call center at a Board of Directors meeting December 1, 2009.

Summary of Required Actions

There were no corrective actions required for this component.

Standard X—Quality Assessment and Performance Improvement

Summary of Findings and Opportunities for Improvement

FBHP delegated the collection and maintenance of quality management and utilization management data to VO, including the responsibility to produce monthly and quarterly encounter/claim files and ensure the accuracy and completeness of encounter submissions. **FBHP** collected, analyzed, and reported data to the Department for a wide range of quality indicators and studies, including accessibility data, member satisfaction data, utilization metrics, and measures related to coordination of care. The BHO provided evidence that it actively used data collected to improve the quality of services provided to members and that it had a process in place to continuously evaluate the impact and effectiveness of the quality assessment and performance improvement (QAPI) program.

Summary of Strengths

FBHP had an active Quality Improvement/Utilization Management Committee in place that reviewed data for a wide variety of performance improvement measures, identified opportunities for improvement, and made recommendations regarding strategies to further enhance performance. **FBHP** also had a substantial number of clinical practice guidelines in place, including several evidence-based practices. The BHO made member- and family-friendly “tip” documents related to the guidelines available to both members and families.

Summary of Required Actions

There were no corrective actions required for this component.

3. Follow-up on FY 2008–2009 Corrective Action Plan for Foothills Behavioral Health Partners, LLC

Methodology

As a follow-up to the FY 2008–2009 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all components for which the BHO 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 2008–2009 compliance monitoring site review, or until the time of the on-site portion of the BHO's FY 2009–2010 site review.

Summary of 2008–2009 Required Actions

As a result of the FY 2008–2009 site review, Foothills Behavioral Health (FBH) was required to develop a plan of corrective action to address deficiencies in the areas of notices of action and appeals.

The definition of an action included in FBH's policies and member materials was incomplete. FBH was required to 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 results of the on-site review of notice of action records, FBH was required to:

- ◆ Ensure that it mails all notices of action within 10 days of receiving a request for services.
- ◆ Ensure that each notice 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.

Based on the results of the on-site review of appeal records, FBH was required to ensure that appeals are resolved and notification sent within the required time frames.

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 best interest of the member.

FBH described an expedited review process in its policies and member materials; however, the process did not include the procedure for notifying members in writing if a 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.

Summary of Corrective Action/Document Review

FBH submitted its CAP to HSAG and the Department in June 2009. After review of the proposed plan, HSAG and the Department determined that, if implemented as written, the plan would successfully address all required actions. HSAG and the Department approved FBH's CAP in July 2009 and asked that FBH submit evidence that the plan had been implemented by August 31, 2009.

In July 2009, FBH partnered with VO to form **Foothills Behavioral Health Partners (FBHP)**. In August 2009, FBH/FBHP submitted documentation to demonstrate implementation of the proposed CAP. HSAG and the Department carefully reviewed all documentation and determined that all required actions had been addressed.

Summary of Continued Required Actions

FBHP successfully completed the FY 2008–2009 required actions. There were no required actions continued from FY 2008–2009.

Appendix A. **Compliance Monitoring Tool** *for* **Foothills Behavioral Health Partners, LLC**

The completed compliance monitoring tool follows this cover page.

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Foothills Behavioral Health Partners, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.114(a)	1. The Contractor defines Emergency Medical Condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ◆ Serious impairment to bodily functions ◆ Serious dysfunction of any bodily organ or part	Documents Submitted/Location Within Documents: 270L Emergency and Post-Stabilization Services Policy_I.pdf (see Pages 2-3, Section IV.A defines Emergency Medical Condition) - FBHPartners Member Handbook 101409.pdf (Misc folder – Page 7, 11 provides definition of emergency medical condition and instructs members on how to access emergency services) - C214 Member Request Policy.pdf (see Pages 2-5, Section V.B.1-5, and V.C.1 - discusses protocols for VO staff to direct members to the nearest facility to obtain services in any life-threatening emergency) - Provider Handbook (Misc folder – Page 14 of the .pdf file defines Emergency Medical Condition for providers) - UM delegation policy final 2009.doc (entire document specifies FBHPartners delegates UM program responsibilities to ValueOptions – relevant for all elements in this standard) - Delegation agreement – executed 0912.pdf (see in Standard IX Subcontracts and Delegation folder – pg 2 Article II 2.02b & a; pg 6-7 Exhibit A - #1& #2; pg 11-13 Exhibit B; relevant for all elements in this standard) - Management Services Agreement FINAL 091216.pdf (see in Standard IX Subcontracts and Delegation folder – pg 13-14 Exhibit A; relevant for all elements in this standard)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Foothills Behavioral Health Partners, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
	Findings: FBHP delegated utilization management activities, including the authorization and adjudication of emergency and poststabilization services, to VO. The terms of the delegation agreement were described in FBHP’s Utilization Management policy and in a delegation agreement between the two parties. VO’s Emergency and Poststabilization Services policy included a definition for the term emergency medical condition that addressed the prudent layperson requirement and was consistent with 42 CFR 438.114(a). A definition of emergency services was also included in the FBHP Member Handbook and in the provider handbook applicable to each of the VO partnership BHOs (will be referred to throughout this tool as the Provider Handbook). Required Actions: None		
42CFR438.114(a)	2. The Contractor defines Emergency Services as follows: ◆ Services furnished by a provider that is qualified to furnish these services under this title ◆ Needed to evaluate or stabilize an emergency medical condition	Documents Submitted/Location Within Documents: 270L Emergency and Post-Stabilization Services Policy_I.pdf (see Page 3, Section IV.C)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: VO’s Emergency and Poststabilization Services policy included a definition of emergency services that was consistent with 42 CFR 438. The policy stated that emergency services were mental health and medical services provided by a qualified provider to evaluate or stabilize an individual experiencing an emergency medical condition. Required Actions: None		

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Foothills Behavioral Health Partners, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.114(a)	3. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition.	Documents Submitted/Location Within Documents: 270L Emergency and Post-Stabilization Services Policy_I.pdf (see Page 3, Section IV.D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Section IV.D of VO's Emergency and Poststabilization Services policy defined the term "poststabilization services" as covered services related to an emergency psychiatric condition that were provided after a member was stabilized to maintain the stabilized condition or to resolve the member's condition. The policy also stated that poststabilization services end when the member is transferred from the emergency room to a psychiatric inpatient setting or discharged from the emergency room to a lower level of care.		
	Required Actions: None		
42CFR438.114(c)(1)	4. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor.	Documents Submitted/Location Within Documents: 1. 270L Emergency and Post-Stabilization Services Policy_I.pdf (see Page 1, Section III.A) 2. Procedures for Handling Emergency Room and Outpatient Lab Charges_I.pdf (see Page 1) Procedure. 3. Claims Delegation policy final 2009.doc (entire document specifies FBHPartners delegates Claims processing responsibilities to ValueOptions – relevant for elements 4,5,6,&9 in this standard)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: VO's Handling Emergency Room and Outpatient Lab Charges Claims policy stated that members may access emergency services from both in-network and out-of-network providers without prior authorization. The VO Emergency and Poststabilization Services policy also acknowledged that VO covered emergency services regardless of whether the provider that furnished the service had a contract with VO. At the interview, VO staff members stated that personnel responsible for the adjudication of claims were instructed to process claims for emergency and poststabilization services regardless of whether the provider was in-network or out-of-network.		

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Foothills Behavioral Health Partners, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
	Required Actions: None		
42CFR438.114(c)(1)	5. The Contractor may not deny payment for treatment obtained under either of the following circumstances: ◆ A member had an emergency medical condition, including cases in which the absence of immediate medical attention would <i>not</i> have had the following outcomes ▪ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy ▪ Serious impairment to bodily functions ▪ Serious dysfunction of any bodily organ or part ◆ A representative of the Contractor's organization instructed the member to seek emergency services	Documents Submitted/Location Within Documents: 270L Emergency and Post-Stabilization Services Policy_I.pdf (see Pages 1-2, Section III. B & C) - Procedure for Handling Emergency Room and Outpatient Lab Charges_I.pdf (see Page 1, Procedure) - Provider Manual.pdf (Misc folder; Page 14)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Emergency and Poststabilization Services policy instructed staff not to deny claims for treatment obtained by members presenting with an emergency medical condition. The policy also prohibited the denial of claims in cases where a representative of VO directed the member to seek emergency services. During the interview, VO staff reported that the number of denied emergency claims was less than 5 percent and that all emergency claims were approved if a psychiatric diagnosis could be established. The FBHP medical director periodically reviewed a sample of denied emergency claims to help ensure that payment for the claims was not inappropriately denied.		
	Required Actions: None		

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Foothills Behavioral Health Partners, LLC

Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.114(d)(1)	6. The Contractor does not: ◆ Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services	Documents Submitted/Location Within Documents: 270L Emergency and Post-Stabilization Services Policy_I.pdf (see Page 2, Section III.C) - Procedure for Handling Emergency Room and Outpatient Lab Charges_I.pdf (see Page 1, Procedure)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: VO's Emergency and Poststabilization Services policy indicated that what constituted an emergency medical condition was not based on a list of diagnoses or symptoms. The policy also stated that emergency claims were not to be denied in the event that the emergency provider failed to notify the member's primary care provider, VO, or the Department within 10 days of presentation for emergency care.		
	Required Actions: None		
42CFR438.114(d)(2)	7. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.	Documents Submitted/Location Within Documents: 270L Emergency and Post-Stabilization Services Policy_I.pdf (see Page 2, Section III.D) - FBHPartners Member Handbook 101409.pdf (see Misc folder– Page 13 informs members that they are not responsible for payment of services (any services) covered by Medicaid)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: VO's Emergency and Poststabilization Services policy indicated that VO did not hold a member who had an emergency medical condition liable for payment of any subsequent screening and treatment needed to diagnose or stabilize the individual. FBHP Member Handbook also informed members that they were not to be charged for any Medicaid-covered services and instructed them to contact the BHO if they received a bill.		
	Required Actions: None		

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Standard I—Coverage and Authorization of Services—Emergency and Poststabilization Services Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.114(d)(3)	8. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment.	Documents Submitted/Location Within Documents: 1. 270L Emergency and Post-Stabilization Services Policy_I.pdf (see Page 2, Section III.E)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: VO's Emergency and Poststabilization Services policy included language allowing the attending emergency physician or other provider treating the member to determine when the member was sufficiently stabilized for transfer or discharge. The policy also stated that the provider's determination was binding on VO, which was responsible for payment.		
	Required Actions: None		
42CFR438.10(f)(6)(viii)(B)	9. The Contractor does not require prior authorization for emergency services.	Documents Submitted/Location Within Documents: 1. 270L Emergency and Post-Stabilization Services Policy_I.pdf (see Page 2, Section III.F) 2. Procedure for Handling Emergency Room and Outpatient Lab Charges_I.pdf (see Page 1, Procedure) 3. Provider Handbook (Misc Folder – Page 14) 4. FBHPartners Member Handbook (Misc folder – Page 11)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: VO's Emergency and Poststabilization Services policy and its Handling Emergency Room and Outpatient Lab Charge Claims policy stated that precertification was not required for any emergency or poststabilization service. FBHP Member Handbook and the Provider Handbook also indicated that emergency care did not require prior authorization. During the interview, staff members from VO reported that there were no known cases this review period where a request for an emergency service was required by VO staff to be prior authorized. Staff members also indicated that they had the ability to produce an exception report whenever it was suspected that staff members were inappropriately requiring prior authorization for emergency services.		
	Required Actions: None		

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Results for Standard I—Emergency and Poststabilization Services

Total	Met	=	<u>9</u>	X	1.00	=	<u>9</u>
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>
Total Applicable		=	<u>9</u>	Total Score	=	<u>9</u>	

Total Score ÷ Total Applicable		=	<u>100%</u>
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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.100(a)(1)	1. The Contractor has written policies regarding member rights.	Documents Submitted/Location Within Documents: 1. FBHP Policy Member Rights Rev 12-18-09.doc (entire document) 2. FBHP Policy 2 nd Opinion 12-18-09.doc (entire document) 3. FBHP Policy Adv Dir 12-18-09.doc (entire document) 4. FBHP Policy Privacy of Protected Health rev Info 12-18-09.doc (entire document) 5. FBHP Policy Grievance System: Grievances and Appeals with Guide rev 12-21-09 (see folder Standard VI Grievance System—Grievances only, entire document) 6. FBH Partners Auth to Release Info rev 08-10-2009.doc	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP maintained several written policies and procedures regarding member rights and protections. FBHP’s Member Rights policy addressed the requirement that members be fully informed of their rights and responsibilities, that staff from OMFA help ensure that the BHO’s system partners and providers respected the rights of individuals served by the program, and for various monitoring activities to verify that members’ rights were upheld. FBHP also had policies regarding the right to request a second opinion at no cost to the member and the right to receive assistance in writing an advance directive.		
	Required Actions: None		

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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR 438.100(a)(2)	2. The Contractor ensures that its staff and affiliated providers take member rights into account when furnishing services to members.	Documents Submitted/Location Within Documents: 1. FBHP Policy Member Rights Rev 12-18-09.doc, entire document 2. Provider Manual (See Misc folder, see pp. 90-91) 3. FBH Partners Auth to Release Info form (this form documents the client's rights around confidentiality). 4. Jefferson Center for Mental Health (JCMH) Revised Consent to Treat form (This form documents that the JCMH client has received the Client Rights.) 5. Mental Health Center of Boulder & Broomfield Counties (MHCBBC) Receipt of Member Handbook 10-09 form (This form documents that MHCBBC client has received the Client Rights.) 6. JCMH New Empl day4.ppt (see slides 3,4,9, & 10-12) 7. JCMH Rights Annual Trng—admin staff 2009.ppt (see slides 2,4,5,6 & 7. This documents training of admin staff.) 8. JCMH Rights Annual Trng—clinical-12-09.ppt (see slides 2-13, & 15. This documents training of clinical staff.) 9. MHCBBC Annual Train Client Rights & Critical Incidents 2009, zip file (see slides 3 and 11- 19.) 10. New Hire Orientation Agenda MHCBBC.doc (See Consumer Rights and Confidentiality Section on p. 1 <u>and</u> Slides 3, and 11-19 of the MHCBBC Annual Train Client Rights and Critical Incidents 2009 zip file. The section of	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
		the annual training on client rights is used for the new employee orientation training.) 11. JCMH Adv Dir questions.doc . (This is a screen shot from the center’s electronic record.) 12. MHCBBC Adv Dir questions.doc. (This is a screen shot from the center’s electronic record.) 13. VO Provider Forum Training Presentation 7-09.pdf (see slides 4, 73, 74, 76, 77, 78, 90, 91,& 94.) 14. Member Rights as posted on FBHPartners (www.fbhpartners.com) and also accessed from links on the Partner Mental Health Center’s (PMHC’s) web sites.	
	Findings: FBHP’s Member Rights policy described the role played by OMFA in training and monitoring providers to ensure that staff considered member rights when furnishing services. Information regarding member rights was also included in the Provider Handbook. The BHO provided examples of several trainings, including a training offered to staff at the JCMH regarding client rights, customer service, and grievances and appeals. FBHP monitored provider performance in the area of member rights through the use of chart reviews, member satisfaction surveys, and a review of any trends in grievances and appeals related to rights and protections.		
	Required Actions: None		

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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.100(b)(2) & (3)	3. The Contractor ensures that members have the right to: ◆ Receive information in accordance with information requirements (42CFR438.10) ◆ Be treated with respect and with due consideration for his or her dignity and privacy ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation ◆ Request and receive a copy of his or her medical records and request that they be amended or corrected as specified in 45CFR164.524 and 164.526 ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210)	Documents Submitted/Location Within Documents: Bullet one: 1. Policy Member Information Rev 12-18-09.doc (entire document). 2. FBHP Policy Member Rights rev 12-18-09(entire document). 3. FBHP Policy Cultural Competency and Plan 12-18-09 (see especially Goals I-X of the Plan on pages 8-12.). 4. FBHPartners Spanish Member Handbook 121709.pdf 5. FBHPartners Member Handbook (Misc. folder, required information is found throughout the Handbook). 6. FBHPartners Member Handbook (Misc. folder, see p. 10 top of page for how special needs and language needs are addressed). 7. FBHPartners Member Handbook (Misc. folder, see p. 25, last two paragraphs, for how Member can get information about FBHPartners and annual mailing). 8. FBHP Enrollment Letter Aug 09, entire letter. Monthly new enrollee mailings: These mailings include the following documents, all of which are found in this Standard IV folder: 9. FBHPartners Member Handbook (a pdf file), 10. FBHP Emery Serv flyer MHCBBC Engl, 11. FBHP Ombuds flyer Eng 5-12-08.doc, 12. FBHP PCP letter Eng 7-17-09.doc, 13. FBHP EPSDT letter Eng Jan 09.doc,	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
		14. FBHP EPSDT Contacts 2009 Eng.doc, 15. FBHP Privacy Notice English 7-17-09.doc 16. FBHP member mailings.docx (This document shows the monthly member mailings for Aug., Sept., Oct. and Nov. 2009.) 17. OMFA poster MHCBBC.pub (This poster, which informs clients about the OMFA, is at all MHCBBC sites. A similar poster is at all JCMH sites and at the FBHPartners main office.) 18. MemberConnect on the FBHP web site (www.fbhpartners.com) has a searchable provider database. 19. JCMHProviderDirectorySites.pdf (This printout is available to Members on request.) 20. MHCBBCProviderDirectorySites.pdf. (This printout is available to Members on request.) Bullets two-seven: 21. Member Rights listed in FBHPartners Member Handbook (See Misc. folder, p. 15 & 16, bullets 1, 4, 7, 8, 10, 24.) 22. FBHPartners Member Handbook (See Misc. folder, p. 10 top of page and entire document 23. FBHP Policy Privacy of Protected Health Info rev 12-18-09.doc (See II., III., V., VI, VII, VIII n policy , and pp. 5,6&7 of the Notice which is attached to policy) 24. Provider Manual (See Misc folder, pp. 17 & 18). 25. FBHP Policy Cultural Competency and Plan 12-18-09.doc (See policy and purpose on page 1 and Cult Comp goals and objectives pp 8-12.)	

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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
		26. FBHP Policy 2 nd Opinion rev 12-18-09, entire document. 27. JCMH Client Rights posting.doc 28. MHCBBC Client Rights posting.doc	
	Findings: FBHP addressed member rights, including all of those required by 42 CFR 438.100(b)(2) & (3), in FBHP's Member Rights and Privacy of Protected Health Information policies. Information regarding member rights and protections was also communicated to members through several documents, including the FBHP Member Handbook, posters, and a flyer provided to new enrollees. Information included in the Desk Review Form indicated that staff from OMFA was responsible for ensuring that member information was disseminated as required and that the rights of members were respected. The BHO's Member Rights policy stated that any trends in grievances and appeals related to member rights were referred to the FBHP quality improvement director and medical director for review and follow-up. At the interview, staff members stated that there had not been any identified trends in grievances during this review period related to rights violations.		
	Required Actions: None		
42CFR438.100(c)	4. The Contractor ensures that each member is free to exercise his or her rights and that exercising those rights does not adversely affect the way the Contractor treats the member.	Documents Submitted/Location Within Documents: 1. Member Rights listed in FBHPartners Member Handbook (See Misc. folder, p. 15 & 16, bullet 16.) 2. FBHP Policy Member Rights Rev 12-18-09, entire document. 3. Provider Manual (See Misc. folder, pp. 17, 18).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: Information regarding the freedom of members to exercise their rights without affecting how they are treated by their provider was detailed in the FBHP Member Handbook and in the Provider Handbook. The Member Rights policy also provided staff guidance regarding the entitlement of members to freely exercise their rights without fear of retaliation. Information provided at the time of the desk review was that OMFA was responsible for monitoring and follow-up on any reports of provider retaliation related to members exercising their rights. During the interview, staff indicated that FBHP had not received any member complaints in this area during the period under review.		
	Required Actions: None		

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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.100(d)	5. Contractor complies with any other federal and State laws (such as Title VI of the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act, and Titles II and III of the Americans with Disabilities Act and other laws regarding privacy and confidentiality).	Documents Submitted/Location Within Documents: 1. FBHP Policy Cultural Competency and Plan 12-18-09.doc (See entire document.) 2. FBHPartners Policy Member Rights Rev 12-18-09.doc (See entire document.) 3. FBHPartners Member Handbook (See Misc. folder, statements at top and bottom of inside front cover.) 4. FBHPartners Member Handbook (See Misc. folder, p. 10, top). 5. Member Rights listed in FBHPartners Member Handbook (Misc. folder, see pp. 15 & 16, bullets 4, 5, 6, 7,10,20,21, and 22). 6. FBHPartners Member Handbook (See Misc. folder, p.16, bottom). 7. FBHP Policy Privacy of Protected Health Info Rev 12-18-09.doc. (See entire document.) 8. FBH Partners Auth to Release Info rev 08-10-09 (See entire document.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP's Member Rights policy and FBHP Member Handbook included general information regarding confidentiality and the right of members to be free from discrimination based on race, age, and disability. FBHP's Privacy of Protected Health Information policy also addressed the safeguards put in place by the BHO to ensure the safety of members' PHI. Information included in the desk review materials provided by FBHP indicated that the director of OMFA was responsible for monitoring any violation of federal or State rights, including the protection of PHI, and that any serious violations or patterns of violations would result in a CAP.		
	Required Actions: None		

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Standard IV—Member Rights and Protections			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.224	6. The Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these requirements are applicable.	Documents Submitted/Location Within Documents: 1. Policy: Privacy of Protected Health Information (see entire document, including Privacy Notice). 2. HIPAA complaint form.doc 3. HIPAA Complaint Log.doc 4. HIPAA Accounting form.doc 5. HIPAA Denial of Access to PHI.doc 6. HIPAA Disclosure Accounting.doc 7. HIPAA Request to Access PHI.doc 8. Member Rights (Misc. folder, see FBHPartners Member Handbook with listing of Rights on pp. 15 & 16, bullets 20 & 21. 9. FBH Partners Auth to Release Info rev 08-10-09.doc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP's Privacy of Protected Health Information policy described the BHO's commitment to safeguarding the disclosure of PHI for all members in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The director of OMFA also acted as the HIPAA privacy officer and was responsible for the following activities: (1) ensuring that the Privacy Notice was mailed to new enrollees, (2) ensuring that both FBHP staff and volunteers received training on HIPAA, (3) responding to any complaints regarding HIPAA violations, (4) responding to requests to access medical records, and (5) maintaining a log of HIPAA complaints.		
	Required Actions: None		

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Results for Standard IV—Member Rights and Protections									
Total	Met	=	<u>6</u>	X	1.00	=	<u>6</u>		
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>		
Total Applicable		=	<u>6</u>		Total Score	=	<u>6</u>		
Total Score ÷ Total Applicable						=	<u>100%</u>		

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Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.402(a) Volume 8 8.209.1	1. The Contractor has a system in place that includes a grievance process.	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook (See Misc. folder, pp. 18, 19, 20). 2. FBHPPolicy Grievance Appeal with Guide Rev 12-21-09. (See entire document--policy is on pp. 1-8; Grievance and Appeal Guide for Members is on pp. 9-17). 3. Member Rights listed in FBHPartners Member Handbook, pp. 15 & 16, bullets 16 and 17 in Misc. folder. 4. FBHP's web site (www.FBHP.com) and links from PMHC web sites. 5. JCMH Client Rights posting.doc. (See folder Standard IV Member Rights and Protections.) The list of client rights includes grievance-related rights. 6. MHCBBC Client Rights posting.doc (See folder Standard IV Member Rights and Protections.) The list of client rights includes grievance-related rights. 7. Member Rights listed on pp. 96 & 97 of the Provider Manual (see Misc. folder.) Independent providers are required to post or hand out these rights to clients. 8. OMFA poster MHCBBC.pub (See folder Standard IV Member Rights and Protections.) This poster, which informs clients about the OMFA, is at all MHCBBC sites. A similar poster is at all JCMH sites and at the FBHPartners main office.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
		9. JCMH New Employ day4.ppt, slides 3, 4, 9, & 10-12. (See folder Standard IV Member Rights and Protections.) 10. JCMH Rights Annual Trng-admin staff 2009.ppt, slides 2, 4, 5, 6 & 7. (See folder Standard IV Member Rights and Protections.) 11. JCMH Rights Annual Trng-clinical-12-09.ppt, slides 2-13, & 15. (See folder Standard IV Member Rights and Protections.) 12. MHCBBC Annual Train Client Rights & Critical Incidents 2009, zip file, slides 3 and 11, 15, 18, & 19. (See folder Standard IV Member Rights and Protections.) 13. New Hire Orientation Agenda MHCBBC.doc, Consumer Rights and Confidentiality Section (See folder Standard X QI.) 14. VO Provider Forum Training Presentation 7-09.pdf, slides 4, 73, 74, 76, 77, 78, 90, 91, & 94. (See folder Standard IV Member Rights and Protections.) 15. FBHPartners Ombuds flyer Eng 5-12-08 (See folder Standard IV Member Rights and Protections.) This flyer is posted at all PMHC sites and either posted or handed out at all Independent Provider sites.)	
	Findings: The FBHP Grievance and Appeal policy and Grievance and Appeal Guide detailed the grievance process FBHP put in place to receive, process, and resolve member grievances. The FBHP Member Handbook listed member rights, which included the member's right to file a grievance. The FBHP Member Handbook provided evidence that member rights and the grievance process were communicated to members. FBHP staff stated that the majority of grievances were from people who were served at the mental health		

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Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
	centers and that they file their grievance with member advocates from OMFA, who were located on-site at the mental health centers. FBHP staff stated that OFMA staff received grievances, conducted investigations, involved clinical staff when needed, and communicated with members about grievances filed. FBHP staff stated that sometimes members filed grievances through the Department or through the ombudsman program. The grievance record review provided evidence that FBHP received and processed grievances filed by members. Required Actions: None		
42CFR438.400(b) Volume 8 8.209.2	2. The Contract defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or an employee, or failure to respect the member’s rights.	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook, (see Misc. folder, p. 18, bottom.) 2. FBHPartners Policy Grievance Appeal with Guide Rev 12-21-09. (See p. 2 of policy section and top of pp. 9 and 16 in Guide section.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Grievance and Appeal policy defined a grievance as, “an oral or written expression of dissatisfaction about any matter other than an action.” The policy further stated that grievances included complaints about quality of care, customer service, and/or violations of a member’s rights. The FBHP Member Handbook provided evidence that FBHP communicated the definition of a grievance to members.		
	Required Actions: None		

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Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.402(b)(1) Volume 8 8.209.1	3. The Contractor has provisions for who may file grievances: ◆ A member may file a grievance (or his or her authorized representative), ◆ A provider may file a grievance on behalf of a member (Colorado permits the provider to act as the member's authorized representative)	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook (See Misc. folder, p. 18, middle-see DCR definition.) 2. FBHPartners Member Handbook (See Misc. folder, p. 19, middle.) 3. Member Rights listed in FBHPartners Member Handbook, pp. 15 & 16, bullets 14 & 17. (See See Misc. folder.) 4. FBHPartners Policy Grievance and Appeal with Guide Rev 12-21-09.doc: This policy document includes the policy (pp. 1-9) as well as the Grievance and Appeal Guide (pp. 10-18). The Guide is posted at the PMHCs and is given to when they file a grievance. See the policy statement at top of p. 1 and DCR definition at top of page 2 in the policy section. In the guide, see the first paragraph on page 10 and the definition of DCR at the bottom of page 16. 5. FBHPartners Policy Member Rights Rev 12-18-09.doc (See folder Standard IV Member Rights and Protections). See p. 1 (Purpose and DCR definition); and p. 3, IV.G. 6. FBHPartners DCR form 7. FBH Partners Auth to Release Info rev 08-10-2009.doc. (See folder Standard IV Member Rights and Protections) 8. Provider Manual: (See Misc. folder, p 28, paragraph 3; pp. 90 & 91; 91-93; and 96 & 97.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.402(b)(3) Volume 8 8.209.5.D	Findings: The FBHP Grievance and Appeal policy detailed the provisions by which a member may file a grievance. The policy stated that a member or his or her representative, called a “designated client representative,” may file a grievance on behalf of a member. The policy stated that a provider may serve as the designated client representative for a member and file a grievance on the member’s behalf. The FBHP Member Handbook provided evidence that FBHP communicated to members who may file a grievance.		
	Required Actions: None		
	4. The Contractor accepts grievances orally or in writing.	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook (See Misc. folder, p. 18, bottom.) 2. FBHPartners Policy Grievance and Appeal with Guide Rev 12-21-09.doc (See Grievance definition on p 2 and on p.10 in the Guide, see If you Want to File a Grievance).	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The FBHP Grievance and Appeal policy contained the provision that members, or their designated client representatives, may file grievances orally or in writing. The policy also described the process by which FBHP accepts and processes oral and written grievances. The FBHP Member Handbook contained the provision that members or their designated client representatives may file grievances orally or in writing. FBHP staff stated that members may file a grievance with family and member advocates at the mental health centers, through the ombudsman program, or directly with the Department.			
Required Actions: None			

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Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.402(b)(2) Volume 8 8.209.5.A	5. The member has 20 calendar days from the date of the incident to file a grievance.	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook (See Misc. folder, p. 19, middle) 2. FBHPartners Policy Grievance and Appeal with Guide Rev 12-21-09.doc. (see p. 5 in policy and p10 in Guide.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Grievance and Appeal policy contained the provision that members had 20 calendar days from the date of the incident to file a grievance. The FBHP Member Handbook detailed the provision that members must file their grievance within 20 calendar days from the date the event happened.		
	Required Actions: None		
42CFR438.406(a) Volume 8 8.209.4.C	6. In handling grievances, 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.	Documents Submitted/Location Within Documents: 1. Member Rights listed in FBHPartners Member Handbook, pp. 15 & 16, bullets 6, 13, 14, 15. (See Misc. folder.) 2. FBHPartners Policy Grievance and Appeal with Guide Rev 12-21-09.doc. In the policy section, see Purpose on p. 1 and Procedures (Procedures II.B., G, J, K, L, and M).on p. 2. In the Guide, see the section at bottom of p. 9. 3. FBHPartners Griev Ack.doc (last paragraph) 4. FBHPartners Policy Member Rights Rev 12-18-09.doc (See folder Standard IV Member Rights and Protections, p. 6 VI. A through G.) 5. OMFA poster MHCBBC.pub (See folder Standard IV Member Rights and Protections. This poster, which informs clients about the OMFA, is at all MHCBBC sites. A similar poster is at all JCMH sites and at the FBHPartners main office.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
	Findings: The FBHP Grievance and Appeal policy contained the provision that OMFA would assist any member or designated client representative with completing forms; putting a grievance or appeal in writing; completing any procedural steps, including appealing at the State level; and accessing interpreter services (foreign language and sign language), translation services, and teletype (TTY) and Relay Colorado services. The FBHP Member Handbook contained instructions for members to contact an FBHP client and family advocate or the OMFA director if they required assistance with filing a grievance. The Jefferson Center for Mental Health Client Rights poster contained member rights information and information about the assistance members may seek if they wish to file a grievance or have any questions. The poster included the TTY phone number and toll-free numbers for members to call for assistance.		
	Required Actions: None		
42CFR438.406(a) Volume 8 8.209.5.B	7. The Contractor acknowledges each grievance in writing within two working days of receipt.	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook (See Misc. folder, p. 19, bottom). 2. FBHPartners Policy Grievance Appeal with Guide Rev 12-21-09.doc. See p. 5 (Procedures IV.A.) in policy section and p.10 (middle of page) in Guide section. 3. FBHPartners Griev Ack.doc. 4. Grievance Tracking Sheet.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Grievance and Appeal policy detailed FBHP’s provision for acknowledging receipt of all grievances within two working days. The FBHP Grievance Acknowledgment Letter template provided evidence of the type of letter FBHP sent to its members to acknowledge receipt of a grievance. Of the 10 grievance files reviewed, 9 of the files provided evidence that the grievance was acknowledged within two working days. One of the grievances was acknowledged outside of the required time frame.		
	Required Actions: FBHP must ensure that all grievances are acknowledged within two working days of receipt of the grievance.		

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Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.406(a) Volume 8 8.209.5.C	8. The Contractor ensures that the individuals who make decisions on grievances are individuals who: ◆ Were not involved in any previous level of review or decision-making ◆ If deciding a grievance regarding the denial of expedited resolution of an appeal, or a grievance that involves clinical issues, has the appropriate clinical expertise in treating the member's condition or disease.	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook (See Misc. folder, p. 19, bottom.) 2. FBHPartners Policy Grievance Appeal with Guide Rev 12-21-09.doc. See p. 5 (IV.A.3) in policy section and p.2 (middle) in Guide section. 3. FBHPartners Griev Ack & Dec.doc. 4. FBHPartners Griev Dec.doc. 5. FBHPartners Griev Ack.doc.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Grievance and Appeal policy contained the provision that FBHP would forward grievances that involved a clinical issue to a licensed clinician with the appropriate expertise in treating the member's condition and who did not participate in any previous level of review or decision making. The FBHP Grievance and Appeal Guide contained the provision that FBHP would ensure that individuals who made decisions on grievances were not involved in any prior decision making and ensure that staff making the decisions would have the necessary training to make decisions on grievances involving a clinical issue. Of the 10 grievance files reviewed, all 10 files provided evidence that the individuals making decisions on the grievances were not involved in any previous level of review or decision making. Of the 10 grievance files reviewed, 5 of the grievances involved a clinical issue. However, 2 of the 5 grievances that involved a clinical issue did not provide evidence that the decision was rendered by a staff person with the appropriate clinical expertise to make a decision on the grievance.		
	Required Actions: FBHP must ensure that the individuals who make decisions on grievances have the appropriate level of expertise in treating the member's condition for all grievances that involve a clinical issue. Furthermore, FBHP should document in the grievance file the individual(s) who made the decision on a member's grievance and the level of expertise of the individual(s) to render a decision on a grievance that involved a clinical issue.		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.408(b)&(d) Volume 8 8.209.5.D &F	9. The Contractor must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the Contractor receives the grievance. The notice includes: ◆ The results of the disposition/resolution process ◆ The date it was completed	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook (See Misc. folder, pp. 19 & 20.) 2. FBHPartners Policy Grievance Appeal with Guide Rev 12-21-09.doc. See p. 5 (IV.A.5) in policy section and middle of p.10 in Guide section. 3. FBHPartners Griev Ack & Dec.doc. 4. FBHPartners Griev Dec.doc. 5. FBHPartners Griev Ack.doc. 6. Grievance Tracking Sheet.	☐ Met ☒ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Grievance and Appeal policy contained the requirement to provide a notice of disposition within 15 working days from the date of the grievance and include the following in the notice: the disposition of the grievance, the date the decision was made, the member's right to appeal to the Department, the time frames in which the appeal must be made, that OMFA can help with the appeal, and that the Department's decision would be final. Of the 10 grievance files reviewed, 9 had a notice of resolution sent to the member within 15 working days. All 10 files contained a notice of resolution. However, one grievance notice did not describe the results of the grievance process or investigation and, therefore, did not contain the required content.		
	Required Actions: FBHP must ensure that all grievance notices of disposition include the results of the disposition/resolution process.		

Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.408(c) Volume 8 80209.5.E	10. The Contractor may extend the timeframes for resolution of grievances by up to 14 calendar days if: ◆ The member requests the extension, or ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook (See Misc. folder, p. 19, bottom). 2. FBHPartners Policy Grievance and Appeal with Guide Rev 12-21-09.doc. See p.5 (IV.A.4) in policy section and middle of p.2 in Guide section. 3. FBHPartners Griev Extra Time.doc. 4. Grievance Tracking Sheet.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Grievance and Appeal policy contained the provision that FBHP may extend the time frame for resolution of a grievance by up to 14 calendar days if the member requested an extension or if FBHP demonstrated that additional information was needed. The policy also contained the provision that FBHP provided written notification to a member when a 14-day extension was requested by FBHP, with an explanation of the need for the delay and how the delay was in the member's best interest. The FBHP Grievance Disposition Extension Letter template provided evidence of the form letter FBHP used to notify members of the extension. Of the 10 grievance files reviewed, there was one instance in which FBHP staff required additional time to collect information for the grievance, which was in the member's best interest. FBHP staff notified the member in writing of the extended timeline to resolve the grievance. Once the grievance was resolved, FBHP staff provided written disposition to the member within the required, extended time frame.		
	Required Actions: None		

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Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.408(c)(2) Volume 8 80209.5.E	11. If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay.	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook (See Misc. folder, p. 19, last paragraph.) 2. FBHPartners Policy Grievance and Appeals with Guide Rev 12-21-09.dod. See p. 5 (IV.A.4) in policy section and middle of page 2 in Guide section. 3. FBHPartners Griev Extra Time.doc.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Grievance and Appeal policy contained the provision that FBHP provided written notification to members when a 14-day extension was requested by FBHP, with an explanation of the need for the delay and how the delay was in the member’s best interest. The FBHP Grievance Disposition Extension Letter template provided evidence of the form letter FBHP used to notify members of the extension. Of the 10 grievance files reviewed, there was one instance in which FBHP staff required additional time to collect information for the grievance, which was in the member’s best interest. FBHP staff provided the reason for the delay in writing to the member.		
	Required Actions: None		

Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.414 Volume 8 8.209.3.B	12. 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 timeframes 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 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 ◆ Appeal rights available to providers to challenge the failure of the Contractor to cover a service	Documents Submitted/Location Within Documents: 1. Provider Manual (see Misc. folder, pp. 22 & 23 (second opinion); p.28 (3rd paragraph); pp.30-33; and pp. 90-97. 2. FBHPartners Member Handbook (Misc. folder, pp. 18 & 19.) All Independent providers receive a copy of the Member Handbook when they join the network. Note that the last bulleted item in Requirement 12 (appeal rights available to providers) is not applicable in Colorado.	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

Standard VI—Grievance System—Grievances Only			
References	Requirement	Evidence Submitted by the BHO	Score
	Findings: As part of its delegated functions, VO provided grievance system information, specified in 42 CFR 438.10, to independent providers as part of the approved credentialing packet, which included the Provider Handbook and Member Handbook. The Provider Handbook provided evidence that providers were informed of the following: the right to file grievances; the toll-free numbers to file a grievance orally; 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 a State fair hearing; the availability of assistance with filing a grievance, an appeal, or requesting a State fair hearing; and the fact that, when requested by a member, benefits continue if the appeal or request for a State fair hearing is filed within the time frames specified for filing. The Member Handbook listed all of the methods by which members may file a grievance and included the toll-free telephone numbers available to members to file a grievance orally. The Member Handbook contained the provision that, if benefits continued during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal was pending if the final decision was adverse to the member. The Member Handbook and the Provider Handbook contained the provision that a provider may serve as a member’s designated client representative and file an appeal on the member’s behalf, with the written permission of the member. FBHP staff stated that PMHC staff received member grievance system training at new employee orientation. FBHP staff stated that PMHC staff also received a copy of the FBHP Member Handbook, which contained the required provisions. Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.416 Volume 8 8.209.3.C	13. The Contractor maintains records of all grievances, and submits quarterly reports to the Department.	Documents Submitted/Location Within Documents: 1. FBHPartners Policy Grievance and Appeal with Guide Rev 12-21-09.doc. See policy section--p. 2 (Procedures I. A –E), and p. 4 (III.A. 1-5.) 2. FBHPartners Qtr. 1 FY 09-10 Griev and Appeal Report.xls (See folder Standard X QI.) 3. FBHPartners Griev and Appeal Report Qtr. 1 FY 09-10.doc (See folder Standard X QI.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Grievance and Appeal policy detailed the process for maintaining grievance information and submitting quarterly reports to the Department. The FBHP Grievance and Appeal Report for Quarter 1 provided evidence that FBHP tracked, trended, and analyzed member grievances and provided the analysis to the Department.		
	Required Actions: None		

Results for Standard VI—Grievances					
Total	Met	=	<u>10</u>	X	1.00 = <u>10</u>
	Partially Met	=	<u>3</u>	X	.00 = <u>0</u>
	Not Met	=	<u>0</u>	X	.00 = <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA = <u>0</u>
Total Applicable		=	<u>13</u>	Total Score	= <u>10</u>
Total Score ÷ Total Applicable				=	<u>77%</u>

Standard VII—Provider Participation and Program Integrity			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.102(a)	1. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient for the following: ◆ The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered ◆ Any information the member needs in order to decide among all relevant treatment options ◆ The risks, benefits, and consequences of treatment or non-treatment ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions	Documents Submitted/Location Within Documents: 1. Provider Contract Colorado Medicaid Provider Addendum_VII.pdf (see Page 1, Section B.6) 2. FBHPartners Provider Network delegation policy final 2009.doc (entire document which describes FBHPartners delegation of provider network functions to ValueOptions; relevant for elements 1-6) 3. Delegation agreement – executed 0912.pdf (see in Standard IX Subcontracts and Delegation folder – pg 2 Article II 2.02 c&e; pg 8 &10 Exhibit A - #3& #5; pg 12 Exhibit B; relevant for all elements in this standard) 4. Management Services Agreement FINAL 091216.pdf (see in Standard IX Subcontracts and Delegation folder – pg 18-19 Exhibit A; relevant for all elements in this standard)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The FBHP Provider Network Delegation policy stated that FBHP delegated operational responsibility for provider networking and contracting to VO. The Colorado Medicaid Provider Addendum of the VO Provider Contract detailed VO's provisions for not prohibiting or restricting a health care professional from advising or advocating on behalf of a member who is the provider's patient. The VO Facility Agreement and the VO Provider Agreement contained the provision that nothing stated in the agreements can be construed as prohibiting or penalizing communication between facility/practitioner and members regarding available treatment options, including appropriate or medically necessary care for members. The Provider Handbook listed member rights, which included the right to participate in the member's health care, including the right to refuse treatment. The FBHP Revised Consent to Treat form, which was administered by providers, provided evidence that FBHP communicated to providers and members that providers were responsible for explaining the risks, benefits, and consequences of treatment.			

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References	Requirement	Evidence Submitted by the BHO	Score
	Required Actions: None		
42CFR438.102(b)	2. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: ◆ To the State ◆ To member before and during enrollment ◆ To members within 90 days after adopting the policy with respect to any particular service (consistent with the format provisions in 42CFR438.10) (The Contractor need not furnish information on how and where to access the service.)	Documents Submitted/Location Within Documents: 1. FBHPartners Member Handbook.pdf (see Misc folder Page 11)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Member Handbook contained the provision that FBHP would not deny services based on moral or religious objections.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.12(a)(1) 42CFR438.214(c)	3. The Contractor does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and does not discrimination against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	Documents Submitted/Location Within Documents: 1. N401 Primary Source Verification Policy_VII.pdf (see Pages 1-2, Sections A.1-11 and IV.G)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Primary Source Verification policy detailed VO's nondiscriminatory provisions that providers will not be discriminated against based on their specialty, license or certification, or the population to which they provide services.		
	Required Actions: None		
42CFR438.12(a)(1)	4. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.	Documents Submitted/Location Within Documents: 1. N201 Practitioner Credentialing Process Policy.pdf (see Page 4, Section H.2) 2. Provider Program Participation Denial Letter.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing Process policy provided evidence that VO maintained provisions for declining to include providers in its network as a result of the credentialing process. The policy stated that recommendations to deny participation in the network were forwarded to the VO NCC for review and a determination of network participation. If the VO NCC's recommendation was to deny credentialing, the practitioner was notified in writing of the reason(s) for the denial within five business days of the date of the decision, and the practitioner was notified of his or her right to appeal to the VO Provider Appeals Committee within 30 calendar days from the date on the letter of notification. The VO Provider Program Participation Denial Letter template provided evidence of the type of communication sent to providers if the VO declined participation in the provider network to a provider or group of providers. FBHP staff stated that all providers who met the credentialing criteria were approved and accepted into the network.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.106	5. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor’s debts in the event of the Contractor’s or subcontractor’s insolvency ◆ Covered services provided to the member for which the State does not pay the Contractor ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider that provides the services under a contractual, referral, or other arrangement ◆ Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly	Documents Submitted/Location Within Documents: 1. Provider Contract Colorado Medicaid Addendum.pdf (see Page 3, Section H.3) 2. ValueOptions Practitioner Agreement.pdf (see Pages 4-5) 3. ValueOptions Facility Agreement.pdf (see Page 5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Colorado Medicaid Provider Addendum contained provisions that Medicaid members are not held liable for payments of covered services that are the legal obligation of VO and/or the payor in instances including the insolvency of a payor or VO, breach of the agreement by VO, and/or nonpayment for covered services. The VO Practitioner Agreement and VO Facility Agreement provided evidence of VO’s provision that a practitioner or facility may not in any event—including nonpayment by VO or a payor, insolvency of VO or a payor, or breach of the agreement—bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a member, subscriber, enrolled person to whom health care services have been provided, or person acting on behalf of the member for whom health care services were provided pursuant to the agreement.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.214(d)	6. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act.	Documents Submitted/Location Within Documents: 1. FBHPartners Credentialing & Recredentialing Delegation Policy.doc (see Folder VIII Credentialing) 2. N401 Primary Source Verification Policy.pdf (see Page 4) 3. N401H Sanction Notification Letter.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Credentialing & Recredentialing Delegation policy detailed FBHP’s provisions for delegating the operational responsibilities of credentialing and recredentialing to VO. The policy also detailed the BHO’s provisions for conducting annual reviews prior to the automatic renewal of the delegation agreement to ensure that VO maintained compliance with all applicable credentialing and recredentialing standards and regulations. The BHO’s reviews were to ensure that the delegate did not employ or contract with providers excluded from participation in federal health care programs under Title XI of the Social Security Act, Sections 1128 and 1128A. The VO Primary Source Verification policy listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities.		
	Required Actions: None		

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Standard VII—Provider Participation and Program Integrity			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.608	7. The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse and include: - Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards - The designation of a compliance officer and a compliance committee that are accountable to senior management - Effective training and education for the compliance officer and the Contractor's employees - Effective lines of communication between the compliance officer and the Contractor's employees - Enforcement of Standards through well publicized disciplinary guidelines - Provision for internal monitoring and auditing - Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the Medicaid managed care contract requirements	Documents Submitted/Location Within Documents: FBHPartners Policy Investigation – reporting Fraud Abuse Final.doc - commitment to comply – pg 1, policy and purpose - lines of communication – pg 2, Sec #2 - prompt response and corrective action – pg 2 – Sec #1-8 FBHPartners Policy Detection of Fraud and Abuse Final.doc - commitment to comply – pg 1, policy and purpose - effective training – pg 2 sec I A, B - effective lines of communication – pg 3 Sec II B - internal monitoring and auditing – Table pg 2-3 FBHPartners CORP COMPLIANCE PLAN FINAL_2_091216.pdf - commitment to comply – pg 2-3 - designation of a compliance officer – pg 9 - effective training – pg 11 - effective lines of communication – pg 12, Sec 1 & 2 - enforcement of standards – pg 9 4th paragraph - internal monitoring and auditing – pg 14-15 - prompt response and corrective action – pg 13 - 14	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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References	Requirement	Evidence Submitted by the BHO	Score
		FBHPartners Policy Medical Record Accuracy 2009.doc (Standard X QI Folder, Entire policy re: monitoring and auditing) FBHPartners Emp Hdbk 091124.doc (enforcement of standards and employee training – pg 2-3) Corp Comp Minutes 090929.doc (internal monitoring and prompt response, corrective action pg 2 under <i>FBHP</i>)	
	Findings: The FBHP Investigation—Reporting Fraud Abuse and the FBHP Detection of Fraud and Abuse policies and the FBHP Corporate Compliance Plan provided evidence of FBHP’s written procedures and plan for guarding against fraud and abuse and maintaining a standard of conduct, describing FBHP’s commitment to comply with all applicable federal and State standards. The FBHP Corporate Compliance Plan described the designation of a compliance officer and a compliance committee accountable to senior management, training and education for the compliance officer and FBHP’s employees, lines of communication between the compliance officer and FBHP employees, enforcement of standards through publicized disciplinary guidelines, provision for internal monitoring and auditing, provision for prompt response to detected offenses, and development of corrective action initiatives related to Medicaid managed care contract requirements. FBHP staff stated that the BHO conducted site visits and chart audits to verify that services billed to the BHO and paid for were documented in the file. In one instance, FBHP staff discovered a discrepancy and required a CAP from the provider. FBHP staff stated that the provider complied with the corrective action and the issue was resolved.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.610	8. The Contractor may not knowingly have a director, partner officer, employee, subcontractor, or owner (owning 5 percent or more of the entity) who is debarred, suspended or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549.	Documents Submitted/Location Within Documents: FBHPartners Policy Detection of Fraud & Abuse FINAL.doc (see pg 2 Sec II.A) FBHPartners CORP COMPLIANCE PLAN FINAL_2_091216.pdf (see pg 6 #1)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Detection of Fraud and Abuse policy and the FBHP Corporate Compliance Plan provided evidence of FBHP's written procedures and plan for conducting background checks on all of FBHP's new employees, partner officers, subcontractors, and owners of 5 percent or more of the entity. Background checks were conducted on these individuals prior to their affiliation with FBHP to ensure that they had not been excluded from participating in procurement or nonprocurement activities under federal acquisition regulation. FBHP staff stated that the BHO scans the Office of Inspector General (OIG) database monthly to verify that staff members at the PMHCs or any independent providers are not identified.		
	Required Actions: None		

Results for Standard VII—Provider Participation and Program Integrity									
Total	Met	=	<u>8</u>	X	1.00	=	<u>8</u>		
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>		
Total Applicable		=	<u>8</u>	Total Score	=	<u>8</u>			

Total Score ÷ Total Applicable		=	<u>100%</u>
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Standard VIII—Credentialing and Recredentialing			
References	Requirement	Evidence Submitted by the BHO	Score
NCQA—CR1	1. The Contractor has a well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members.	Documents Submitted/Location Within Documents: 1. N101 Overview of National Networks Policy.pdf (Entire policy) 2. N201 Practitioner Credentialing Process.pdf (Entire policy) 3. N203 Facility Provider Credentialing Process.pdf (Entire policy) 4. N501 Practitioner Recredentialing Process.pdf (Entire policy) 5. N502 Facility Program Clinic Recredentialing Process.pdf (Entire policy) 6. FBHPartners Credentialing Delegation Policy final 2009.doc (entire document; this policy describes FBHPartners' delegation of credentialing to ValueOptions and is relevant for all elements in this standard) 7. FBHPartners Policy Credentialing Program 2009.doc (entire document; this policy describes FBHPartners' specific procedures for credentialing individual providers within the Partner MHCs as well as delegation of IPN credentialing to ValueOptions) 8. FBHPartners Credentialing ManualPMHC.doc (entire document outlines FBHPartners Partner MHC credentialing procedures) 9. FBHPartners Credentialing committee minutes-8-19-09.doc (minutes from FBHPartners credentialing committee for Partner MHCs) 10. FBHPartners Credentialing committee minutes-10-15-09.doc (minutes from FBHPartners credentialing committee for Partner MHCs)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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References	Requirement	Evidence Submitted by the BHO	Score
		11. Delegation agreement – executed 0912.pdf (see in Standard IX Subcontracts and Delegation folder – pg 2 Article II 2.02c; pg 8 Exhibit A - #3; pg 13 Exhibit B; relevant for all elements in this standard) 12. Management Services Agreement FINAL 091216.pdf (see in Standard IX Subcontracts and Delegation folder – pg 14-15 Exhibit A; relevant for all elements in this standard)	
	Findings: The FBHP Credentialing Manual detailed FBHP’s credentialing and recredentialing process, which included delegation of most of the credentialing and recredentialing activities to VO. The FBHP Credentialing Manual and the FBHP Credentialing/Recredentialing—Delegation Oversight policy included provisions for VO’s credentialing and recredentialing process whereby VO was responsible for credentialing and recredentialing individual providers within the network and for primary source verification of PMHC individual providers. The FBHP Credentialing Manual and the FBHP Credentialing Program policy maintained that all PMHC staff/providers followed the same credentialing and recredentialing process used by VO, except for the final decision step, which was made by a combined committee of PMHC and FBHP staff, with final approval by the FBHP medical director. The FBHP Credentialing/Recredentialing—Delegation Oversight policy described FBHP’s oversight of VO’s credentialing and recredentialing program, which included verifying that VO maintained a well-defined credentialing and recredentialing process for credentialing and contracting with licensed practitioners to provide services to members. The VO Practitioner Credentialing Process and Facility Provider Credentialing Process policies described VO’s credentialing process for evaluating and selecting providers to participate in the network and provide services to members. VO’s process for credentialing practitioners included the use of an application completed by the practitioner, attestation from the practitioner, primary source verification, and recommendations to the medical director to approve credentialing of practitioners who completed the credentialing process and whose files were considered “clean,” without any information that would deny credentialing to the practitioner. The VO Facility Provider Credentialing Process policy described VO’s credentialing process for facilities and stated that all facilities must complete the credentialing process and be approved by the VO NCC prior to executing an agreement with VO. VO staff stated that CLCC reviewed and made recommendations for approval or denial of credentialing files to the NCC prior to the NCC’s review of credentialing files.		

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	The VO Practitioner Recredentialing Process and Facility Provider Recredentialing Process policies described VO’s process for recredentialing providers who participate in the network and provide services to members. VO’s process for recredentialing practitioners included the use of an application completed by the practitioner, attestation from the practitioner, primary source verification, and recommendations to the medical director to recredential practitioners whose files were considered “clean,” without any information that would deny recredentialing to the practitioner. The VO Facility Provider Recredentialing Process policy described VO’s recredentialing process for facilities and stated that all facilities must complete the recredentialing process and be approved by the VO NCC. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of recredentialing files to the NCC prior to the NCC’s review of recredentialing files. The FBHP Credentialing Manual described the FBHP Credentialing Committee, which was composed of a multidisciplinary team of representatives from human resources, utilization management, member and family affairs departments, and members of the clinical staff. The FBHP Credentialing Committee was responsible for reviewing credentialing and recredentialing files from staff employed by the PMHCs only, and making credentialing and recredentialing decisions based on the information collected by the applicant and primary source verification information received from VO. The FBHP Credentialing Committee meeting minutes of August 19, 2009, and October 15, 2009, provided evidence that the FBHP Credentialing Committee reviewed and made a determination based on PMHC credentialing and recredentialing files. FBHP staff stated that the PMHC credentialing process is one of the conditions for employment at a PMHC. FBHP stated that staff members were informed prior to their employment that their employment at a PMHC was conditioned upon passing the credentialing process. Required Actions: None		

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NCQA CR1— Element A Element B NCQA CR9— Element A NCQA CR10— Element A Element B Element C 42CFR438.214(a) NCQA CR1— Element A and B NCQA CR9 CR10-Element A and C	2. The Contractor has (and there is evidence that the Contractor implements) written policies and procedures for the selection and retention of providers that specify: 2.A. The types of practitioners to credential and recredential. This includes all physicians and nonphysician practitioners who have an independent relationship with the Contractor. (Examples include psychiatrists, psychologists, clinical social workers, psychiatric nurse specialist, and or licensed professional counselors.	Documents Submitted/Location Within Documents: 1. N205 Discipline Specific Credentialing Criteria for Practitioners – Entire policy 2. N301 Development of Credentialing Criteria.pdf (entire policy) 3. N410 Acceptable State Licensure for Practitioner Participation.pdf (entire policy) 4. N410A State Licensure Grid.pdf 5. N410B Advanced Practice Nurse (APN) Standards.pdf 6. Provider Credentialing Criteria Checklist.pdf (entire document) 7. FBHPartners Credentialing ManualPMHC.doc (see pg 3 under section A) 8. FBHPartners Policy Credentialing Program 2009.doc (see pg 1 Sec 2B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Discipline Specific Credentialing Criteria for Practitioners policy specified the types of practitioners that VO credentialed and recredentialled, including all physician and nonphysician practitioners who had an independent relationship with VO. The VO Applicable State Licensure Grid detailed the applicable state licenses for all physician and nonphysician providers by state, which included Colorado. The VO Provider Credentialing Criteria Checklist contained the specific criteria, by provider specialty, of documents and information that must be sent to VO prior to processing the credentialing application for each practitioner. The VO Provider Data Sheet, which was generated from the VO NetworkConnect online provider credentialing and recredentialing database, contained evidence of the types of practitioners that were to be credentialed or recredentialled. The FBHP Credentialing Manual and the FBHP Credentialing Program policy detailed the provision that all PMHC staff/providers followed the same credentialing and recredentialing process used by VO, except for the final decision step, which was made by a combined committee of PMHC and FBHP staff, with final approval by the FBHP medical director. The FBHP Credentialing Committee meeting minutes of August 19, 2009, and October 15, 2009, provided evidence that the FBHP Credentialing Committee reviewed and made a determination based on PMHC credentialing and recredentialing files.			
Required Actions: None			

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	2.B. The verification sources used	Documents Submitted/Location Within Documents: 1. N401 Primary Source Verification Policy.pdf (Entire policy) 2. N401A Primary Source Verification Report.pff 3. FBHPartners Credentialing ManualPMHC.doc (see pg 2 under for verifications sources.)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Primary Source Verification policy detailed VO's process for verifying at the primary source providers' credentials, licenses, and applicable education and experience as part of the credentialing and recredentialing processes. The policy listed the types of primary source databases used, such as the National Practitioner Data Bank (NPDB) and OIG, to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider's involvement with terrorists or terrorist activities. The FBHP Credentialing Manual listed the verification sources used to verify providers' credentials, licenses, and applicable education and experience as part of the credentialing and recredentialing processes, which included sources such as the NPDB and OIG databases, and the National Student Clearinghouse.		
	Required Actions: None		
	2.C. The criteria for credentialing and recredentialing	Documents Submitted/Location Within Documents: 1. N201 Practitioner Credentialing Process.pdf (Entire policy) 2. N203 Facility Provider Credentialing Process.pdf (Entire policy) 3. N205 Discipline Specific Credentialing Criteria for Practitioners.pdf (entire policy) 4. N206 Credentialing Criteria for Facility Organizational Providers.pdf (entire policy) 5. N401 Primary Source Verification Policy.pdf (Entire policy) 6. N501 Practitioner Recredentialing Process.pdf (Entire policy) 7. N502 Facility Program Clinic Recredentialing Process.pdf (Entire policy)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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		8. FBHPartners Credentialing ManualPMHC.doc (see pg 2 under credentialing/re-credentialing criteria)	
	Findings: The VO Practitioner Credentialing Process and Facility Provider Credentialing Process policies described VO’s credentialing criteria for evaluating and selecting providers to participate in the network and provide services to members. VO’s criteria for credentialing practitioners included the provision that practitioners submit a completed application and attestation form so VO may complete primary source verification of all licenses, certifications, and educational and employment experience; clinical privileges, if applicable; malpractice history; evidence that the applicant was not excluded from participation in federally funded programs, including Medicare and Medicaid; and criminal background or criminal record. The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source providers’ credentials, licenses, and applicable education and experience as part of the credentialing process. The policy listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities. The VO Facility Provider Credentialing Process policy described VO’s credentialing criteria for facilities and stated that all facilities must complete the credentialing process and be approved by the VO NCC prior to executing an agreement with VO. The VO Credentialing Criteria for Facility/Organizational Providers policy detailed the program-specific criteria that must be met for VO to approve credentialing of a facility. The VO Practitioner Recredentialing Process and Facility Provider Recredentialing Process policies described VO’s criteria for recredentialing providers who participated in the network and provided services to members. VO’s criteria for recredentialing practitioners included the requirement for practitioners to submit a completed application and attestation form. The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source providers’ credentials, licenses, and applicable education and experience as part of the recredentialing processes. The VO Facility Provider Recredentialing Process policy described VO’s recredentialing criteria for facilities and stated that all facilities must complete the recredentialing process and be approved by the VO NCC. The FBHP Credentialing Manual detailed the criteria used to credential and recredential PMHC staff, which included verification of the following: licenses, certifications, and educational and employment experience; clinical privileges, if applicable; malpractice history; evidence that the applicant was not excluded from the participation in federally funded programs, including Medicare and Medicaid; and criminal background or criminal record. Required Actions: None		

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	2.D. The process for making credentialing and recredentialing decisions	Documents Submitted/Location Within Documents: 1. N101 Overview of National Networks Policy.pdf (Entire policy) 2. N201 Practitioner Credentialing Process.pdf (Entire policy) 3. N501 Practitioner Recredentialing Process.pdf (Entire policy) 4. N203 Facility Provider Credentialing Process.pdf (Entire policy) 5. N502 Facility Program Clinic Recredentialing Process.pdf (entire policy) 6. N601 Role of National Credentialing Committee.pdf (Entire policy) 7. N604 Role of Local Credentialing Committee.pdf (Entire policy) 8. FBHPartners Credentialing ManualPMHC.doc (see pg 3 under Sec A and pg 6 Sec F)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing Process and Facility Provider Credentialing Process policies described VO’s process for making credentialing decisions and selecting providers to participate in the network. VO’s process for credentialing practitioners included the use of an application completed by the practitioner, attestation from the practitioner, and primary source verification. The policies described the process by which “clean” files with recommendations for approval were forwarded to the VO medical director, who acted on behalf of the VO NCC, to approve clean credentialing files. The VO Role of Local Credentialing Committee policy detailed the roles and responsibilities of the CLCC. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of credentialing files to the NCC prior to the NCC’s review of credentialing files. Recommendations to deny credentialing applications were forwarded to the NCC for review and determination of network participation. The VO Practitioner Recredentialing Process and Facility Provider Recredentialing Process policies described VO’s criteria for recredentialing providers who participated in the network and provided services to members. VO’s criteria for recredentialing practitioners included the requirement for practitioners to submit a completed application and attestation form. The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source providers’ credentials, licenses, and applicable		

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	education and experience as part of the recredentialing process. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of recredentialing files to the NCC prior to the NCC’s review of recredentialing files. The VO Facility Provider Recredentialing Process policy described VO’s recredentialing criteria for facilities and stated that all facilities must complete the recredentialing process and be approved by the VO NCC. The FBHP Credentialing Manual and FBHP Credentialing Program policy detailed the provision that all PMHC staff/providers followed the same credentialing and recredentialing process used by VO, except for the final decision step, which was made by a combined committee of PMHC and FBHP staff, with final approval by the FBHP medical director. The FBHP Credentialing Committee meeting minutes of August 19, 2009, and October 15, 2009, provided evidence that the FBHP Credentialing Committee reviewed and made a determination based on PMHC credentialing and recredentialing files. Required Actions: None		
	2.E. The process for managing credentialing/recredentialing files that meet the Contractor’s established criteria	Documents Submitted/Location Within Documents: 1. N202 Organization of Practitioner Credentialing & Recredentialing File.pdf (Entire policy) 2. FBHPartners Credentialing ManualPMHC.doc (see pg 3 under Sec A)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Organization of Practitioner Credentialing & Recredentialing File policy described VO’s use of a proprietary electronic database for storing and managing credentialing and recredentialing files for practitioners and facilities. According to the criteria established by policy, the credentialing database stored the following: provider agreements, applications, compliance documents, correspondence, credentialing/recredentialing information, disenrollment, education, foreign network documentation, invalid documents, legal documents, licensure, malpractice insurance, primary source verification documents and results, resumes, and other documents. The FBHP Credentialing Manual described the process for maintaining the confidentiality of PMHC credentialing files, which included maintaining files in a secure, locked location in the human resources department and storing electronic information in a secure database maintained by FBHP and VO. Required Actions: None		

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	2.F. The process for delegating credentialing or recredentialing (if applicable)	Documents Submitted/Location Within Documents: 1. FBHPartners Credentialing Delegation Policy final 2009.doc (entire document; this policy describes FBHPartners’ delegation of credentialing to ValueOptions) 2. FBHPartners Policy Credentialing Program 2009.doc (FBHPartners maintains a process for credentialing all partner MHC providers and follows the same criteria as laid out by ValueOptions) 3. Delegation agreement – executed 0912.pdf (see in Standard IX Subcontracts and Delegation folder – pg 2 Article II 2.02c; pg 8 Exhibit A - #3; pg 13 Exhibit B) 4. Management Services Agreement FINAL 091216.pdf (see in Standard IX Subcontracts and Delegation folder – pg 14-15 Exhibit A)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Credentialing Manual detailed FBHP’s credentialing and recredentialing process, which included delegation of most of the credentialing and recredentialing activities to VO. The FBHP Delegation Agreement provided evidence of the delegation relationship. The FBHP Credentialing Manual and the FBHP Credentialing Delegation policy included provisions for VO’s credentialing and recredentialing process whereby VO was responsible for credentialing and recredentialing individual providers within the network and for primary source verification of PMHC individual providers. The FBHP Credentialing Manual and FBHP Credentialing Program policy maintained that all PMHC staff/providers followed the same credentialing and recredentialing process used by VO, except for the final decision step, which was made by a combined committee of PMHC and FBHP staff, with final approval by the FBHP medical director. The FBHP Credentialing and Recredentialing Delegation policy described FBHP’s oversight of VO’s credentialing and recredentialing program, which included verifying that VO maintained a well-defined credentialing and recredentialing process for credentialing and contracting with licensed practitioners to provide services to members.		
	Required Actions: None		

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	2.G. The process for ensuring that credentialing and recredentialing are conducted in a non-discriminatory manner, (i.e., must describe the steps the Contractor takes to ensure that it does not make credentialing and recredentialing decisions based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or patients in which the practitioner specializes)	Documents Submitted/Location Within Documents: 1. N101 Overview of National Networks Policy.pdf (entire policy) 2. N201 Practitioner Credentialing Process.pdf (see Page 2, Section IV.D) 3. FBHPartners Credentialing ManualPMHC.doc (see pg 1 under Sec “Non-discrimination”)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing policy described VO’s process for credentialing providers who sought to participate in the network. The policy contained VO’s nondiscrimination clause that VO did not make credentialing decisions based on an applicant’s race, ethnic/national identity, gender, age, or sexual orientation, or based on the type of procedure or patient in which the practitioner specialized. The VO Practitioner Recredentialing Process policy described VO’s process for recredentialing providers who participated in the network. The policy contained VO’s nondiscrimination clause that VO did not make recredentialing decisions based on an applicant’s race, ethnic/national identity, gender, age, or sexual orientation, or based on the type of procedure or patient in which the practitioner specialized. The VO Overview of National Networks policy contained the provision that the NCC was made up of a diverse group of peers who were required to sign statements of nondiscrimination to participate on the panel. The policy described the steps the NCC took to ensure that credentialing and recredentialing activities occurred in a nondiscriminatory manner. These steps included an annual evaluation of network policies to ensure that practices did not occur in a nondiscriminatory manner and a biannual audit of 15 practitioner files to review credentialing activity for potential discrimination. The Bi-Annual Audit Report for July through December 2009 contained evidence of VO’s review of credentialing files to determine that discrimination did not occur during the credentialing and recredentialing processes. The VO Overview of National Networks policy also described the process by which the credentialing director reviewed quarterly reports that captured any documented telephone calls or letters from providers alleging discrimination. The FBHP Credentialing Manual detailed FBHP’s provision for performing all PMHC staff credentialing and recredentialing activities in a nondiscriminatory manner and that recruitment of providers and credentialing and recredentialing decisions were made without consideration for the individual’s race, ethnic/national identity, gender, age, or sexual orientation, or for the type of procedure or patient in which the practitioner specialized.		
	Required Actions: None		

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	2.H. The process for notifying practitioners if information obtained during the Contractor’s credentialing/recredentialing process varies substantially from the information they provided to the Contractor	Documents Submitted/Location Within Documents: 1. N207 Practitioner Rights and Notification Policy.pdf (see Page 3, Section V.B.1-2) 2. FBHPartners Credentialing ManualPMHC.doc (see pg 4 Sec A #3)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Rights and Notification policy described VO’s process for notifying practitioners if information obtained during the credentialing and recredentialing processes varied from the information provided to VO by the practitioner. The policy stated that VO credentialing staff notified the practitioner within five business days if information presented by the practitioner differed from what was discovered during the primary source verification process. VO staff stated that if information reported by the practitioner on the application differed from the information obtained from primary source verification, VO notified the practitioner by telephone, e-mail, or fax prior to issuing the formal letter. The VO Practitioner Rights and Notification policy further stated that the applicant had 10 business days to submit clarification and/or provide supporting documentation to resolve the conflict and continue the review process. The policy included provisions in the event practitioners did not respond to the request for clarification, at which time the credentialing administrator forwarded the file to the NCC with a recommendation to deny initial credentialing or disenroll the practitioner from the network. The FBHP Credentialing Manual contained the provision that if discrepancies were noted or if the file was incomplete, a representative of the Credentialing Committee would contact the applicant within five working days to inform the applicant that information obtained during the credentialing process varied from the information received from the applicant.			
Required Actions: None			
	2.I. The process for ensuring that practitioners are notified of the credentialing/recredentialing decision within 60 calendar days of the committee’s decision	Documents Submitted/Location Within Documents: 1. N201 Practitioner Credentialing Process.pdf (see Page 1, Section III.D.5) 2. N601 Role of National Credentialing Committee.pdf (See Page 1, Section III.B) 3. FBHPartners Credentialing ManualPMHC.doc (see pg 4 Sec A #5)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	Findings: The VO Role of National Credentialing Committee policy included the provision that practitioners and providers were notified of all favorable network participation/retention decisions within 60 calendar days of the NCC’s decision. Practitioners and providers were notified of all decisions for denial or disenrollment within five business days of the NCC’s decision. The FBHP Credentialing Manual contained the provision that applicants who met the credentialing requirements were notified in writing within 60 days of the committee’s decision.		
	Required Actions: None		
	2.J. The medical director or other designated physician’s direct responsibility and participation in the credentialing/recredentialing program	Documents Submitted/Location Within Documents: 1. N601 Role of National Credentialing Committee.pdf (see Page 1, Section III.C; Page 2, Section IV, Section V.A. and V.F.2) 2. N604 Role of Local Credentialing Committee.pdf (See Page 2, Section V.B) 3. FBHPartners Credentialing ManualPMHC.doc (see pg 1 under “role of Medical director) 4. FBHPartners Policy Credentialing Program 2009.doc (see pg 2 Sec III)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Role of National Credentialing Committee policy detailed the roles and responsibilities of the committee. The policy also described the leadership of the committee, which consisted of two cochairpersons, the chief medical officer or designated medical director, and the credentialing representative within the national network. The November 2009 NCC minutes provided evidence of the designated medical director’s participation on the committee. The FBHP Credentialing Manual detailed the roles and responsibilities of the medical director, who participated on the credentialing committee and maintained oversight and ultimate responsibility for the credentialing and recredentialing activities involving PMHC staff members who served members of the FBHP health plan.		
	Required Actions: None		

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	2.K. The process for ensuring the confidentiality of all information obtained in the credentialing/recredentialing process, except as otherwise provided by law	Documents Submitted/Location Within Documents: 1. N409 Confidentiality of Provider Other Credentialing Information.pdf (see Page 1, Section III.B) 2. FBHPartners Credentialing ManualPMHC.doc (see pg 3 Sec A)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Confidentiality of Provider Other Credentialing Information policy described VO's provision for maintaining the confidentiality of practitioner information obtained for credentialing. The policy detailed the process for ensuring the confidentiality of information, which included: maintaining a secure electronic format or physically secure file cabinet that contained confidential information, requiring credentialing staff to sign a confidentiality and nondisclosure agreement, confirming the practitioner's identity prior to disclosing confidential information telephonically, ensuring that NCC participants sign a confidentiality and nondisclosure agreement on an annual basis, and ensuring that information is not released without prior explicit consent from providers. The FBHP Credentialing Manual described the process for maintaining the confidentiality of PMHC credentialing files, which included maintaining files in a secure, locked location in the human resources department and storing electronic information in a secure database maintained by FBHP and VO.		
	Required Actions: None		
	2.L. The process for ensuring that listings in provider directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty	Documents Submitted/Location Within Documents: 1. N412 Provider Directory & Other Enrollee Information.pdf (see Page 1, Section III) 2. FBHPartners Credentialing ManualPMHC.doc (see pg 3 Sec A)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Provider Directory & Other Enrollee Information policy provided evidence of VO's process to ensure that listings in provider directories and other materials for members were consistent with credentialing data, including information about education, training, certification, and specialty. Information listed in the provider directory was derived from the credentialing database, which was not to be changed unless authorized by the provider.		
	Required Actions: None		

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	2.M. The right of practitioners to review information submitted to support their credentialing/recredentialing application	Documents Submitted/Location Within Documents: 1. N207 Practitioner Rights and Notification Policy.pdf (see Page 1, Section III.1) 2. FBHPartners Credentialing ManualPMHC.doc (see pg 4, Sec B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The Practitioner Rights and Notification policy detailed VO's provision for allowing practitioners to review information submitted to support their credentialing and recredentialing applications. The FBHP Credentialing Manual contained the provision that practitioners had the right to review information submitted to support their credentialing or recredentialing application.			
Required Actions: None			
	2.N. The right of practitioners to correct erroneous information	Documents Submitted/Location Within Documents: 1. N207 Practitioner Rights and Notification Policy.pdf (see Page 1, Section III.3) 2. FBHPartners Credentialing ManualPMHC.doc (see pg 4, Sec B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Rights and Notification policy described VO's process for notifying practitioners if information obtained during the credentialing and recredentialing process varied from the information provided to VO by the practitioner. The policy stated that applicants had the opportunity to submit clarification and/or provide supporting documentation to resolve the conflicting or erroneous information.			
The FBHP Credentialing Manual detailed FBHP's provision allowing practitioners to correct erroneous information.			
Required Actions: None			

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	2.O. The right of practitioners, upon request, to receive the status of their application	Documents Submitted/Location Within Documents: 1. N207 Practitioner Rights and Notification Policy.pdf (see Page 1) 2. FBHPartners Credentialing ManualPMHC.doc (see pg 5, Sec B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Rights and Notification Policy described the right of practitioners to request information regarding the status of their credentialing and recredentialing applications and to receive that information by credentialing staff. The policy stated that practitioners could request the status of their credentialing or recredentialing application by calling the National Networks Provider Line or the credentialing administrator directly, or by written communication. The credentialing application provided evidence that credentialing and recredentialing applicants were notified of their right to inquire about the status of the application. The FBHP Credentialing Manual outlined the provider's right to be informed of the status of his or her application.			
Required Actions: None			
	2.P. The right of the applicant to receive notification of their rights under the credentialing program	Documents Submitted/Location Within Documents: 1. N207 Practitioner Rights and Notification Policy.pdf (see Page 1, Section III.3) 2. FBHPartners Credentialing ManualPMHC.doc (see pg 5, Sec B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Practitioner Rights and Notification policy provided evidence of VO's provision for credentialing and recredentialing applicants to receive notification of their rights under the credentialing program, such as the right to review information in their credentialing application, correct erroneous information, and request information about the status of their application. The FBHP Credentialing Manual outlined the providers' right to be notified of their rights at the time of application. The VO Credentialing Application Cover Letter, which was sent to providers who requested a credentialing application, provided evidence that practitioners were notified of their rights under the credentialing program at the time of applying for credentialing and inclusion in the network.			
Required Actions: None			

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	2.Q. How the Contractor accomplishes ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles including: ◆ Collecting and reviewing Medicare and Medicaid sanctions ◆ Collecting and reviewing sanctions or limitations on licensure ◆ Collecting and reviewing complaints ◆ Collecting and reviewing information from identified adverse events ◆ Implementing appropriate interventions when it identified instances of poor quality, when appropriate	Documents Submitted/Location Within Documents: 1. N710 Ongoing Monitoring of Provider Sanctions.pdf (see Page 1, Section III) 2. N710A State Sanctions Log.pdf 3. N710C Office of Inspector General Log.pdf 4. N703 Involuntary Suspension Quality of Care.pdf (see Page 1) 5. 309 Quality of Care Issues and Outlier Practice Patterns.pdf (Entire policy) 6. 308 Critical Adverse Incidents Policy.pdf (Entire policy) 7. FBHPartners Credentialing ManualPMHC.doc (see pg 6 Sec D) 8. FBHPartners Policy Qual Care Concerns Final FY 10.doc (Folder Standard X QI, entire policy)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Ongoing Monitoring of Provider Sanctions policy detailed VO’s provision for continually monitoring practitioner sanctions, complaints, and quality issues between recredentialing cycles. The policy stated that it was the responsibility of the credentialing administrator to review disciplinary action/sanction reports to identify any VO credentialed practitioners or organizational providers sanctioned by Medicare/Medicaid, a federal or state agency, and/or a licensure or certification board. The review also consisted of identifying any practitioner who was excluded or opted out of the Medicare program. The policy contained the provision that disciplinary action reports must be reviewed within 30 days of their release date by the reporting entity. For any VO provider identified on the disciplinary action/sanction report, the credentialing administrator queried the NPDB to obtain additional information on the sanction or disciplinary action. The policy also specified the provision for the credentialing administrator to forward complaints, quality issues, sanctions, or other adverse events to the NCC with the recommendation to review the information and make a decision regarding the practitioner’s participation in the network. The FBHP Credentialing Manual listed the strategies FBHP used to monitor and investigate provider performance between recredentialing cycles, such as clinical record reviews, grievance and complaint monitoring, professional conduct reports monitoring, and encounter record and billing monitoring.		
	Required Actions: None		

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	2.R. The range of actions available to the Contractor if the provider does not meet the Contractor's standards of quality	Documents Submitted/Location Within Documents: 1. N701 Practitioner and Provider Compliance.pdf (see Pages 3, Section V.B.8.1-2, C, D and Page 4, Section V.E) 2. N703 Involuntary Suspension Quality of Care.pdf (see Pages 1, Section III and Page 3, Section V.B) 3. N705 Practitioner Disenrollments.pdf 4. FBHPartners Credentialing ManualPMHC.doc (see pg 6 Sec D) 5. FBHPartners Policy Qual Care Concerns Final FY 10.doc (Folder Standard X QI, entire policy)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner and Provider Compliance policy, the VO Involuntary Suspension Quality of Care policy, and the VO Practitioner Disenrollments policy provided evidence of VO's provision to provide a written warning or suspend or terminate a practitioner's involvement in the provider network if the provider did not meet VO's standards of quality. The FBHP Credentialing Manual detailed FBHP's provision for reporting adverse licensure or professional conduct to the NPDB and the Colorado Department of Regulatory Agencies.		
	Required Actions: None		
	2.S. If the Contractor has taken action against a practitioner for quality reasons, the Contractor reports the action to the appropriate authorities	Documents Submitted/Location Within Documents: 1. N701 Practitioner and Provider Compliance – Pages 3, Section V.B-E 2. N703 Involuntary Suspension Quality of Care – Page 3, Section V.E.2 3. N705 Practitioner Disenrollments – Entire policy 4. FBHPartners Credentialing ManualPMHC.doc (see pg 6 Sec D) 5. FBHPartners Credentialing ManualPMHC.doc (see pg 6 Sec D)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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References	Requirement	Evidence Submitted by the BHO	Score
	Findings: The VO Involuntary Suspension Quality of Care policy described the process by which VO notified the appropriate authorities, such as the NPDB and appropriate licensing boards, when it took action against a practitioner for quality reasons.		
	Required Actions: None		
	2.T. A well defined appeal process for instances in which the Contractor chooses to alter the conditions of a practitioner's participation based on issues of quality of care or service	Documents Submitted/Location Within Documents: 1. N606 Provider Appeal Process.pdf (Entire policy) 2. N607 Fair Hearing Process.pdf (Entire policy) 3. ValueOptions Practitioner Agreement.pdf (Page 4, Section 2.9 and Page 7, Section 6.2) 4. FBHPartners Credentialing ManualPMHC.doc (see pg 5 Sec c)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Provider Appeal Process policy detailed the process by which providers may file an appeal based on issues of quality of care or service. The policy stated that provider appeals are reviewed by the Provider Appeals Committee. The policy specified that the provider may file an appeal with VO or the Department if the provider disagrees with the findings of the Provider Appeals Committee. The VO Practitioner Agreement and Provider Handbook provided evidence that the provider appeal process was communicated to providers upon enrollment.		
	Required Actions: None		
	2.U. How the Contractor makes the appeal process known to practitioners	Documents Submitted/Location Within Documents: 1. Provider Handbook (Folder Miscellaneous, Page 5, Appeals) 2. ValueOptions Practitioner Agreement.pdf (see Page 4, Section 2.9) 3. FBHPartners Credentialing ManualPMHC.doc (see pg 5 Sec B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Agreement and Provider Handbook provided evidence that the provider appeal process was communicated to providers upon enrollment. The FBHP Credentialing Manual stated that notification of providers' right to appeal was also provided to practitioners in writing at the time of application.		

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	Required Actions: None		
NCQA CR2— Element A	3. The Contractor designates a credentialing committee that uses a peer-review process to make recommendations regarding credentialing and recredentialing decisions. The committee includes representation from a range of participating practitioners.	Documents Submitted/Location Within Documents: 1. N601 Role of National Credentialing Committee (NCC).pdf (see Page 1, Section III.A) 2. N604 Role of Local Credentialing Committee (LCC).pdf (Entire policy) 3. NCC Minutes November 2009.pdf 4. LCC Minutes November 2009.pdf 5. FBHPartners Policy Credentialing Program 2009.doc (see pg 1 Sec IIA) 6. FBHPartners Credentialing ManualPMHC.doc (see pg 1-2; “Credentialing Committee”) 7. FBHPartners Credentialing committee minutes-8-19-09.doc (minutes from FBHPartners credentialing committee for Partner MHCs) 8. FBHPartners Credentialing committee minutes-10-15-09.doc (minutes from FBHPartners credentialing committee for Partner MHCs)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Credentialing Manual and the FBHP Credentialing Delegation policy included provisions whereby VO was responsible for credentialing and recredentialing individual providers within the network and for primary source verification of PMHC individual providers. The FBHP Credentialing Manual and FBHP Credentialing Program policy maintained that all PMHC staff/providers followed the same credentialing and recredentialing process used by VO, except for the final decision step, which was made by a combined committee of PMHC and FBHP staff, with final approval by the FBHP medical director. The VO Role of National Credentialing Committee policy detailed the roles and responsibilities of the committee and defined the committee as a standing subcommittee of the Quality Council. The policy also stated that the NCC used a peer review process to make decisions. The VO of Colorado Local Credentialing Committee policy detailed the roles and responsibilities of the CLCC for reviewing and rendering credentialing and recredentialing decisions. VO staff stated that the CLCC reviewed and made recommendations for approval or denial of recredentialing files to the NCC prior to the NCC’s review of recredentialing files. The		

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	November 2009 VO NCC meeting minutes provided evidence of the range of disciplines represented on the committee, such as psychiatrists, psychologists, licensed clinical social workers, and counselors. The FBHP Credentialing Manual described the FBHP Credentialing Committee, which was composed of a multidisciplinary team of representatives from human resources, utilization management, member and family affairs departments, and clinical staff. The FBHP Credentialing Committee was responsible for reviewing credentialing and recredentialing files and making credentialing and recredentialing decisions based on the information collected by the applicant and primary source verification information received from VO. The FBHP Credentialing Committee meeting minutes of August 19, 2009, and October 15, 2009, provided evidence of a peer review process used to make decisions about credentialing and recredentialing of PMHC staff. Required Actions: None		
NCQA CR2— Element B	4. The Contractor provides evidence of the following: ◆ Credentialing committee review of credentials for practitioner who do not meet established thresholds ◆ Medical director or equally qualified individual review and approval of clean files	Documents Submitted/Location Within Documents: 1. NCC Minutes November 2009 2. LCC Minutes November 2009 3. FBHPartners Credentialing committee minutes-8-19-09.doc (minutes from FBHPartners credentialing committee for Partner MHCs) 4. FBHPartners Credentialing committee minutes-10-15-09.doc (minutes from FBHPartners credentialing committee for Partner MHCs)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing Process and Facility Provider Credentialing Process policies described VO’s process for making credentialing decisions and selecting providers to participate in the network. The policies described the process by which “clean” files with recommendations for approval were forwarded to the VO medical director, who acted on behalf of the VO NCC to approve clean credentialing files. The November 2009 VO NCC meeting minutes provided evidence of the committee’s review of the credentials of providers who did not meet minimum thresholds. The meeting minutes also provided evidence of the medical director’s review and approval of “clean” practitioner credentialing files. The FBHP Credentialing Committee meeting minutes of August 19, 2009, and October 15, 2009, provided evidence of the committee’s review of applicants for initial credentialing and recredentialing. Some of the applicants met the credentialing criteria while others were pending because they did not meet the thresholds. Required Actions: None		

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NCQA CR3— Element A Element B	5. The Contractor conducts timely verification (using primary sources) of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Verification includes: ◆ A current, valid license to practice ◆ A valid DEA or CDS certificate ◆ Education and training, including board certification, if applicably ◆ Work history ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner	Documents Submitted/Location Within Documents: 1. N401 Primary Source Verification Policy.pdf (see Page 1-2, Section III.A, Page 3, Section V.D.1, Page 4, Section V.D.10, 11 and 14) 2. N401A Primary Source Verification Report.pdf 3. Provider Credentialing Criteria Checklist.pdf 4. FBHPartners Credentialing ManualPMHC.doc (see pg 2 Credentialing-re-credentialing criteria; pg 8-9 CC checklists)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP delegated primary source verification of all independent and PMHC providers to VO. The VO Primary Source Verification policy detailed VO's process for verifying at the primary source providers' current, valid license to practice; valid U.S. Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate; education and training, including board certification, if applicable; work history; and a history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. The policy listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider's involvement with terrorists or terrorist activities.		
	Required Actions: None		

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NCQA CR4— Element A NCQA CR7— Element C	6. Practitioners complete an application for network participation (at initial credentialing and recredentialing) that includes a current and signed attestation and addresses the following: ◆ Reasons for inability to perform the essential functions of the position, with or without accommodation ◆ Lack of present illegal drug use ◆ History of loss of license and felony convictions ◆ History of loss or limitation of privileges or disciplinary activity ◆ Current malpractice insurance coverage (minimums= physician—.5mil/1.5mil; facility—.5mil/3mil) ◆ The correctness and completeness of the application	Documents Submitted/Location Within Documents: 1. N201 Practitioner Credentialing Process.pdf (see Page 1, Section III.A, Page 3, Section V.D.1-6) 2. FBHPartners Credentialing ManualPMHC.doc (see pg 3 under Sec A) 3. COUnivCredAppFormRevised 2-2009.pdf (form FBHPartners 's PMHC provider applicants must complete for credentialing/re-credentialing)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Credentialing Process policy detailed VO's credentialing process, which included the procedure for practitioners to complete and submit an application and attestation statement that addressed the following: reasons for inability to perform the essential functions of the position with or without accommodation, lack of present illegal drug use, history of loss of license and felony convictions, history of loss or limitation of privileges or disciplinary activity, current malpractice insurance coverage, and the correctness and completeness of the application. The FBHP Credentialing Manual also contained the provision that PMHC applicants must complete an application for credentialing or recredentialing, which included an attestation form for applicants to sign.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
NCQA CR5— Element A	7. The Contractor receives information on practitioner sanction before making a credentialing decision, including - State sanctions, restrictions on licensure or limitations on scope of practice - Medicare and Medicaid sanctions	Documents Submitted/Location Within Documents: - N401 Primary Source Verification Policy.pdf (see Pages 1-2, Section III.A.1-11, Page 3, Section V.D.1 and Page 4, Section V.D.10, 11 and 14) - N401H Sanction Notification Letter.pdf - FBHPartners Credentialing ManualPMHC.doc (see pg 3 under “prohibited relationships”)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Primary Source Verification policy listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities. The VO Practitioner Credentialing Process policy described the process by which the network coordinator forwarded clean credentialing files to the medical director, who had the authority to approve clean files on behalf of the NCC and forward recommendations for denial to the NCC for review and determination. Only complete credentialing files, with all primary source verification documents enclosed, were forwarded to the medical director or the NCC for review and determination.		
	The FBHP Credentialing Manual described the process by which the FBHP Credentialing Committee obtained primary source verification information from VO prior to determining credentialing or recredentialing status. This information included a summary of State sanctions, restrictions on licensure or limitations on scope of practice, or Medicare and Medicaid sanctions.		
	Required Actions: None		

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NCQA CR6— Element A	8. The Contractor has a process to ensure that the offices of all practitioners meets its office-site standards. The organization sets standards for ◆ Office site criteria ▪ Physical accessibility ▪ Physical appearance ▪ Adequacy of waiting and examining room space ▪ Availability of appointments ◆ Medical/treatment record criteria ▪ Secure/confidential filing system ▪ Legible file markers ▪ Records are easily located	Documents Submitted/Location Within Documents: 1. N406A Practitioner Site Visit.pdf (Entire policy) 2. N406AA Data Definitions for the Environmental Site Review Tool for Practitioners.pdf 3. N406AC Practitioner Environmental Site Review.pdf 4. N406B Facility Organization Site Visit.pdf (Entire policy) 5. N406BA Data Definitions for the Organization Facility Environmental Site Review.pdf 6. N406BB Organization Facility Environmental Site Review.pdf 7. Facility Site Review Mile High Council.pdf 8. Facility Site Review Jacob Family Services Main Street.pdf 9. Facility Site Review Jacob Family Services Remington Street.pdf 10. Jacob Family Services Credentialing Letter.pdf 11. Mile High Credentialing Letter.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Practitioner Environmental Site Review form and the VO Organization Facility Environmental Site Review form provided evidence that VO maintained a process to ensure that the offices of all practitioners met office-site standards. The completed Organization Facility Environmental Site Review tools for Mile High Council, Jacob Family Services Main Street, and Jacob Family Services Remington Street provided evidence that VO conducted site visits and assessed the following criteria: physical accessibility and Americans with Disabilities Act (ADA) compliance, physical appearance, adequacy of waiting and examining room space, availability of appointments, medical/treatment record criteria, secure/confidential filing system, and legible file markers. VO also verified that records were easily located.		
	Required Actions: None		

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NCQA CR6— Element B	9. The Contractor implements appropriate interventions by: ◆ Conducting site visits of offices about which it has received member complaints ◆ Instituting actions to improve offices that do not meet thresholds ◆ Evaluating effectiveness of the actions at least every six months, until deficient offices meet the thresholds ◆ Monitoring member complaints for all practitioner sites at least every six months ◆ Documenting follow-up visits for offices that had subsequent deficiencies	Documents Submitted/Location Within Documents: 1. N406A Practitioner Site Visit.pdf (see Pages 1, Section III, Page 3, Section V.E-H, and Page 4, Section V.K) 2. N406B Facility Organization Site Visit.pdf (Entire policy)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Site Visit policy described VO’s provision for conducting a structured site visit review for all practitioners’ offices with two or more documented member complaints in a six-month time frame when those complaints related to physical accessibility, physical appearance, the adequacy of waiting/examining room space, the availability of appointments, and/or the adequacy of treatment record-keeping. VO also conducted a site visit review when a quality-of-care issue indicated that a site visit might resolve the issue and/or when contractually obligated. The policy detailed VO’s procedure for requiring a CAP for office site visits that did not meet the minimum performance thresholds. The policy also stated that VO would conduct a follow-up visit every six months to evaluate the effectiveness of the interventions detailed in the facility’s CAP and to determine if the facility met the minimum performance threshold. The policy detailed the provisions by which VO documented the site visits and forwarded the information to the NCC.		
	Required Actions: None		

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NCQA CR7— Element A Element B Element D NCQA CR8	10. The organization formally recredentials its practitioners (at least every 36 months) through information verified from primary sources. The information includes: ◆ A current, valid license to practice ◆ A valid DEA or CDS certificate ◆ Board certification ◆ A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner ◆ State sanctions, restrictions on licensure, or limitations on scope of practice ◆ Medicare and Medicaid sanctions	Documents Submitted/Location Within Documents: 1. N501 Practitioner Recredentialing Process – Page 1, Section III and Page 2, Section IV.C 2. N502 Facility Program Clinic Recredentialing Process – Page 1, Section IV.A, Page 2, Section V.D-E and Page 3, Section V.G 3. FBHPartners Credentialing ManualPMHC.doc (see pg 6 Sec F; pg 9 Re-credentialing checklist)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The Practitioner Recredentialing Process policy described VO’s process for recredentialing practitioners, which included primary source verification of identified credentialing elements at least every 36 months. The VO Primary Source Verification policy detailed VO’s process for verifying at the primary source providers’ current, valid license to practice; valid DEA or CDS certificate; education and training, including board certification, if applicable; work history; and a history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. The policy also listed the types of primary source databases used to verify any Medicare or Medicaid sanctions, other federal sanctions, or a provider’s involvement with terrorists or terrorist activities.		
	The FBHP Credentialing Manual contained the provision that licensed PMHC staff were recredentialed at least every 36 months.		
	Required Actions: None		

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NCQA CR11— Element A	11. The Contractor has (and implements) written policies and procedures for the initial and ongoing assessment of (organizational) providers with which it contracts, which include:	Documents Submitted/Location Within Documents: 1. N203 Facility Provider Credentialing Process.pdf (see Pages 2-3, Section V.G) 2. N203A Facility Provider Credentialing Workflow.pdf 3. N206 Credentialing Criteria for Facility.pdf Organizational Providers.pdf (see Page 1, Section III, Page 2, Section IV.A.1 and IV.A.6)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	11.A. The Contractor confirms that the provider is in good standing with state and federal regulatory bodies.		
	Findings: The VO Facility Provider Credentialing Process policy detailed VO's provision for credentialing organizational providers. The policy stated that eligibility was determined by the extent to which applicants met VO credentialing criteria. The VO Credentialing Criteria for Facility Organizational Providers policy listed the facility/organization criteria, which were applicable to all providers, and the program-specific criteria for specialized providers, such as inpatient psychiatric facilities. The VO Facility Provider Credentialing Process policy described the process by which VO staff verified that providers were in good standing with State and federal regulatory bodies.		
	Required Actions: None		
	11.B. The Contractor confirms whether the provider has been reviewed and approved by an accrediting body.	Documents Submitted/Location Within Documents: 1. N206 Credentialing Criteria for Facility Organizational Providers.pdf (see Page 2 Section IV.4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Facility Provider Credentialing Process policy detailed VO's provision for credentialing organizational providers. The policy further defined eligibility as determined by the extent to which applicants met VO credentialing criteria. The VO Facility Provider Credentialing Process policy described the process by which a credentialing verification specialist verified the facility/organizational provider's accreditation status from the accrediting body to determine that accreditation was current at the time of the credentialing decision.		
	Required Actions: None		

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	11.C. If there is no accreditation status, the Contractor conducts an on-site quality assessment.	Documents Submitted/Location Within Documents: 1. N206 Credentialing Criteria for Facility Organizational Providers.pdf (see Page 2, Section IV.4) 2. Facility Site Review Mile High Council.pdf 3. Facility Site Review Jacob Family Services Main Street.pdf 4. Facility Review Jacob Family Services Remington Street.pdf 5. Jacob Family Services Credentialing Letter.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Facility Provider Credentialing Process policy described the process by which a credentialing verification specialist requested that a structured site visit be scheduled and completed for applicants that meet established credentialing criteria, but are not accredited. The facility site reviews for Mile High Council, Jacob Family Services Main Street, and Jacob Family Services Remington Street provided evidence that VO conducted the site visits.			
Required Actions: None			
	11.D. At least every three years, the Contractor confirms that the organizational provider continues to be in good standing with state and federal regulatory bodies, and if applicable, is reviewed and approved by an accrediting body. The Contractor conducts a site visit every three years if the organizational provider is not reviewed and approved by an accrediting body.	Documents Submitted/Location Within Documents: 1. N502 Facility Program_Clinic Recredentialing Process.pdf (see Pages 1-2, Section IV.A)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
Findings: The VO Facility Program Clinic Recredentialing Process policy described VO's recredentialing process, which included a review of organizational providers to determine if they remained in good standing. The VO Facility Provider Credentialing Process policy described the process by which the credentialing verification specialist requested that a structured site visit be scheduled and completed for applicants who met established credentialing criteria, but were not accredited. This site visit was conducted prior to recredentialing decisions and within 36 months from the initial or previous recredentialing decision.			

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	Required Actions: None		
	11.E. The selection process and assessment criteria for each type of nonaccredited organizational provider with which the Contractor contracts.	Documents Submitted/Location Within Documents: 1. N206 Credentialing Criteria for Facility Organizational Providers.pdf (Entire policy)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Credentialing Criteria for Facility Organizational Providers policy detailed VO's selection process and assessment criteria for each type of nonaccredited organizational provider with which it contracts.		
	Required Actions: None		
NCQA CR11— Element A	12. Site visits for nonaccredited facilities include a process for ensuring that the provider credentials its practitioners.	Documents Submitted/Location Within Documents: 1. N206 Credentialing Criteria for Facility Organizational Providers.pdf (see Page 8, Section V.C.16.c) 2. Facility Environmental Site Review.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Facility Environmental Site Review audit form provided evidence that VO maintained a process for ensuring that the facility credentialed its practitioners. The completed Facility Site Review report for Mile High Council provided evidence that VO verified that the organization credentialed its practitioners.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
NCQA CR11— Element B	13. The Contractor’s organizational provider assessment policies and process includes at least: ◆ Inpatient facilities ◆ Residential facilities ◆ Ambulatory facilities	Documents Submitted/Location Within Documents: 1. N206 Credentialing Criteria for Facility Organizational Providers.pdf (Entire policy) 2. Facility Environmental Site Review.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO Credentialing Criteria for Facility Organizational Providers policy described the process for credentialing facilities and organizational providers. The policy detailed the program-specific criteria for the following provider types: inpatient psychiatric, inpatient detoxification, inpatient substance abuse rehabilitation, residential, partial hospitalization, 23-hour observation, ambulatory detoxification, intensive outpatient, day treatment, halfway house, methadone maintenance program, treatment group home, therapeutic foster care, home health, respite care, outpatient mental health and/or substance abuse clinic, eating disorders, dual diagnosis, pathological gambling, crisis intervention, crisis stabilization, psychiatric residency training programs, therapeutic nursery programs, employee assistance program services, and child placement agency.		
	Required Actions: None		
NCQA CR11— Element D	14. The Contractor has documentation that organizational providers have been assessed.	Documents Submitted/Location Within Documents: 1. Facility Site Review Mile High Council.pdf 2. Facility Site Review Jacob Family Services Main Street.pdf 3. Facility Site Review Jacob Family Services Remington Street.pdf 4. N206 Credentialing Criteria for Facility Organizational Providers.pdf (Entire policy). 5. N406AC Practitioner Environmental Site Review.pdf	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The VO facility site review reports provided evidence that VO conducted a site visit and assessed the following organizational providers: Mile High Council, Jacob Family Services Main Street, and Jacob Family Services Remington Street. Each assessment included a review of the physical appearance and accessibility of the office, the adequacy of waiting and examining room space, the availability of appointments, medical record confidentiality and security, and the organization of medical records.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
NCQA CR12— Element A—H	15. If the Contractor delegates any credentialing activities, the Contractor: ◆ Has a written delegation document with the delegate ◆ Retains the right to approve, suspend, and terminate individual practitioners, providers, and sites. This right is reflected in the delegation agreement ◆ Audits credentialing files annually against NCQA standards ◆ Performs an annual substantive evaluation of delegated activities against NCQA standards and organization expectations ◆ Evaluates regular reports ◆ The organization identifies and follows up on opportunities for improvement, if applicable	Documents Submitted/Location Within Documents: 1. FBHPartners Credentialing Delegation Policy 2009.doc (entire policy) 2. Delegation agreement – executed 0912.pdf (see in Standard IX Subcontracts and Delegation folder – pg 2 Article II 2.02c; pg 8 Exhibit A - #3; pg 13 Exhibit B) 3. Management Services Agreement FINAL 091216.pdf (see in Standard IX Subcontracts and Delegation folder – pg 14-15 Exhibit A)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The FBHP Credentialing Manual detailed FBHP’s credentialing and recredentialing process, which included delegation of most of the credentialing and recredentialing activities to VO. The FBHP Credentialing Manual and the FBHP Credentialing Delegation policy included provisions for VO’s credentialing and recredentialing process whereby VO was responsible for credentialing and recredentialing individual providers within the network and for primary source verification of PMHC individual providers. The FBHP Credentialing Delegation policy detailed the requirements of the delegation, which specified the following: FBHP’s right to approve, suspend, and terminate individual practitioners, providers, and sites; FBHP’s policy to audit credentialing files annually against NCQA standards; FBHP’s annual evaluation of delegated activities against NCQA standards and organization expectations; FBHP’s ongoing review and evaluation of reports; and VO’s follow up on opportunities for improvement, if applicable.		
	Required Actions: None		

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Results for Standard VIII—Credentialing and Recredentialing									
Total	Met	=	<u>39</u>	X	1.00	=	<u>39</u>		
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>		
Total Applicable		=	<u>39</u>	Total Score	=	<u>39</u>			

Total Score ÷ Total Applicable		=	<u>100%</u>
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Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.230(a)(1) Contract: IL.H.1	1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor.	Documents Submitted/Location Within Documents: 1. FBHP Policy Delegation of BHO respon final 2009.doc (see pg 1 Policy statement; pg 2 sec IV and V) 2. FBHP Policy Monitoring of Delegates final 2009.doc (entire document) 3. Delegation Agreement – Executed 0912.pdf (see pg 2-3 Article III 3.01; pg 7-13 Exhibit A and B) 4. V2003 FBHP All Data Disposition by month.xls (1 st qtr report reconciling encounters/claims – entire document) 5. FBHP 2009 Census.xls (UM delegation reports – monitoring) 6. QI_UM min December 2009.doc (UM delegation reports - monitoring) 7. FBHP_NOA_Report – Q1 FY '10.doc (UM delegation report)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP delegated several managed care functions to VO, including claims, clinical and utilization management services, credentialing, health information systems, provider network management, and data reporting. FBHP's Monitoring of Delegates and Delegation of BHO Responsibilities policies clarified that FBHP was ultimately responsible for all delegated functions. The terms and conditions of the delegation, including reporting requirements, were detailed in the Delegation Agreement between the two parties. FBHP provided a copy of an Authorization of Inpatient Days report used to monitor VO performance under the agreement. Minutes from a December 10, 2009, Quality Improvement/Utilization Management Committee meeting also documented that VO performance related to delegated functions was reviewed and discussed.		
	Required Actions: None		

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Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.230(b)(1) Contract: II.H.1	2. Before any delegation, the Contractor evaluates a prospective subcontractor's ability to perform the activities to be delegated.	Documents Submitted/Location Within Documents: 1. Pre-delegation site visit questions ValueOptions.doc (entire document; set of questions used to evaluate potential delegate ValueOptions) 2. FBHP Policy Delegation of BHO respon final 2009.doc (see pg 1, sec I and II)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP's Delegation of BHO Responsibilities policy required a thorough evaluation of a potential delegate before delegation. FBHP conducted a full-day predelegation review of VO August 20, 2009, to assess the delegate's ability to carry out its responsibilities under the agreement. The site visit included a review of policies and other administrative documents as well as interviews with key VO staff. Findings from the predelegation assessment were reviewed at FBHP's Board of Directors meeting September 22, 2009.		
	Required Actions: None		
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR 12— Element D	3. There is a written agreement with each delegate.	Documents Submitted/Location Within Documents: 1. Management Services Agreement FINAL 0911216.pdf (entire document) 2. Delegation Agreement Executed 0912.pdf (entire document) 3. FBHP Policy Delegation of BHO respon final 2009.doc (see pg 2, sec IV)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP's Delegation of BHO Responsibilities policy mandated that the responsibilities of any delegate entity be expressed in a written document that identified the delegate's reporting responsibilities and that addressed the corrective action process, including provisions regarding the cancellation of the agreement for nonperformance. The policy also specified that the delegate comply with the terms and conditions of the contract between FBHP and the Department. FBHP had in place both the Delegation Agreement and the Management Services Agreement with VO. The documents defined the services to be delegated and included provisions regarding reporting requirements and monitoring of delegate performance.		
	Required Actions: None		

Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.230(b)(2) Contract: II.H.2 NCQA CR12— Element A Element B Element C	4. The written delegation agreement: - Specifies the activities and reporting responsibilities delegated to the subcontractor - Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate For delegation of Credentialing only, the agreement: - Is mutually agreed upon - Describes the responsibilities of the Contractor and the delegated entity - Describes the delegated activities - Requires at least semiannual reporting to the Contractor - Describes the process by which the Contractor evaluates the delegated entity's performance - Describes the remedies available to the Contractor if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement - Includes a list of allowed uses of PHI - Includes a description of delegate safeguards to protect the information (PHI) from inappropriate uses - Includes a stipulation that the delegate will ensure that subdelegates have similar safeguards	Documents Submitted/Location Within Documents: - Management Services Agreement FINAL 0911216.pdf (pg 6-7 Section 6.2; pg 13-20 specific services under Exhibit A including claims, pg 13, UM, pg 13-14; Credentialing pg 14-15; Health Information System pg 16-17; Provider Network pg 18-19) - Delegation Agreement Executed 0912.pdf (pg 2, Article II; pg 7-10; pg 4 Article V; Exhibit A; pg 11-13 Exhibit B) - FBHP Policy Delegation of BHO respon final 2009.doc (see pg 2, sec IV) For delegation of credentialing: - Management Services Agreement FINAL 0911216.pdf (pg 2 Sec 1.4; pg 5 Sec 5.4; pg 6-7 Section 6.2-6.4; pg 14-15 under Exhibit A) - Delegation Agreement Executed 0912.pdf (pg 2-3 Article III, pg 3-4 Article IV; pg 4 Article V; pg 8 Exhibit A #3; Exhibit B pg 12;)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable

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	◆ Includes a stipulation that the delegate will provide individuals with access to their PHI ◆ Includes a stipulation that the delegate will inform the Contractor if inappropriate use of the information (PHI) occur ◆ Includes a stipulation that the delegate will ensure that PHI is returned, destroyed, or protected if the delegation agreement ends ◆ Includes a stipulation that the Contractor has the right to approve, suspend, and terminate individual practitioners, providers, and sites in situations where it has delegated decision-making		
	Findings: The Delegation Agreement and Management Services Agreement with VO incorporated a list of specific delegated activities and reporting responsibilities. The agreements also included provisions for revoking delegation or imposing other sanctions to address problem performance. All NCQA requirements related to the delegation of credentialing were addressed in the Delegation Agreement or in Exhibit E of the Management Services Agreement between FBHP and VO.		
	Required Actions: None		

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Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.230(b)(3)	5. The Contractor monitors the delegate's performance on an ongoing basis. The Contractor subjects subcontractor/delegate to a formal review according to a periodic schedule established by the State, consistent with industry standards or state MCO laws and regulations.	Documents Submitted/Location Within Documents: 1. FBHP Policy Monitoring of Delegates final 2009.doc (entire document) 2. Delegation Agreement Executed 0912.pdf (pg 2, Article III; pg 11-13 Exhibit B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP's Monitoring of Delegates policy required that the BHO monitor each delegate on an ongoing basis. The policy also stated that FBHP was responsible for conducting a formal annual review of a delegate's operations to assess the accuracy and timeliness of required reporting and to ensure compliance with contract requirements, industry standards, managed care laws, and regulations. FBHP's Delegation Agreement with VO stated that monitoring activity included regular meetings with the delegate, a review of reports submitted to FBHP, and a formal annual review of VO's performance for all delegated functions detailed in the Delegation Agreement. During the interview, staff described steps taken by the BHO to monitor VO performance through an ongoing review of encounter data and other deliverables. A discussion of VO's performance under the Delegation Agreement was also documented in minutes of a Board of Directors meeting December 1, 2009.		
	Required Actions: None		

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Standard IX—Subcontracts and Delegation			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.230(b)(4)	6. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action.	Documents Submitted/Location Within Documents: 1. FBHP Policy Monitoring of Delegates final 2009.doc (pg 4 Article V) 2. Management Services Agreement FINAL 0911216.pdf (pg 6 -7 Sec 6.2 – 6.4) 3. Delegation Agreement Executed 0912.pdf (pg 2, Article III; pg 11-13 Exhibit B)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP's Delegation Agreement and Management Services Agreement with VO described the process for identifying deficiencies and for implementing corrective action to address any problem performance. The documents detailed timelines for response and described the use of sanctions to address any ongoing or recurrent problems with delegate performance. At the time of the interview, FBHP staff reported that no areas of deficiency with VO had been identified and that the BHO used weekly meetings with its delegate to discuss any concerns prior to issues rising to the level of corrective action.		
	Required Actions: None		

Results for Standard IX—Subcontracts and Delegation						
Total	Met	=	<u>6</u>	X	1.00	= <u>6</u>
	Partially Met	=	<u>0</u>	X	.00	= <u>0</u>
	Not Met	=	<u>0</u>	X	.00	= <u>0</u>
	Not Applicable	=	<u>0</u>	X	NA	= <u>0</u>
Total Applicable		=	<u>6</u>	Total Score	=	<u>6</u>

Total Score ÷ Total Applicable		=	<u>100%</u>
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Standard X—Quality Assessment and Performance Improvement			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.240(a)	1. The Contractor has an ongoing Quality Assessment and Performance Improvement (QAPI) Program.	Documents Submitted/Location Within Documents: 1. FBHP Policy QA Program Revised 2009.doc (entire document) 2. QI Work Plan FBHP FY '10 Final.docx (entire document) 3. 1st Qtr QI Plan report FY '10.doc (entire document) 4. QI Program Evaluation '09.doc (entire document as example of annual program evaluation) 5. FBHP Policy Critical Incidents final FY '10.doc (entire document) 6. 1 st Qtr critical incident report, FY '10.doc (entire document) 7. FBHP Policy Qual Care Concerns Final FY '10.doc(entire document) 8. QI_UM Minutes, September 2009 (example of QI/UM committee oversight role) 9. FBHP Policy Medical Record Accuracy 2009.doc (entire document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP delegated the collection and maintenance of quality management and utilization management data to VO, including the responsibility to produce monthly and quarterly encounter/claim files and ensure the accuracy and completeness of encounter submissions. The BHO produced the annual Quality Assessment, Performance Improvement, and Outcomes Program Description and Plan that described the QAPI program structure and detailed performance improvement measures and other quality improvement activities for the upcoming fiscal year. FBHP evaluated performance related to quality initiatives on an ongoing basis. For example, the BHO published the Quality Improvement Annual Report for Fiscal Year 2009 that described measures related to access to care, coordination of care, utilization of services, and member satisfaction. The evaluation described past performance for each quality measure as well as interventions implemented to improve future performance. Oversight of the QAPI program was provided by the Quality Improvement /Utilization Management Committee, composed of members from FBHP, representatives from the BHO's two PMHCs, and VO.		
	Required Actions: None		

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Standard X—Quality Assessment and Performance Improvement			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.240(b)	2. The QAPI Program includes the following basic elements: ◆ Performance improvement projects ◆ The submission of performance measurement data	Documents Submitted/Location Within Documents: PIPs: 1. QI Work Plan FBHP FY '10 Final.docx (pg 3; QI/UM committee role; pg 4 – PIP subcommittee; Appendix A pg 20-22); 2. 1st Qtr QI Plan report FY '10 final.doc (pg 14-15) 3. QI Program evaluation '09.doc (pg 22-23) 4. JCMH ED visit PIP minutes 6_19_09.doc (entire document as project team example) 5. MHCBBC COC PIP minutes 8_25_09.doc (entire document as project team example) 6. QI_UM minutes, August 2009.doc (discussion of PIP plan – last item) Performance Measurement Data: 1. FBHP Policy QA Program Revised 2009.doc (see sec IV, pg 2) 2. QI Work Plan FBHP FY '10 Final.docx (see pg 8-19) 3. 1st Qtr QI Plan Report FY 10 final.doc (pg 3-13) 4. QI program evaluation '09 (pg 2-21) 5. Performance Indicator Report 4th Qtr FY '09 (entire document) 6. ROSC Evaluation FY '09.doc (entire document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP had two performance improvement projects (PIPs) in place during the review period. One study investigated whether targeted interventions improved coordination of care between physical and behavioral health providers for members with schizophrenia, schizoaffective disorder, and bipolar illness. The purpose of the second study was to decrease emergency department utilization for youth 17 years of age and younger by improving access to behavioral health outpatient crisis care, including crisis prevention and education services for youth and their families. At the time of the interview, FBHP staff reported that intervention strategies for the emergency department PIP included distributing flyers and other educational materials reminding youth and families of the		

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	availability of crisis center services. Project team meeting minutes dated June 19, 2009, and August 25, 2009, documented that both PIPs were being actively addressed through the BHO's quality improvement process. In addition, FBHP produced quarterly and annual performance measurement reports, several of which were submitted to the Department as deliverables. The reports included the Quarterly Quality Improvement Plan Report, the Quality Improvement Annual Report, and the Recovery Oriented System of Care Performance Project Report.		
	Required Actions: None		
42CFR438.240(b)(3)	3. The Contractor's QAPI program includes mechanisms to detect both underutilization and overutilization of services.	Documents Submitted/Location Within Documents: 1. FBHP Policy QA Program Revised 2009.doc (see pg 2 Sec IV A 3) 2. QI Work Plan FBHP FY '10 Final.docx (pg 14 item 3b & 3e) 3. 1st Qtr QI Plan report FY '10.doc (pg 8 item 3b & 3e) 4. Performance Indicator Report 4 th Qtr FY '09 (pg 1-4)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: The requirement to monitor under- and overutilization of services was addressed in FBHP's Quality Assessment and Performance Improvement Program policy. FBHP included utilization measures in its Quality Assessment, Performance Improvement, and Outcomes Program Description and Plan for Fiscal Year 2010. The BHO also reported data on several indicators related to under- and overutilization in quality improvement quarterly reports, and shared data with the Quality Improvement/Utilization Management Committee regarding the number of psychiatric admissions per 1,000, the average length of stay for hospital discharges, and under- and overutilization of services following hospitalization.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.240(b)(4)	4. The Contractor’s QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.	Documents Submitted/Location Within Documents: Note: FBHP considers all Members that receive behavioral health services to have “special health care needs” given behavioral health is a specialty health care service. 1. FBHP Policy QA Program Revised 2009.doc (see pg 2 Sec A) 2. QI Work Plan FBHP FY ’10 Final.docx (see pg 1 “overview;” pg 14-16; pg 22-23) 3. 1st Qtr QI Plan report FY ’10.doc (see pg 8-10) 4. QI Program Evaluation ’09.doc (see pg 14-18; pg 24-35 (client survey results include quality and appropriateness of care) 5. FBHP Policy Critical Incidents final FY ’10.doc (entire document) 6. 1st Qtr critical incident report, FY ’10.doc (entire document) 7. FBHP Policy Qual Care Concerns Final FY ’10.doc(entire document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP collected, analyzed, and reported data on multiple measures that assessed the quality and appropriateness of care provided to members with special health care needs. Both the FBHP 1st Quarter Quality Improvement Plan Report and the BHO’s Quality Improvement Annual Report for Fiscal Year 2009 included summary data related to quality-of-care and appropriateness-of-care indicators. Measures in the reports included coordination/timeliness of hospital follow-up, various utilization metrics, measures related to progress toward implementing a recovery-oriented system of care (ROSC), and implementation of evidence-based practices. The BHO also tracked and trended all critical incidents and quality-of-care concerns.		
	Required Actions: None		

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Standard X—Quality Assessment and Performance Improvement			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.240(e)(2)	5. The Contractor has a process for evaluating the impact and effectiveness of the QAPI Program.	Documents Submitted/Location Within Documents: 1. QI program evaluation '09 (entire document) 2. 1st Qtr QI Plan report FY '10.doc (entire document) 3. FBHP Policy QA Program Revised 2009.doc (see pg 1-2, Sec III) 4. QI_UM Minutes, September 2009 (committee review of FY '09 annual report)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP had a process in place to evaluate the impact and effectiveness of the QAPI program annually and throughout the year. Performance data for measures adopted by the Quality Improvement/Utilization Management Committee were included in quality improvement plan reports each quarter. The Quality Improvement Annual Report for Fiscal Year 2009 integrated comprehensive information regarding past performance for each indicator and included a description of the interventions used to enhance study outcomes in the future. Quality Improvement/Utilization Management Committee meeting minutes dated September 24, 2009, documented that the committee reviewed performance improvement findings included in the Quality Improvement Annual Report for Fiscal Year 2009.		
	Required Actions: None		

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Standard X—Quality Assessment and Performance Improvement			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.236(b)	6. The Contractor’s QAPI program addresses practice guidelines. The Contractor adopts practice guidelines that meet the following requirements: ◆ Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field ◆ Considers the needs of the Contractor’s members ◆ Are adopted in consultation with contracting health care professionals ◆ Are reviewed and updated periodically as appropriate	Documents Submitted/Location Within Documents: 1. FBHP Policy Clinical Practice Guidelines 2009.doc (entire document – covers all 4 elements) 2. Guideline committee 8_18_2009_minutes.doc (shows involvement of health care professionals, plan for guideline revisions, consider needs of members through consultation with CFAB) 3. Wellness Guidelines final.doc (example recent guideline developed – see last few pages for literature guideline based on) 4. Tips for Wellness.pdf (example recent tips developed) 5. Wellness_algorithm_final.doc (example recent guideline developed) 6. ODD Clinician Guidelines Final.doc (example recent guideline developed – see last few pages for literature guideline based on) 7. Tips for Parents_ODD.pdf (example recent Tips developed) 8. QI_UM minutes February 2009.doc (see item approval of Wellness guidelines)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP’s Clinical Practice Guidelines policy stated that the Clinical Practice Guidelines Subcommittee was responsible for developing guidelines that: 1) were based on clinical evidence and/or a consensus of behavioral health care professionals, 2) addressed disorders that were highly prevalent among members served by the BHO, 3) included local experts in the development of the guidelines, and 4) were reviewed and updated every three years, or more often if necessary. FBHP provided examples of recently adopted clinical practice guidelines, including an evidence-based wellness guideline and clinician guidelines for the treatment of children with oppositional defiant disorder. Staff indicated that all practice guidelines were approved by the BHO’s Quality Improvement/Utilization Management Committee as well as the Client and Family Advisory Board (CFAB). At the interview, staff members stated that they had recently developed a three-year plan to help guide the Clinical Guidelines Subcommittee in reviewing existing practice guidelines and in adopting new practice protocols.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.236(c)	7. The Contractor disseminates the guidelines to all affected providers, and upon request, to members and potential members.	Documents Submitted/Location Within Documents: 1. FBHP Policy Clinical Practice Guidelines 2009.doc (see pg 2-3 Sec C) 2. FBHPartners Member Handbook 101409.pdf (in Miscellaneous folder; see pg 9) 3. Provider Handbook.pdf (in Miscellaneous folder, see pg 29) 4. Provider_Forum_Training_Presentation_709.pdf (see slide 101 for IPN orientation to guidelines) 5. New Hire Orientation Agenda MHCBBC.doc (see Wed 1-3) 6. JCMH employ orientation Outline.doc (see under clinical) 7. Guidelines_MHCBBC.doc (shows posting of guidelines at Partner MHC) 8. Screen shot of CPG page JCMH.doc (shows posting of guidelines at Partner MHC)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP's Clinical Practice Guidelines policy required the availability of practice guidelines to members. The policy also mandated that providers receive information regarding the guidelines at orientation. Information regarding clinical practice guidelines, including how to access copies of the documents, was included in both the FBHP Member Handbook and in the Provider Handbook. The BHO hosted a presentation for providers regarding clinical practice guidelines in July 2009. In addition, all practice guidelines were posted on FBHP's Web site.		
	Required Actions: None		

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References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.236(d)	8. Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the practice guidelines.	Documents Submitted/Location Within Documents: 1. FBHP Policy Clinical Practice Guidelines 2009.doc (see pg 3 Sec F) 2. Wellness Guidelines final.doc (example recent guideline developed – with matching Tips education sheet for clients) 3. Tips for Wellness.pdf (example recent tips developed – matching with guideline) 4. ODD Clinician Guidelines Final.doc (example recent guideline developed – with matching Tips education sheet for clients) 5. Tips for Parents_ODD.pdf (example recent Tips developed –matching with guideline)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP’s Clinical Practice Guidelines policy stated that the guidelines may be used in making decisions regarding utilization management, member education, coverage of services, and other areas to which the guidelines apply. FBHP developed “tip” documents in collaboration with the CFAB that were used to educate members and families regarding best practices in the treatment of behavioral health disorders. FBHP staff members reported that they also worked closely with the Quality Improvement/Utilization Management Committee and representatives from VO to ensure that clinical practice guidelines were consistent with decisions regarding level-of-care criteria and coverage of services.		
	Required Actions: None		

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Standard X—Quality Assessment and Performance Improvement			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.242(a)	9. The Contractor maintains a health information system that collects, analyzes, integrates, and reports data that is used to support administration of the Contractor's Program.	Documents Submitted/Location Within Documents: 1. FBHP IT_HIS Delegation Policy 2009.doc (entire document) 2. FBHP delegated Health Infor System Flow.docx (entire document) 3. 1 st Qtr QI Plan report FY '10 final.doc (see page 3-13, example of health information reporting) 4. FBHP benefit limit report 1 st qtr FY 10.docx (example of health information reporting)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP delegated the collection, analysis, integration, and reporting of data used for producing many of its QAPI program reports and deliverables to VO. FBHP maintained responsibility for the collection, analysis, and reporting of member survey information and data related to grievances and appeals, access to care, and other special quality improvement projects. FBHP reported performance data on a wide range of quality indicators regarding access to care, coordination of care, member satisfaction, and utilization of services in its quality improvement program quarterly reports. The BHO also provided a copy of a report that tracked members who had exceeded their inpatient benefit.		
	Required Actions: None		

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Standard X—Quality Assessment and Performance Improvement			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.242(a)	10. The Contractor’s health information system must provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility.	Documents Submitted/Location Within Documents: 1. FBHP delegated Health Infor System Flow.docx (entire document) 2. 1 st Qtr QI Plan report FY ’10 final.doc (see pg 8 re: hospital utilization example) 3. FBHP Griev & Appeal Report Qtr 1 FY 09-10.doc (entire document) 4. FBHP Qtr 1 FY 09-10 Griev & Appeal Reprot.xls (entire document)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP’s and VO’s health information systems produced information regarding a wide range of quality improvement indicators, including utilization metrics and data regarding grievances and appeals. Information provided at the time of the desk review was that some reports regarding member disenrollments were produced by the Department. VO staff members indicated that they had the ability to report data regarding members who lose their eligibility due to incarceration. The BHO provided a copy of the Quality Improvement Program Quarterly Report for July through September 2009 that incorporated utilization measures, including psychiatric hospital inpatient days per 1,000 members. FBHP also published the quarterly Grievances and Appeals Narrative Report.		
	Required Actions: None		

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Standard X—Quality Assessment and Performance Improvement			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.242(b)	11. The Contractor collects data on member and provider characteristics and on services furnished to members.	Documents Submitted/Location Within Documents: 1. Provider Network delegation policy final 2009.doc (Folder Standard VII Provider Participation; entire document) 2. Draft FBHP Penetration & Membership characteristics FY10Q1.xls (example of report on member characteristics from health information system) 3. FBHP Provider Report Dec 2009.docx (example of report on provider characteristics form health information system)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP delegated the collection of data on member characteristics and tracking of provider characteristics to VO. VO was also responsible under the Delegation Agreement to collect and report service utilization information. VO produced the Penetration and Member Characteristics Report for the first quarter of FY 2010, which included data on plan members by age as well as information regarding penetration rates. VO also published and periodically updated a provider directory that included contact information for practitioners and information regarding areas of specialty practice and languages spoken.		
	Required Actions: None		

Appendix A. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Compliance Monitoring Tool
for Foothills Behavioral Health Partners, LLC

Standard X—Quality Assessment and Performance Improvement			
References	Requirement	Evidence Submitted by the BHO	Score
42CFR438.242(b)	12. The Contractor ensures that data received from providers is accurate and complete by: ♦ Verifying the accuracy and timeliness of reported data ♦ Screening the data for completeness, logic, and consistency ♦ Collecting service information in standardized formats to the extent feasible and appropriate.	Documents Submitted/Location Within Documents: 1. Delegation Agreement_Executed 0912.pdf (Folder Standard IX Subcontracts & Delegation – see pg 9) 2. FBHP Policy Medical Record Accuracy 2009.doc (see page 2, Sec III) 3. FBHP_Data_Report_Card_October_2009_Final.xls 4. VO SUBMISSION FILE layout.doc (entire document – shows standardized format for encounter submission)	☒ Met ☐ Partially Met ☐ Not Met ☐ Not Applicable
	Findings: FBHP actively monitored data received from providers to ensure that they were accurate, timely, and complete. FBHP's Medical Record Accuracy and Completeness policy described quarterly audits conducted in collaboration with VO that involved the review of a sample of encounters/claims against medical record documentation. The BHO also monitored the encounter claim file submitted by VO through the monthly Data Report Card. The Data Report Card for October 2009 included information regarding the timeliness of data submission by both providers and VO as well as the percentage of encounters with errors. At the interview, FBHP staff indicated that providers were required to use VO's encounter flat file to ensure standardization of encounter submissions.		
	Required Actions: None		

Results for Standard X—Quality Assessment and Performance Improvement									
Total	Met	=	<u>12</u>	X	1.00	=	<u>12</u>		
	Partially Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Met	=	<u>0</u>	X	.00	=	<u>0</u>		
	Not Applicable	=	<u>0</u>	X	NA	=	<u>0</u>		
Total Applicable		=	<u>12</u>	Total Score	=	<u>12</u>			

Total Score ÷ Total Applicable	=	<u>100%</u>
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Appendix B. **Grievance Record Review Tool** *for Foothills Behavioral Health Partners, LLC*

The completed grievance record review tool follows this cover page.



Appendix B. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Site Review Report
for Foothills Behavioral Health Partners, LLC

Plan Name:	Foothills Behavioral Health Partners, LLC
Review Period:	July 1, 2009–December 15, 2009
Date of Review:	January 21, 2010
Reviewer:	Gretchen Thompson
Participating Plan Staff Member:	Hazel Bond

1	2	3	4	5	6	7	8	9	10	11
File #	Case ID #	Date Grievance Received	Date of Acknowledg- ment Letter	Acknowledg- ment Sent in 2 W-days?*	Date of Written Notice of Disposition	# of Days to Notice	Resolved and Notice Sent in 15 W-days?*	Not Involved in Previous Level of Review	Appropriate Level of Expertise?	Resolution Letter Includes Required Content
1	***	7/6/09	7/8/09	Y ☒ N ☐ N/A ☐	7/24/09	18	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
2	***	7/15/09	7/15/09	Y ☒ N ☐ N/A ☐	7/15/09	0	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: A nonlicensed staff person rendered a decision on the grievance, which involved a change in psychiatrist and medication.										
3	***	8/5/09	8/7/09	Y ☒ N ☐ N/A ☐	8/27/09	22	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: On August 26, 2009, a notice of extension was sent to the member, which included the reasons for the extension and new date of resolution. Because this was a nonclinical grievance, the appropriate level of expertise was not applicable.										
4	***	8/11/09	8/13/09	Y ☒ N ☐ N/A ☐	8/27/09	16	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Because this was a nonclinical grievance, the appropriate level of expertise was not applicable.										
5	***	8/18/09	8/20/09	Y ☒ N ☐ N/A ☐	9/9/09	22	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments:										
6	***	8/21/09	8/24/09	Y ☒ N ☐ N/A ☐	8/24/09	3	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☒ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: A nonlicensed staff person rendered the decision on the grievance, which involved a clinical matter.										
7	***	8/27/09	8/27/09	Y ☒ N ☐ N/A ☐	9/25/09	29	Y ☐ N ☒ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☐ N ☒ N/A ☐
Comments: The resolution letter was not sent within the required time frame and it did not contain the results of the investigation or a resolution. Because this was a nonclinical grievance, the appropriate level of expertise was not applicable.										
8	***	8/28/09	9/1/09	Y ☒ N ☐ N/A ☐	9/21/09	24	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Because this was a nonclinical grievance, the appropriate level of expertise was not applicable.										
9	***	9/10/09	9/14/09	Y ☒ N ☐ N/A ☐	9/14/09	4	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐ N/A ☐
Comments: Because this was a nonclinical grievance, the appropriate level of expertise was not applicable.										



Appendix B. Colorado Department of Health Care Policy & Financing
FY 2009–2010 Site Review Report
for Foothills Behavioral Health Partners, LLC

1	2	3	4	5	6	7	8	9	10	11
File #	Case ID #	Date Grievance Received	Date of Acknowledgment Letter	Acknowledgment Sent in 2 W-days?*	Date of Written Notice of Disposition	# of Days to Notice	Resolved and Notice Sent in 15 W-days?*	Not Involved in Previous Level of Review	Appropriate Level of Expertise?	Resolution Letter Includes Required Content
10	***	9/14/09	10/1/09	Y ☐ N ☒ N/A ☐	10/1/09	17	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐ N/A ☐
Comments: The letter of acknowledgment contained the date, December 18, 2009. It was unclear from the letter of acknowledgment which date the letter was sent to the member to acknowledge the grievance. Therefore, the letter of resolution was used to demonstrate that the grievance was acknowledged, but it was not sent within the required time frame of two working days.										
11				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
12				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
13				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
14				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
15				Y ☐ N ☐ N/A ☐			Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐
Comments:										
# Applicable Elements				10			10	10	5	10
# Compliant Elements				9			9	10	3	9
Percent Compliant				90%			90%	100%	60%	90%

*W-days = Working days

# Applicable Elements	45
# Compliant Elements	40
Percent Compliant	88.9%

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

Table C-1 lists the participants in the FY 2009–2010 site review of **FBHP**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	Title
Gretchen Thompson	Executive Director, State & Corporate Services
Tom Cummins	Consultant
FBHP Participants	Title
Amie Adams	Clinical Director, ValueOptions
Hazel Bond	Director, Office of Member and Family Affairs, FBHP
Lucy Hausner	Client and Family Advocate, FBHP
Linda Runyon	Client and Family Advocate, FBHP
Diane Pohlman	Manager, Administrative Services, FBHP
Donald Rohner	Chief Executive Officer, FBHP
Barbara Smith	Director of Quality Improvement, FBHP
Department Observers	Title
Jerry Ware	Quality/Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2009–2010 for Foothills Behavioral Health Partners, LLC

FBHP is required to submit to the Department a corrective action plan (CAP) for all elements within each standard scored as *Partially Met* or *Not Met*. The CAP must be submitted within 30 days of receipt of the final report. For each 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 CAP has been approved by the Department. Following Department approval, the BHO must submit documents per the timeline that was approved.

Table D-1—Corrective Action Plan Process	
Step 1	Corrective action plans are submitted
	Each BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final external quality review site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification regarding the FTP posting. The BHO will submit the CAP using the template that follows. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of <i>Partially Met</i> or <i>Not Met</i>, 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, it 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 interventions to HSAG via e-mail or through the FTP site, with an e-mail notification regarding the FTP 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 require that, based on the nature and seriousness of the noncompliance, the BHO submit regular reports to the Department detailing progress made on one or more open elements in the CAP.

Table D-1—Corrective Action Plan Process	
Step 6	Documentation substantiating implementation of the plans is reviewed and approved
	Following a review of the CAP and all supporting documentation, the Department will inform the BHO 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 that substantiates the 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 D-2—FY 2009–2010 Corrective Action Plan *for* FBHP

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring/Follow-up Planned	Documents to be Submitted as Evidence of Completion
VI. The Grievance System 7. The Contractor acknowledges each grievance in writing within two working days of receipt.	One of the 10 grievance files reviewed was acknowledged outside of the required time frame. FBHP must ensure that all grievances are acknowledged within two working days of receipt of the grievance.				
8. The Contractor ensures that the individuals who make decisions on grievances are individuals who: ♦ Were not involved in any previous level of review or decision-making ♦ If deciding a grievance regarding the denial of expedited resolution of an appeal, or a grievance that involves clinical issues, has the	During the record review, 2 of the 5 grievances that involved a clinical issue did not provide evidence that the decision was rendered by a staff person with the appropriate clinical expertise to make a decision on the grievance. FBHP must ensure that the individuals who make decisions on grievances have the appropriate level of expertise in treating the member's condition for all grievances that involve a clinical issue. Furthermore, FBHP should document in the grievance file the individual(s) who made the decision on a member's				

Table D-2—FY 2009–2010 Corrective Action Plan *for* FBHP

Standard and Requirement	Required Actions	Planned Intervention and Person(s)/Committee(s) Responsible	Date Completion Anticipated	Training Required/Monitoring/Follow-up Planned	Documents to be Submitted as Evidence of Completion
appropriate clinical expertise in treating the member's condition or disease.	grievance and the level of expertise of the individual(s) to render a decision on a grievance that involved a clinical issue.				
9. The Contractor must dispose of each grievance and provide notice of the disposition in writing, as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the Contractor receives the grievance. The notice includes: ♦ The results of the disposition/resolution process ♦ The date it was completed	One grievance record reviewed notice did not describe the results of the grievance process or investigation. FBHP must ensure that all grievance notices of disposition include the results of the disposition/resolution process.				

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

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

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
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 for other review activities. ◆ HSAG staff members provided an orientation on September 22, 2009, for the BHO and the Department to preview the FY 2009–2010 compliance monitoring review process and to allow the BHO 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 members to the review team. ◆ 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
	◆ Since the BHOs had just completed the RFP/contracting process, with new organization having been formed, HSAG used only the BBA Medicaid managed care regulations to develop HSAG's 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 standards. ◆ Documents submitted for the desk review and during the on-site document review consisted of policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ 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.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	HSAG completed the following activities:
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 it needed and had identified during its desk audit. - HSAG requested and reviewed additional documents it needed and had 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 members to provide an overview of preliminary findings of the review. - HSAG used the FY 2009–2010 Site Review Report Template to compile the findings and incorporate information from the pre-on-site and on-site review activities. - HSAG analyzed the findings and assigned scores. - HSAG determined opportunities for improvement based on the review findings. - HSAG determined actions to be required of the BHO to achieve full compliance with Medicaid managed care regulations.
Activity 7:	Reported Results to the Department
	- HSAG completed the FY 2009–2010 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.