Colorado Medicaid
Community Mental Health Services Program

FY 2010–2011 Site Review Report

for

Foothills Behavioral Health Partners, LLC

May 2011

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

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Overview of FY 2010–2011 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 the State's quality strategy. The Department of Health Care Policy & Financing (the Department) has elected to complete this requirement for the Colorado behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This is the seventh year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2010–2011 site review process, the Department requested a review of three areas of performance. HSAG developed a review strategy and monitoring tools consisting of three standards for reviewing the three performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, and Standard III—Coordination and Continuity of Care.

The BHO's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 20 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid denials that occurred between January 1, 2010, and September 15, 2010. For the record review, the BHO received a score of *Yes* (compliant), *No* (not compliant), or *Not Applicable* for each of the elements evaluated. For cases in which the reviewer was unable to determine compliance due to lack of documentation, a score of *Unknown* was used. Compliance with federal regulations was evaluated through review of the three standards and administrative denial records. The BHO received an overall percentage of compliance score for the standards and a separate overall percentage of compliance score for the record review.

This report documents results of the FY 2010–2011 site review activities for the review period—January 1, 2010, through the dates of the on-site review, February 17 and 18, 2011. Section 2 contains summaries of the findings, opportunities for improvement, strengths, and required actions for each standard area. Section 3 describes the extent to which the BHO was successful in completing corrective actions required as a result of the 2009–2010 site review activities. Appendices A and B contain details of the findings. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action process the BHO will be required to complete and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing the three standards, HSAG used the BHO's contract requirements and regulations specified by the BBA, with revisions issued June 14, 2002, and effective August 13, 2002. HSAG conducted a desk review of materials submitted prior to the on-site review activities, a review of documents and materials provided on-site, and on-site interviews of key BHO personnel to determine compliance. 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 findings from review of the three standards follow in Appendix A. Details of the findings from the on-site denials record review follow in Appendix B.

The three standards chosen for the FY 2010–2011 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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 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 three areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, health care furnished by the BHO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the BHO's services related to the areas 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 requirement 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 requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for enhancement for some requirements, regardless of the score. Recommendations for enhancement for requirements scored as *Met* did not represent noncompliance with contract requirements or BBA regulations.

Table 1-1 presents the score for **Foothills Behavioral Health Partners, LLC** (**FBHP**) for each of the standards. Details of the findings for each standard follow 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	Coverage and Authorization of Services	33	33	32	1	0	0	97%
II	Access and Availability	12	12	12	0	0	0	100%
III	Coordination and Continuity of Care	6	6	6	0	0	0	100%
	Totals	**51**	**51**	**50**	**1**	**0**	**0**	**98%**

Table 1-2—Summary of Scores for Record Review

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials Record Review	120	81	81	0	49	100%

2. Summary of Performance Strengths and Required Actions

for **Foothills Behavioral Health Partners, LLC**

Overall Summary of Performance

FBHP earned an overall percentage-of-compliance score of 100 percent for two of the three standards HSAG reviewed (Standard II—Access and Availability and Standard III—Coordination and Continuity of Care). For Standard I (Coverage and Authorization of Services), **FBHP** earned a score of 97 percent. These scores demonstrated a very strong understanding and implementation of the Medicaid managed care regulations.

Standard I—Coverage and Authorization of Services

Summary of Findings and Opportunities for Improvement

HSAG found **FBHP**'s utilization management (UM) department (through its delegate, ValueOptions [VO],) to be well organized and operated. The utilization policies and procedures were written clearly and included all the requirements. During the on-site review of denial records, HSAG found that **FBHP**'s notice of action letters included all the required content and explained the reasons for the action in easy-to-understand terms. HSAG found extensive evidence that the procedures used to process denials were consistent with **FBHP**'s policies and with federal and State regulations.

Summary of Strengths

While **FBHP** delegated UM and authorization of services to VO, HSAG found extensive evidence that **FBHP** maintained a close relationship with its delegate and demonstrated a strong ownership of delegated services. **FBHP** had standardized criteria for utilization review and showed that it used those criteria consistently to make utilization review determinations.

Summary of Required Actions

HSAG found a conflict between **FBHP**'s policies and its member handbook. While **FBHP**'s policies clearly stated that no prior authorization was required for poststabilization services, the member handbook led the reader to believe that prior authorization was required. **FBHP** must clarify the member handbook to provide information that is consistent with its policies.

Standard II—Access and Availability

Summary of Findings and Opportunities for Improvement

FBHP's policies and procedures were written clearly and included all the required language. **FBHP**'s access standards were clearly communicated to staff members, providers, and members. It used a variety of mechanisms to ensure that its network was adequate to meet the needs of its members. The member handbook and provider manual included the right of members to ask for and obtain a second opinion and the circumstances under which a member could obtain services outside of the network.

Summary of Strengths

FBHP demonstrated strong provider oversight regarding access and availability, including processes for the community mental health centers (CMHCs) and the independent provider network (IPN). It employed several methods to ensure that its access standards were well known to both members and providers and that the standards were adhered to. **FBHP**'s Office of Member and Family Affairs played an active role in ensuring that members understood the standards and that care was readily accessible (especially regarding second opinions).

FBHP's cultural competence plan was comprehensive and included goals, objectives, and activities designed to ensure that effective and culturally and linguistically competent mental health services were accessible to members enrolled in **FBHP**. **FBHP** had made significant progress implementing this plan.

Summary of Required Actions

There were no required actions for this standard.

Standard III—Coordination and Continuity of Care

Summary of Findings and Opportunities for Improvement

HSAG found **FBHP**'s policies and procedures to be well written and comprehensive. These procedures clearly outlined the exceptions of providers regarding their responsibility to coordinate care with other providers and agencies. On-site interviews demonstrated that staff members were thoroughly trained and that procedures were being implemented as written.

Summary of Strengths

FBHP demonstrated a very strong line of communication between its administration and its providers regarding expectations for coordination of care. **FBHP** employed a variety of methods to emphasize the importance of coordinating care and to ensure that its expectations were clear to all providers. **FBHP** conducted comprehensive medical record reviews to assess for the presence and content of the individualized assessments and service plans. If **FBHP** found instances of noncompliance, it required providers to develop corrective action plans and followed up to ensure that the plans were implemented.

Summary of Required Actions

There were no required actions for this standard.

3. Follow-up on FY 2009–2010 Corrective Action Plan

for **Foothills Behavioral Health Partners, LLC**

Methodology

As a follow-up to the FY 2009–2010 site review, each BHO was required to submit a corrective action plan (CAP) to the Department addressing all requirements for which it received a score of *Partially Met* or *Not Met*. The BHO was required to describe planned interventions designed to achieve compliance with these requirements, the timelines associated with the activities, anticipated training and follow-up activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether the BHO successfully completed each of the required actions. HSAG and the Department continued to work with **FBHP** until the BHO completed each of the required actions from the FY 2009–2010 compliance monitoring site review.

Summary of 2009–2010 Required Actions

As a result of the FY 2009–2010 site review, **FBHP** was required to ensure that it acknowledges all grievances within two working days of 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. Furthermore, **FBHP** was required to 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.

Summary of Corrective Action/Document Review

FBHP submitted its corrective action plan in June 2010. It was reviewed and approved by HSAG and the Department. In August 2010, **FBHP** submitted revised documents in support of having completed all required actions.

Summary of Continued Required Actions

FBHP had no actions continued from the FY 2009–2010 site review process.

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
1. The Contractor ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. *42CFR438.210(a)(3)(i)* Contract: II.I.1.d	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder - Entire doc) 3. VO Colorado 202L Medical Necessity – Entire policy 4. VO Colorado 223L Treatment Planning – Entire policy 5. VO Colorado 236L Clinical Level Care Guidelines – Entire policy 6. VO Colorado 259L Enhanced Clinical Management of Outpatient Services – Entire policy 7. Level of Care Guidelines – Entire folder of guideline documents 8. Clinical Rounds Minutes 2010OCT27 – Entire document 9. FBHPartners Member Handbook 102209 (Misc folder - Pages 7-9) 10. FBHP Prov Manual Pt 1 of 2 (Misc folder – Page 3, Section II, *Continuum of Services* and Section IV, *Utilization Management Procedures*) 11. Section13.4 Covered Diagnoses 12. www.fbhpartners.c om (Member handbook and provider manual posted) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). Multiple policies and avenues exist for ValueOptions® (VO) to ensure that services provided to FBHPartners' members are reasonably expected to achieve their outcome. In addition to following policy and procedures, VO staff reference the Level of Care Guidelines for all levels of care to determine clear admission, continued stay and discharge criteria for use in case reviews. The guidelines are used to insure that services are appropriate for each member's situation	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	and the services are reasonably expected to achieve the outcome for which the service is furnished. ValueOptions®' clinical staff reviews guidelines, formally, at least annually. Members are made aware of the services that are available to them through the member handbook. The information includes explanations of covered benefits, available services, medical necessity and how determinations are made. Each new enrollee receives a copy of the handbook upon enrollment and handbooks are always available on the FBHPartners Web site.	
Findings: The FBHP Delegation Agreement between FBHP and VO delegated administrative services in the FBHP service area to VO, including UM and authorization of services as well as the administrative services of provider oversight and support. The FBHP UM Delegation policy included the processes for delegating operational responsibilities for FBHP's UM program to a qualified delegate (in this case, VO). FBHP oversight of activities delegated to VO was accomplished by the FBHP Quality Improvement/Utilization Management (QI/UM) Committee's review of policies, activities, and reports. The VO Medical Necessity policy described the use of standardized methods such as using pertinent clinical information and level-of-care (LOC) criteria and guidelines to make utilization review determinations. The VO Distribution of Clinical Level of Care Guidelines and Diagnostic Criteria policy described the process for developing and updating clinical guidelines. The VO Enhanced Clinical Management of Outpatient Services policy described the process for reviewing specific cases for the appropriateness of services (i.e., multiple providers, multiple family members, members approaching benefit limits). Methods of monitoring to ensure that services were provided in a sufficient amount, duration, and scope included chart audits (for both the IPN and CMHCs) as well as weekly clinical rounds. The October 27, 2010, and November 17, 2010, clinical rounds meeting minutes demonstrated team discussion of pertinent clinical issues and processing of complex cases. The member handbook described covered services. The provider manual described authorization processes and covered services.		
Required Actions: None		
2. The Contractor does not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42CFR438.210(a)(3)(ii)* Contract:	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 202 L Medical Necessity (Pages 3-5, Section V.A-F) 4. VO Colorado 303L Peer Advisor Adverse Determinations	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
II.I.1.e	(Entire policy) 5. FBHPartners Member Handbook 102209 (Misc folder – Pages 7-9) 6. Section13.4 Covered Diagnoses 7. Clinical Rounds Minutes 2010NOV17 (Highlighted section) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' staff refers to Medical Necessity and Clinical Criteria definitions to authorize care, based on individual case review to ensure that care is not arbitrarily reduced or denied based on diagnostic categories or conditions. Variables such as the member's situation and other care available are also taken into account in each individual situation as demonstrated by the Clinical Rounds process. ValueOptions®' staff refers cases for possible adverse clinical decisions to the Peer Advisor for review. Members are made aware of the services available to them through the member handbook. The information includes a description of services, a definition of medical necessity and an explanation of how to access the clinical care guidelines.	
Findings: The FBHP Delegation Agreement required VO to provide UM for authorization of services, maintain UM policies and procedures, and maintain authorization records. The VO Medical Necessity policy described the use of standardized criteria for making utilization review (UR) determinations. The VO Peer Advisor Adverse Determinations policy described the use of the peer advisor review process to make adverse determinations. The on-site record review revealed that peer advisors were PhD- or MD-level clinicians. On-site review of 20 denial records demonstrated that utilization staff made UR determinations based on whether the service was a covered service under the contract and on the established medical necessity and UR criteria.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
3. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. ◆ Consistent with the Contractor's published practice guidelines. ◆ On the basis of the Department's established utilization requirements or utilization review standards. *42CFR438.210(a)(3)(iii)* Contract: II.I.1.f	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 202L Medical Necessity (Page 3, Section IV. A-B) 4. VO Colorado 272L Tracking Medicaid Benefit Limits – (Entire policy) 5. Level of Care Guidelines (Entire folder of guideline documents) 6. FBHPartners Member Handbook 102209 (Misc folder – Page 7) 7. FY Inpatient Benefit Limit 2010 – Example of weekly monitoring report 8. www.fbhpartners.com **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions® has several policies that explain medical necessity, Medicaid benefit limits and clinical criteria which are based on the level of care guidelines. Members are informed of the various levels of care and the services available in the member handbook and have access to the Level of Care guidelines through the FBHPartners Web site.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The FBHP Delegation Agreement required VO to maintain UR LOC guidelines/criteria. The UR LOC guidelines/criteria were available in the provider tab on FBHP's Web site. The VO Medical Necessity policy described the development of UR criteria and guidelines for making UR determinations. The VO Tracking Medicaid Benefit Limits policy described the process for tracking when a member was close to reaching benefit limits and for communicating with the provider when necessary. The FY 2010 Inpatient Benefit Limit report provided an example of a tracking report and demonstrated FBHP/VO monitoring of members close to reaching benefit limits. The member handbook explained each covered service. During the on-site interview, FBHP staff members explained that intensive levels of care—e.g., inpatient, acute treatment unit (ATU), or residential treatment center

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
(RTC)—require prior authorization with clinical care manager (CCM) review. Staff also clarified that while lower levels of care (e.g., routine outpatient services) also required prior authorization, these service requests did not require CCM review and could be accomplished online or via a telephonic automated system. The purpose of authorizing lower levels of care in this manner was to register the use of the services and for utilization control and reporting. Staff members explained that if providers attempted to use the online or automated system to authorize a higher level service, the system would prompt a CCM to contact the provider the next day and process the request.		
Required Actions: None		
4. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State Medicaid program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: • The prevention, diagnosis, and treatment of health impairments, • The ability to achieve age-appropriate growth and development, • The ability to attain, maintain, or regain functional capacity. *42CFR438.210(a)(4)* Contract: I.A.23	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 202L Medical Necessity (Entire policy, especially Section IV.A (State's definition)) 4. VO Colorado 223L Treatment Planning (Entire policy) 5. FBHPartners Member Handbook 102209 (Misc folder – Page 9) 6. FBHP Prov Manual Pt 1 of 2 (Misc folder – Page 13, Section IV, *Utilization Management Procedures*) 7. Section13.4 Covered Diagnoses **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). Medically necessary services are needed for the diagnosis or treatment of a health impairment and also to prevent deterioration in functioning as a result of a covered mental health disorder. ValueOptions®' policies are based on the State Medicaid Program's definition for medical necessity and the covered diagnoses to best serve members. The member handbook includes this information for members to reference.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The VO Medical Necessity policy contained the State definition of medical necessity. The member handbook contained a definition of medical necessity that was consistent with the State definition and at the required readability level.		
Required Actions: None		
5. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR438.210(b)* Contract: II.I.1.g	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 203L Medical Necessity Determination (Pages 6-15 and Section IV) 4. VO Colorado 204L Intake Data Collection for Initial Authorization to Higher Levels of Care (Entire policy) 5. VO Colorado 206L Data Collection for Continued Authorization to Higher Levels of Care (Entire policy) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policies clearly define and outline the procedures and information needed for each type of authorization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Medical Necessity Determination policy described procedures for processing requests for authorization of initial and continuing services. The policy also described processes for documenting the determination and time frames for making the UR determination. The VO Intake Data Collection for Initial Authorization to Higher Levels of Care policy described the information needed and used to make preservice UR determinations for intensive levels of care, such as inpatient, ATU, or subacute services. The VO Data Collection for Continued Authorization to Higher Levels of Care policy described the information needed and used to make UR determinations for continuing authorization of intensive levels of care.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
6. The Contractor's written policies and procedures include mechanisms to ensure consistent application of review criteria for authorization decisions. *42CFR438.210(b)(2)(i)* Contract: II.I.1.j and II.I.1.q	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. ValueOptions® C409 Interrater Reliability (Entire policy) 4. VO Colorado 236L Clinical Level Care Guidelines (Page 2, Section V.A.2.c) 5. VO Colorado 408L Care Management Documentation Audit (Page 1, Sections I.A and III.A) 6. Initial Assessment Audit Report 2010JUL01 (entire doc) Example of documentation audit report **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policies ensure consistent application of criteria for authorization decisions. Documentation audit reports demonstrate staff documents the same information for use in consideration of the authorization decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Interrater Reliability (IRR) policy was a VO national policy and included the process for ongoing local IRR activities and an annual, companywide IRR for staff members engaging in UR activities. During the on-site interview, FBHP staff members confirmed that the VO requirement to pass was 80 percent. The Initial Assessment Audit Report (performed quarterly) measured CCM compliance with obtaining each of the required information elements from the member during the initial contact. The IRR survey scores for Colorado provided results for the Colorado Call Center staff on the VO national IRR test. Other methods of ensuring consistency of authorization decisions included review of UR and other clinical issues, as well as case processing of complex cases during weekly clinical rounds meetings.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
7. The Contractor's written policies and procedures include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* Contract: II.I.1.j	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 202L Medical Necessity (Page 4, Section V.D) 4. VO Colorado 203L Medical Necessity Determination (Page 20, Section M.2) 5. VO Colorado 303L Peer Advisor Adverse Determinations (Page 1, Section III.C) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policies direct staff to contact the provider, when necessary, for a review determination. In addition, VO policies outline a formal process which includes consult with a requesting provider, upon request, for reconsideration when initial authorization is denied. Finally, appropriate attempts are made to contact the requesting provider for reconsideration/peer to peer review before finalizing any adverse clinical decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Medical Necessity policy included the process for requesting additional medical records from the requesting provider when there is difficulty in making a review determination. The VO Medical Necessity Determination policy and the VO Peer Advisor Adverse Determinations policy described the processes of peer clinical review and reconsideration (peer-to-peer review). The on-site review of denial records demonstrated that the CCM documented in the electronic system that the requesting provider was offered a peer-to-peer review prior to finalizing the determination and sending a notice of action.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
8. The Contractor's written policies and procedures include the provision that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. *42CFR438.210(b)(3)* Contract: II.I.1.h and Exhibit V.A.4	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado Policy 303L Peer Advisor Determinations (Pages 1-2, Sections III.B and IV.C) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policy states the required expertise of the VO Peer Advisors who make decisions to deny or authorize less service than requested.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: During the on-site interview, FBHP management and UM staff described both the peer advisor determination process and the peer-to-peer reconsideration review process. Staff clarified that any cases that did not initially meet the criteria for authorization by the CCM were escalated to the peer advisor (who was at a psychiatrist level for inpatient or an ATU or RTC and PhD level for nonovernight levels of care). Staff also reported that peer-to-peer reconsideration reviews were also performed by the same peer level based on the level of service requested. On-site review of records demonstrated that the notice of action letters specifically named the staff member who made the determination and that FBHP/VO policies regarding the qualifications of the individual making the determination were followed.		
Required Actions: None		
9. The Contractor's written policies and procedures include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42CFR438.210(c)* Contract: II.I.1.j	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 203L Medical Necessity Determination (Page 8-14, Section V.D-G) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policy outlines the processes for notifying the requesting provider	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	and involved member of any decision to deny or authorize less care than requested, for all types of requests and levels of care. Specifically, • **Section V.D.4** outlines that for denials/limited authorization or urgent prospective requests, the requesting provider is notified telephonically at the time of determination, and that the member, facility and provider all receive written notice of the determination; • **Section V.E.4** outlines the same notification guidelines indicated above for urgent concurrent reviews; • **Section V.F.4** outlines the same notification guidelines indicated above for routine initial reviews; and • **Section V.G.5** outlines the same notification guidelines indicated above for routine concurrent reviews.	
Findings: The VO Medical Necessity Determination policy included the process for verbal (telephonic) and written notification to the provider and written notification to the member. The on-site review of denial records demonstrated that the CCM documented verbal notification to the requesting provider. Copies of the notice of action letter in the denial records indicated that the requesting provider also received a copy of the letter.		
Required Actions: None		
10. The Contractor's written policies and procedures include the following timeframes for making standard and expedited authorization decisions: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 days. *42CFR438.210(d)* Contract: Attachment K: 8.209.4.A.3.c and 8.209.4.A.6	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 203L Medical Necessity Determination (Pages 6 – 15, Section V.C-H) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policy specifies the timeframes for each type of authorization and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	level of care. Specifically, • **Section V.C** outlines all authorization timeframes for decisions. Standard (non-urgent) decisions are made within 10 calendar days and expedited decisions (urgent) are made within 72 hours; • **Section V.D.1** notes 72 hours as timeframe for expedited initial authorizations; • **Section V.E.1** notes 72 hours as the maximum timeframe for concurrent urgent authorizations (expedited); • **Section V.F.1** notes the timeframe for routine initial authorizations is 10 calendar days; • **Section V.G.1** notes the timeframe for routine concurrent authorization is 10 calendar days; and, • **Section V.H.1** notes the timeframe for retroactive authorization request decisions is 10 calendar days.	
Findings: The VO Medical Necessity Determination policy included the required determination time frame for standard authorization decisions. For expedited authorization decisions, the policy stated the time frame as three calendar days or 72 hours. Three calendar days (equivalent to 72 hours) exceeded the federal requirement of three working days. The on-site review of 20 denial records demonstrated that the UR determination and notification to the member was made within the required time frames.		
Required Actions: None		
11. The Contractor's written policies and procedures include the following timeframes for possible extension of timeframes for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* Contract: None	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 203L Medical Necessity Determination (Pages 6-7 and 10-11, Sections V.D and V.F) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®'	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	policy details the conditions and timeframes for possible extensions for expedited and standard authorization decisions. For expedited authorizations, due to the urgent nature of the care and to meet URAC requirements, extensions are only give due to lack of information. **Section V.D.2** outlines the timeframe for an urgent (expedited) case is 4-5 calendar days' extension. For standard (routine) authorizations: • **Section V.F.2** notes a 14 calendar day extension is available if there is a lack of information to make an authorization decision; • **Section V.F.3** notes a 14 day extension is available if there are circumstances beyond the control of ValueOptions®.	
Findings: The VO Medical Necessity Determination policy included the provision that standard authorization determination time frames may be extended by up to 14 calendar days if the member requests the extension or if the BHO determines that the extension is in the member's best interest. For expedited decisions, the policy stated that if the determination cannot be made within three calendar days, FBHP must notify the member and provider of the request to extend the authorization decision time frame within 24 hours of the decision to extend the time frame. The policy also stated that the provider is given two days to provide additional clinical information needed and that if the information is not received within the required time frame, the decision would be made with the available information. Although federal regulations allow for extensions of expedited decisions of up to 14 calendar days, FBHP staff members explained that VO is URAC-accredited and that URAC does not allow an extension of 14 calendar days for expedited decisions. FBHP staff members stated that FBHP/VO policies are designed to comply with both URAC and BBA requirements.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
12. The Contractor maintains a comprehensive utilization management (UM) program to monitor the access to, use, consumption, levels, and intensity of care, outcomes of, and appropriate utilization of covered services. Contract: II.I.1.a	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. ValueOptions® C101 Utilization Management Program Description (Entire policy) 4. ValueOptions® C101A UM Program Description Outline (Entire policy) 5. ValueOptions® C102 Quality Management_Utilization Management Work Plans (Entire policy) 6. ValueOptions® PR303 Monitoring Network Access and Availability (Entire policy) 7. VO Colorado 103L Revisions to the Utilization Management Program Description Work Plan (Entire policy) 8. FBHP UM Plan Goals FY10_11 (Sections IV-V, Goal 1-4) 9. FBHP UM Program Annual Evaluation FY2010_No PHI (Entire document – specific to outcome monitoring – pg 9-10 [hosp utilization/1,000, hosp LOS]; pg 12-13 process of care outcomes –clinical outliers) 10. FBHPartners ATC Q1FY11 final (see Access folder; Entire report demonstrates monitoring of access to care timeframes) 11. QI Program evaluation ’10 (see Access folder; pg 4-7 [access] & pg 12-16 [care quality/appro]). Approved and monitored by the QI/UM committee **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions® does develop and maintain a utilization management program to monitor the access to, usage, levels of care, outcomes of, and appropriate utilization of covered services as supported by the submitted documents.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The VO UM Program Description Outline was a VO national outline that specified the content requirement for the UM program descriptions of local service centers (such as VO Colorado in Colorado Springs). The VO UM/QM Work Plans policy was a VO national policy that described the required content for local service center UM/QM work plans. The FBHP UM Program Description outlined the committee structure of the national VO program as well as the recommended local FBHP QI/UM Committee structure. The program description was comprehensive and delineated the tasks and reporting responsibilities, scope of the FBHP quality improvement (QI) and UM programs, and the processes for medical necessity and UR determinations (through the UM policies and procedures incorporated in the UM program by reference. The 3 BHO Colorado Client Assessment Record (CCAR) Outcomes report and the FBHPartners Access to Care (ATC) report demonstrated reporting and evaluation of UM-related performance measure data. During the on-site interview, FBHP staff reported that typical utilization reports reviewed and discussed weekly addressed services used six months prior to hospitalization, the top 10 and top 20 users of service by service mix and by diagnosis, the top 5 diagnoses, the average daily census, and inpatient average length of stay. Staff also stated that other utilization reports were reviewed as needed.		
Required Actions: None		
13. The Contractor evaluates the medical necessity, appropriateness, efficacy, and efficiency of health care services, referrals, procedures, and settings. Contract: II.I.1.a	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 202L Medical Necessity (Entire policy) 4. VO Colorado IV403 Provider Treatment Record Review, Analysis and Reporting (Page 1, Section III.A) 5. FBHP UM Program Annual Evaluation FY2010_No PHI (Entire document) 6. 3 BHO Chart Audit Summary Results 2010OCT – Entire document 7. 3 BHO Perf Meas IP ALOS – Entire document 8. 3 BHO Perf Meas Discharges per 1000 – Entire document 9. FBHP MHSIP_YSSF Survey Report FY2010 (see Access folder - Entire document) 10. Facility Site Visit Tool	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Description of Process: This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). Annually, ValueOptions® conducts a comprehensive review of the quality and utilization management programs which evaluate efficiency, efficacy and appropriateness of services, referrals, and procedures. Throughout the year, appropriateness and efficacy of health care services are evaluated through Treatment Record Reviews, Chart Audits and the CCAR instrument. These monitoring activities ensure appropriate treatment planning and various aspects of care. Performance measures and satisfaction survey reports provide evidence of the monitoring and evaluation of health care services, procedures and settings, as in the example reports included. These and similar reports are reviewed and evaluated through the BHO Quality and Utilization Management Committees. Efficiency of Call Center operations is monitored through various telephone statistics and the timeliness of authorization decisions. Additionally, each facility is required, per NCQA, to have an accreditation or undergo a facility site visit upon credentialing and recredentialing. The on-site reviewer uses the facility site visit tool in order to measure contract compliance.	
Findings: The VO Medical Necessity policy described processes for making medical necessity and UR determinations. The VO Provider Treatment Record Review, Analysis, and Reporting policy described the process for evaluating treatment records against medical record requirements. The 3 BHO Chart Audit Summary Results document reported the results of the VO audit of FBHP IPN providers (completed by VO QI staff). The FBHP QI director used the same tool to audit the FBHP CMHCs. Other processes for evaluating outcomes and the efficiency and effectiveness of service provision included performance measure reporting and daily or weekly review of UM reports and data.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
14. The Contractor's UM program is under the direction of an appropriately qualified clinician and includes policies and procedures that have been reviewed by the Department. Contract: II.I.1.a	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. FBHP UM Plan Goals FY10_11 (Page 7) 4. Bechtold_CV – Outlines the qualifications of the current FBHP Medical Director who provides oversight to the UM program **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). The FBHP UM Plan Goals explains that the FBHP Medical Director provides oversight for the utilization management program. Also included in the materials is the resumé of the FBHP Medical Director which highlights his expertise.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP QI/UM Program Description stated that the medical director is responsible for oversight of the UM program. The medical director's participation in the UM program was evidenced by participation in committee meetings and documentation within the denial records of the medical director having completed peer review determinations. Day-to-day management and oversight of UM operations was also accomplished by the clinical director (a licensed marriage and family therapist) and clinical peer advisor (a PhD-level clinical psychologist).		
Required Actions: None		
15. The Construction of the UM program does not impede Member's timely access of services. Contract: II.I.1.b	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 210L Member Request_Routine (Entire policy, especially Page 1, Section III.A) 4. VO Colorado 211L Member Request_Urgent (Entire policy, especially Page 1, Section III.A) 5. VO Colorado 203L Medical Necessity Determination (Entire	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	policy, especially Sections III.A-B, V.A.2and V.B) 6. VO Colorado 238L Service for Deaf and Hard of Hearing Clients (Entire policy) 7. ValueOptions® PR303 Monitoring Network Access and Availability (Entire policy) 8. FBHPartners ATC Report Q1FY11 final (see Access folder - Entire report) Demonstrates access timeframe monitoring **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policies are designed to assist members with timely access to services, with all member requests receiving evaluation as to the urgency of the members' needs. Medical necessity determinations are made promptly so as not to interfere with the member's access to services and timeliness of authorization decisions is closely monitored. All standards for timeliness of authorization decisions are dependent on type and time of request. However, no authorizations are required for Emergency and Post Stabilization services. Specific policies are in place to address any special needs to assist members with timely access to treatment.	
Findings: The VO Member Request policies (routine and urgent) described assigning risk levels, the procedures, and responsibilities for processing and responding to requests for services in a timely manner. The FBHP ATC report demonstrated monitoring compliance with timely access to care standards. The running average for FY 2009–2010 compliance was 99.8 percent for initial requests for routine services, 100 percent for urgent requests, 100 percent for emergency call-backs, and 99.5 percent for emergency face-to-face contacts. Review of denial records on-site demonstrated that the average time that requests were processed and notification provided was two days.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
16. The Contractor ensures that the UM program incorporates mechanisms to continuously update guidelines, policies and procedures used in making determinations based on evaluation of new medical technologies and new application of established technologies, including medical procedures, drugs, and devices. Contract: II.I.1.k	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 104L Developing and Updating Clinical Criteria (Entire policy) 4. VO Colorado 105L Developing and Updating Treatment Guidelines (Entire policy) 5. VO Colorado 218L New Clinical_Medical Technologies – (Entire policy) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policies listed above describe the mechanisms to continuously update guidelines, policies and procedures used in making determinations based on evaluation of new medical technologies and new application of established technologies, including medical procedures, drugs, and devices.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Developing and Updating Clinical Criteria policy described annual update and review of clinical criteria. The VO New Medical Technology policy described the process for evaluating new clinical/medical technology. The process included presentation to the Quality Improvement Steering Committee (QISC) by any member of the QISC and final determination by the Board of Directors. QI/UM Committee meeting minutes demonstrated committee review and approval of policies and UR review criteria as well as consideration of new evidenced-based practices.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
17. The Contractor maintains mechanisms to evaluate the effects of the UM program. Contract: II.I.1.l	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. ValueOptions® C113 Utilization Management Program Evaluation (Entire policy) 4. ValueOptions® C113A UM Program Evaluation Outline (Entire policy) 5. FBHP UM Program Annual Evaluation FY2010_No PHI (Entire document) 6. 3 BHO Perf Meas IP ALOS (Entire report) Part of dashboard-type presentation of UM indicators. 7. 3 BHO Perf Measure Discharges per 1000 (Entire report) Part of dashboard-type presentation of UM indicators) 8. 3 BHO Perf Indicators Q4 FY10.swf (Flash file presentation of QI/UM performance indicators) 9. FBHP Notice of Action Log JUNE2010 – Entire report **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions® completes an annual evaluation of the Utilization Management programs. Throughout the year a variety of performance measures and reports (examples listed above) are monitored and reviewed within the BHO quality and clinical committees.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP FY 2010 UM Annual Evaluation contained evaluation of UM staff performance, departmental procedures, and performance measures against goals.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
18. The Contractor has UM review standards that are the same for network providers as they are for out-of-network or unaffiliated providers. Contract: II.I.1.n	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. 3 BHO Colorado Medicaid Addendum Contract (Page 1, Section B (5)) 4. VO Colorado 274L Provision of Services through an Out of Network Provider (Entire policy) 5. SCA Letter Practitioner with Cover (Entire document, especially Page 2, paragraph 3) 6. SCA Letter Facilities with Cover (Entire document) 7. FBHP Provider Manual Pt 1 of 2(Misc folder – Page 13, Section IV, *Utilization Management Procedures)* **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions® has mechanisms to ensure network and out-of-network providers follow the same utilization management review standards. In addition to a policy that explains the provision of services for network providers, out of network providers must sign a contract addendum in order to treat BHO partner Colorado members. All providers must comply with utilization management procedures as outlined in the provider handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The 3 BHO Medicaid Contract Addendum incorporated the provider handbook into the contract between FBHP/VO and the CMHCs. The single-case agreement (SCA) template also incorporated the provider handbook, by reference, into the agreement and provided the Web site address where the provider handbook could be found on FBHP's Web site. The provider handbook described processes and procedures for obtaining authorizations. The VO Provision of Services Through an Out of Network Provider policy described the criteria and process for entering into an SCA and stated that once the SCA is in place, services are authorized using medical necessity and UR review criteria. During the on-site interview, FBHP staff confirmed that CMHC, IPN, and SCA providers were given access to the same provider handbook, as well as the same processes for obtaining service authorization.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
19. The Contractor's written policies and procedures provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42CFR438.210(e)* Contract: II.D.6.a.1 and II.I.1.c	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. Code of Conduct Annual Training (Entire document) 4. Annual Acknowledgment Signature Page (Sections 2 and 4) 5. Code of Conduct Training Certification 0810 (Entire document) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions® has policies in place that define conflict of interest and specifically state that employees are not provided incentives, nor permitted to accept gifts in relation to any UM activities. ValueOptions®' staff annually receives training regarding conflict of interest and employee code of conduct.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP code of conduct training included specific conduct requirements for UM and QI staff members, including the requirement to attest to the agreement that no incentives for utilization decisions are permitted. During the on-site interview, FBHP staff explained that all staff members are required to undergo this training at hire and annually, signing the acknowledgment attesting to receipt of the training, their understanding of the requirements related to the training, and their understanding that utilization decisions are made based on appropriateness of care. The acknowledgment also specifically stated that VO does not reward practitioners or other individuals for denials of services. FBHP provided a signed example for review.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
20. The Contractor defines Emergency Medical Condition as a 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. *42CFR438.114(a)* Contract: I.A.10	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post-Stabilization Services (Pages 2-3, Section IV.A defines Emergency Medical Condition). 4. FBHPartners Member Handbook 102209 (Misc folder – Page 13). Provides definition of emergency medical condition and instructs members on how to access emergency services. 5. ValueOptions® C214 Member Request (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. 6. FBHP Prov Manual Pt 1 or 2 (Misc folder – Page 9) Defines Emergency Medical Condition for providers. **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' 270L Emergency and Poststabilization Services policy defines emergency medical conditions. Members receive information in the member handbook about what defines an emergency or crisis and how to obtain emergency services. ValueOptions®' staff assists members and directs them to the nearest facility/ER when there is any question of an emergency medical condition. The provider handbook defines emergency medical condition for providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the BBA definition of emergency medical condition. The member handbook included a definition of emergency medical condition that met federal requirements and was at the State-required readability level. The VO Member		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Request policy included processes for determining a member's risk level during an initial call to request services. Risk Levels 3 and 4 were defined as conditions consistent with the BBA definition of emergency medical condition. The provider handbook included the BBA definition of emergency medical condition.		
Required Actions: None		
21. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition. *42CFR438.114(a)* Contract: I.A.11	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post-Stabilization Services (Page 3, Section IV.C.) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' 270L Emergency and Poststabilization Services policy clearly outlines the definition of emergency services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the BBA-compliant definition of emergency services. The member handbook included descriptions of emergency services and emergency care that were consistent with the BBA definition of emergency services and were at the required readability level.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
22. The Contractor defines Poststabilization Care Services 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. *42CFR438.114(a)* Contract: I.A.29	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post-Stabilization Services (Page 3, Section IV.D.) 4. FBHPartners Member Handbook102209 (Misc. folder, page 11, middle of page, under "What happens When an Emergency is Over?") **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' 270L Emergency and Poststabilization Services policy clearly defines post stabilization care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the BBA-compliant definition of poststabilization services. The definition of poststabilization services in the member handbook was consistent with the federal definition.		
Required Actions: None		

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Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
23. The Contractor makes emergency services available to members without preauthorization. *42CFR438.10(f)(6)(viii)(B)* Contract: II.I.1.p.1	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 203L Medical Necessity Determination (Page 5, Section B) 4. VO Colorado 270L Emergency and Post-Stabilization Services (Page 2, Section III.F.) 5. VO Colorado ER claims procedures (Entire policy) 6. FBHP Prov Manual Pt 1 or 2 (Misc Folder – Page 10) 7. FBHPartners Member Handbook 102209 (Misc folder – Page 13) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' 270L Emergency and Poststabilization Services policy outlines that no authorization is required for emergency services. In addition, the provider and member handbooks detail this specific information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Medical Necessity Determinations policy, the VO Emergency and Post-Stabilization Services policy, and the ER Claims policy and procedures stated that no authorization is needed for emergency services provided in- or out-of-network. The provider manual delineated the expectations of providers in emergency situations. The member handbook informed members that no prior authorization is needed for emergency services.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
24. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42CFR438.114(c)(1)(i)* Contract: II.D.6.a.1	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post-Stabilization Services (Page 1, Section III.A.) 4. VO Colorado ER claims procedures (Entire policy) 5. FBHPartners Member Handbook102209 (Misc. folder, page 11, under "What if I have an emergency?", last paragraph) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' Colorado ER claims procedures indicates members can access these services without prior authorization. This procedure document states that claims for emergency services are accepted and paid for any provider, regardless of network status. Claims processors are instructed to consider claims from In or Out of network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that FBHP covers and pays for emergency services regardless of whether the provider has a contract with FBHP/VO. The ER Claims policy and procedures stated that no authorization is needed for emergency services provided in- or out-of-network. The member handbook directed members to go to the nearest emergency room and stated that members do not need prior authorization to receive emergency services and may receive emergency services from any qualified hospital or provider.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
25. 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 *not* have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, • Serious impairment to bodily functions, • Serious dysfunction of any bodily organ or part, ◆ A representative of the Contractor's organization instructed the member to seek emergency services. *42CFR438.114(c)(1)(ii)* Contract: II.D.6.a.2	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post-Stabilization Services (Page 1, Section III.B.1-2) 4. VO Colorado ER claims procedures (Entire policy, especially Page 1, Policy and Section I) 5. FBHP Prov Manual Pt 1 of 2(Misc folder – Page 15) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' 270L Emergency and Poststabilization Services policy clearly outlines that payment may not be denied under either of these circumstances. There is no authorization requirement at all for emergency services. These services are not denied when billed as emergency services, regardless of the actual outcome. Providers are also informed of this requirement through the provider handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that FBHP/VO would not deny payment when the situation was determined to not have been an emergency medical condition. During the on-site interview, FBHP/VO staff reported that the claims system set aside all emergency claims for staff review to ensure appropriate payment of emergency claims.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
26. 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. *42CFR438.114(d)(1)* Contract: II.D.6.c	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post-Stabilization Services (Page 2, Section III.C.1-2) 4. VO Colorado ER Claims Procedures (Page 1, Policy section and Section I) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' 270L Emergency and Poststabilization Services policy does not limit what constitutes an emergency medical condition based on diagnoses, symptoms or refuse to cover emergency services based on the provider, hospital or fiscal agent not notifying the primary care providers within 10 days of presentation for services. During claims processing, ValueOptions®' staff pays these claims and does not review or analyze the criteria based on symptoms or diagnoses for emergency services claims.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the required provisions. The ER Claims policy and procedures indicated that the list of covered diagnoses is used to determine if the services are covered.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
27. 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. *42CFR438.114(d)(2)* Contract: II.D.6.c	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post-Stabilization Services (Page 2, Section III.D). 4. FBHPartners Member Handbook 102209 (Misc folder – Page 15) Informs members that they are not responsible for payment of services (any services) covered by Medicaid. **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' 270L Emergency and Poststabilization Services policy releases the member from liability for payment for any subsequent screening and treatment needed to stabilize an emergency medical condition. Members are informed via the member handbook that the member is not responsible to pay for services covered by the Medicaid plan. Members are instructed to call the Behavioral Health Organization if the member receives a bill for services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that FBHP/VO 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. The member handbook informed members that they are not responsible for payment of any mental health services and instructed members to call FBHP if they receive any bills for mental health services. The provider handbook informed providers that they may not assess any charges to Medicaid recipients for covered services, including co-payments, and that balance billing is not allowed.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
28. 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. *42CFR438.114(d)(3)* Contract: II.D.6.d	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post-Stabilization Services (Page 2, Section III.E.) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' 270L Emergency and Poststabilization Services policy states the attending physician/facility makes decisions independent of any contact with the Behavioral Health Organization regarding stabilization, as there is no preauthorization required for emergency services, and no authorization needs to be on file for the claim to be paid. The provider makes treatment decisions and submits the bill after services have been rendered.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that the provider actually treating the member is responsible for determining when the member is sufficiently stabilized for transfer or discharge. Staff confirmed that the process for on-site FBHP assessment in emergencies includes ensuring that the member is medically stable prior to assessing for the medical necessity of further mental health treatment.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
29. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are pre-approved by a plan provider or other organization representative. *42CFR438.114(e)* *42CFR422.113(c)(2(i)* Contract: II.D.6.e	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post Stabilization Services (Page 2, Section III.G.1) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policy states that the BHO is financially responsible for poststabilization services obtained in-network or out-of-network and are pre-approved by plan providers or ValueOptions®' representatives.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that FBHP is financially responsible for poststabilization care services obtained within or outside the network. The VO Emergency and Post-Stabilization Services policy and the VO Medical Necessity Determination policy stated that no precertification or preauthorization is required to obtain emergency services.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
30. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within 1 hour of a request to the organization for pre-approval of further post-stabilization care services. *42CFR438.114(e)* *42CFR422.113(c)(2)(ii)* Contract: II.D.6.a	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post Stabilization Services (Page 2, Section III.G.2) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policy states if poststabilization services provided in- or out-of-network are not pre-approved by a plan provider or a ValueOptions® representative and are administered to maintain the member's stabilized condition within 1 hour of request for pre-approval of further services, and then the BHO is financially responsible for the post-stabilization services provided.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that FBHP is financially responsible for poststabilization care services obtained within or outside the network. The VO Emergency and Post-Stabilization Services policy and the VO Medical Necessity Determination policy stated that no precertification or preauthorization is required to obtain emergency services. The member handbook stated, "You may need services after the emergency is over to help you stay stable or improve your mental health condition. This is called Post-Stabilization Care. Post-stabilization services are inpatient and outpatient services provided just after an emergency. Your emergency provider must get approval from your BHO for these services after the emergency is over." This statement leads the reader to believe that preauthorization is required for poststabilization care and is in conflict with FBHP policies.		
Required Actions: FBHP must clarify the member handbook to provide information that is consistent with VO/FBHP's policies.		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
31. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: ◆ The organization does not respond to a request for pre-approval within 1 hour, ◆ The organization cannot be contacted, ◆ The organization representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in requirement number 33 is met. *42CFR438.114(e)* *42CFR422.113(c)(2)(iii)* Contract: II.D.6.f	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post Stabilization Services (Pages 2-3, Section III.G.3.a-c(1-4)) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policy details the additional circumstances by which the BHO maintains financial responsibility for provided services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that FBHP is financially responsible for poststabilization care services obtained within or outside the network. The VO Emergency and Post-Stabilization Services policy and the VO Medical Necessity Determination policy stated that no precertification or preauthorization is required to obtain emergency services.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
32. The Contractor must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the contractor. *42CFR438.114(e)* *42CFR422.113(c)(2)(iv)* Contract: II.D.6.g	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post Stabilization Services (Page 2, Section III.D) 4. FBHPartners Member Handbook 102209 (Misc. folder– Page 15) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policy states members are not charged for post stabilization services. Members are informed they cannot be charged for any service covered under Medicaid mental health and are directed to contact the Behavioral Health Organization for assistance if they should receive a bill for services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy included the provision that FBHP/VO does not hold a member who has an emergency medical condition liable for payment of poststabilization services, regardless of whether these services were obtained through FBHP. The member handbook informed members that they are not responsible for payment of any mental health service. The provider handbook informed providers that they may not assess any charges to Medicaid recipients for covered services, including co-payments, and that balance billing is not allowed.		
Required Actions: None		

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
33. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when: ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care, ◆ A plan physician assumes responsibility for the member's care through transfer, ◆ A plan representative and the treating physician reach an agreement concerning the member's care, ◆ The member is discharged. *42CFR438.114(e)* *42CFR422.113(c)(3)* Contract: II.D.6.h	**Documents:** 1. FBHP UM delegation policy final 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 3. VO Colorado 270L Emergency and Post Stabilization Services (Page 3, Section III.G.3.c.1-4) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policy describes all the circumstances which denote the end of the BHOs financial responsibility for post stabilization services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Emergency and Post-Stabilization Services policy and the VO Medical Necessity Determination policy stated that no precertification or preauthorization is required to obtain emergency services. During the on-site interview, FBHP staff described preauthorization processes, clarifying that poststabilization services, provided immediately following the emergency and prior to inpatient hospitalization, do not require prior authorization. Staff confirmed the FBHP/VO policy that inpatient hospitalization and other intensive services (e.g., ATC or RTC services) do require prior authorization.		
Required Actions: None		

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	32	X	1.00	=	32
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	33	**Total Score**		=	32

Total Score ÷ Total Applicable	=	97%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
1. The Contractor ensures that all covered services are available and accessible to members. *42CFR438.206(a)* Contract: II.E	**Documents:** **Policies/Member Information** 1. FBHP Policy Access to Services Revised FY'11 (entire policy). Describes procedures for ensuring overall avail and accessible. 2. FBHP Policy Dual Medicare Medicaid Revised 10_20_10 (entire policy). Describes partner MHC requirements regarding access to dual eligible Medicare/Medicaid. 3. FBHP Policy NCF_ACF Services Revised FY '11 (entire policy). Describes procedures for NCF/ACF member residents to access behavioral health services and monitoring of access. 4. FBHP Policy Member Rights (entire policy, including member rights statement) Explains role of OMFA in ensuring all member rights to access services are upheld 5. FBHP Policy Cultural Competency rev 12_15_10 (pg 1, policy and purpose; pg 2, Sec I-IV) 6. FBHP Cultural Competency Plan (entire plan) Describes FBHP's commitment to access and effective services for all Members, regardless of culture or English language proficiency. Sets goals and responsibilities **Provider Training/information:** 1. FBHP Prov Manual Pt 1 of 2 (in Misc folder) pg 7 (#7); pg 8-10; pg 34 (access information for providers) 2. FBHP Prov Manual Pt 2 of 2 (in misc folder – pg 1 "Improving Access to Psychiatric Services) 3. Provider Newsletter_Feb 2010 (pg 2 – section on Access to Care Standards). 4. Provider Newsletter_Jul 10 (pg 4, section on Access to care Standards) 5. 2010 CO Medicaid provider forum_2010 (slide 33 – 5th bullet, required to report date of offered appt; slide 101-102, training	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	on access standards) 6. MHCBBC Access to Care guidelines[read only][compatibility mode] Routine access guidelines for MHCBBC screening staff 7. JCMH Provider Training Report Final 2010 (cultural competency and client rights[2nd opinion and culturally appro services] under New Employee and Annual Training) Outlines JCMH provider training on client rights 8. MHCBBC New Hire Orientation agenda 02_2010 (consumer rights & confidentiality training – includes culturally appro services and second opinion) 9. MHCBBC 2010 Annual Training Course Listings (course on Client rights, culturally appro services and second opinion) **Monitoring Access/Availability** 1. QI Work Plan FBHP FY11 Final (pg 8-9) Plan for monitoring Member access/availability 2. 1st Qtr report FY '11(2) (Most recent report monitoring of access, pg 3-4; 5,8) 3. Follow-up residential services report Qtr 1, FY '11 (1st Qtr report on monitoring residential follow-up, entire doc). Describes monitoring of residential follow-up 4. QI program eval '10 (pg 2; 4-9; 11-13). Describes FY '10 performance regarding access indicators, including grievances 5. MHSIP_YSS-F Survey Report FY '10 revised 8_13_10 (pg 6-10, areas related to Access). Describes client survey results regarding access. 6. FBHP_EmergAccessIPN_Narrative_Q2FY11 (most recent report on IPN emergency response times). Describes phone call results monitoring IPN emergency response. 7. FBHPartners_ACT_Q1FY11final (entire document). Most recent quarterly Access report to the Department. 8. ACF_NCF_Survey report_FBHP 2010 (entire report).	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Describes results of an ACF/NCF satisfaction survey on behavioral health service access 9. JCMH evening & weekend support (entire doc). Report from JCMH on emerg coverage and weekend program support 10. Extended hours Report JCMH (entire doc). Annually requested report on MHC office and weekend hours) 11. MHCBBC extended hours report (entire doc). Annually requested report on MHC office and weekend hours and emerg coverage 12. MHCBBC response Lafayette office closure (entire doc) Response to request to follow-up of survey concerns) 13. MHCBBC Access to Care Reports-weekly Routine Emerg 11/22/10-11/28/10 (entire doc). Weekly monitoring email from MHCBBC on meeting routine and emergency standards) 14. JCMH weekly access report 12_5 – 12_11_ATS for_FBHP (entire doc). Weekly monitoring report from JCMH on meeting routine and emerg standards) **Description of Process:** The FBHP QI Department is responsible to establishing policies/procedures and monitoring providers regarding access standards. The FBHP Policy on Access and the Provider Manual clearly delineate major access to care procedures, including routine initial outpatient visits, emergency/urgent care, follow-up after hospital and residential discharge, required provider hours of operation, as well as procedures for monitoring member access. Additional special cases access procedures are outlined in the FBHP Policy Dual Medicare/Medicaid Access, FBHP Policy NCF ACF Services as well as the FBHP Policy on Member Rights and Cultural Issues. Supporting documentation is provided showing monitoring and reporting of access requirements and provider training/information.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: FBHP had numerous policies and procedures that described the authorization and provision of covered services, including the FBHP Access to Services policy. The FBHP Access to Services policy addressed the requirements for timely access to services. The policy stated that if FBHP or its CMHC partners are unable to meet the timeliness standards, members are assisted in contacting the VO access line to obtain an appointment. During the on-site interview, FBHP staff members confirmed that the VO call center would take the call from the FBHP CMHCs, if they were at capacity, and contact the member to provide IPN choices. FBHP communicated the appointment standards to providers via the provider handbook and provider newsletters. Members were informed of the appointment standards via the member handbook. FBHP provided evidence that FBHP staff and CMHCs were trained regarding the access standards.		
Required Actions: None		
2. The Contractor maintains and monitors a comprehensive provider network capable of serving the behavioral health needs of all members in the program. *42CFR438.206(b)(1)* Contract: II.E.1.c.1	**Documents Submitted/Location within Documents:** 1. FBHP Policy Provider Network delegation 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder -Entire doc) 3. VO Colorado III306 Measurement of Access and Availability (Entire policy) 4. FBHP Policy Qual Care Concerns Final (see Coordination and Continuity of Care folder - entire policy – outlines FBHP procedures for addressing quality of care concerns of its providers including access) 5. FBHP Policy Medical Records Maintenance Revised 2010 (entire policy) Describes FBHP policy and procedures for monitoring provider medical records 6. ValueOptions® PR302 Network Design and Access Standards (entire doc) 7. FBHP_Emerg Access IPN_Narrative_Q2 FY '11 8. FBHPartners ATC Report Q1FY11 final (Entire document) 9. MHSIP_YSSF Survey Report FY2010 (Entire document) 10. 3 BHO Audit Tool Final 121610 (entire doc) 11. Facility Site Review Tool (entire doc) 12. 2011_Audit_FBHP_No_CAP_Request_Infor_letter (entire doc) 13. 3 BHO Network Adequacy Report Q1FY11(entire report) 14. IPN Provider Network Language Specialties (entire report)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	15. FBHP provider language_final 7_1_10 16. ValueOptions_CO_Partnerships_Provider Directory. A list of IPN for the three BHO partners and partner MHC offices by County. On the FBHP Web site. **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners), although FBHPartners' QI Department staff work closely with VO and maintain BHO policies regarding issues such as QOC concerns, member access, and coordination of care issues. ValueOptions® has several policies that describe the activities involved to assess and maintain a comprehensive provider network to serve the needs of eligible Medicaid members. In addition to policies, ValueOptions®, in partnership with FBHPartners conducts a variety of provider monitoring activities to assure providers are meeting the needs of BHO Medicaid members. These activities include monitoring of accessibility and availability, coordination of care, evaluation of member survey responses regarding treatment and accessibility, review of quality of care concerns, treatment record documentation audits, and facility site reviews.	
Findings: The FBHP Provider Network Delegation policy included the processes for delegating operational responsibilities for management of FBHP's provider network to a qualified delegate (in this case, VO). The FBHP delegation agreement delegated recruitment and maintenance of the provider network, including education and support of providers and preparation of network adequacy reports. FBHP's/VO's provider directory listed all providers contracted with VO/FBHP to provide services by county served. The directory included both independent providers and CMHCs and listed the type of provider, languages spoken, and specialty areas of practice. FBHP provided numerous reports demonstrating that it monitored the timeliness of access and appropriateness of clinical record-keeping. Reports included the 3 BHO Audit Tool (assessing clinical documentation) and utilization and performance measure reports designed to measure access. The 3 BHO Network Adequacy Report contained an analysis of the number of members, number and types of providers in each county served, and the number of miles members must travel to reach providers.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
3. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated Medicaid enrollment, ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. ◆ The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services, ◆ The numbers of network providers who are not accepting new Medicaid patients, ◆ The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities, ◆ The potential physical barriers to accessing provider's locations, ◆ The cultural and language expertise of providers, ◆ Provider to member ratios for behavioral health care services. *42CFR438.206(b)(1)(i) through (v)* Contract: II.E.1.c.1	**Documents:** 1. FBHP Policy Provider Network delegation 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder - Entire doc 3. ValueOptions® PR302 Network Design and Access Standards (entire doc) 4. FY2010 Annual Needs Assessment (entire report) 5. IPN Provider Network Language Specialties (entire report) 6. FBHP provider Language_final 7_1_10 7. ValueOptions_CO_Partnerships_Provider Directory 8. 3 BHO Network Adequacy Report Q1FY11(entire report) 9. Facility Site Review Tool (entire doc) 10. FBHP Provider Manual part 1 of 2 (Misc folder – Page 20, Section V, *Member Choice of Providers*, Page 85, Section XVI, *Transportation)* **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions® reviews the network adequacy for FBHPartners regularly to ensure Medicaid members have a range of providers that are able to serve their needs. The review includes the number of providers, specialties, languages, locations, and accessibility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The 3 BHO Network Adequacy Assessment and the 3 BHO Network Adequacy Report addressed the upward trends in member eligibility and penetration rates as well as analysis of encounter claims trends. The report also evaluated the numbers and types of providers, languages spoken and specialty areas, and geographic locations of network providers and members in the service areas.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
4. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. *42CFR438.206(b)(3)* Contract: II.E.1.a.12	**Documents:** **Policies/Member Information** 1. FBHP Policy Second Opinions rev 12-15-10 final (entire document) 2. Second Opinion Workflow 2010 (entire doc). The Policy and Workflow diagram affirm the Member's right to a second opinion, distinguishes between this right and the right to appeal a Notice of Action -explains process 3. FBHPartners Member Handbook 102209 (See Misc folder - p 15, Your Rights as a Medicaid Member, 9th bullet from top) **Provider Training/Information** 4. FBHP Prov Manual Pt 1 of 2 (see Misc folder - pg 21 – Section on Second Opinion) 5. 2010 CO Medicaid Provider Forum_2010 (slide 115, training on second opinion) 6. Client Right Training MHCBBC 2009 (slide #17, third bullet) Annual Training material for MHCBBC providers 7. JCMH Provider Training Report Final 2010 (client rights[2nd opinion] under New Employee and Annual Training) 8. JCMH Rights Annual Training –Clinical 1_1_10 (slide 5) 9. MHCBBC New Hire Orientation agenda 02_2010 (consumer rights & confidentiality training – includes second opinion) 10. MHCBBC 2010 Annual Training Course Listings (course on Client rights, second opinion) **Description of Process:** The Office of Member and Family Affairs is responsible for establishing member rights policies and procedures, including the right to a second opinion. The right to a second opinion is listed in the Member rights Statement and all providers receive training on this. Members wanting a second opinion are referred to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	ValueOptions staff, as the Provider Network Delegate, who gives the member 2-3 referrals in the IPN. The member contacts one of these providers and the provider obtains authorization from ValueOptions, as FBHP's UM Delegate. The provider gives a copy of the second opinion to the member and to VO, who provides it to the original clinician.	
Findings: The FBHP Second Opinion policy described the process for responding to requests for a second opinion. The policy stated that FBHP's delegate (VO) processes these requests. The FBHP/VO Second Opinion Workflow diagram assisted CCM and FBHP staff members receiving calls for a second opinion. The diagram helped staff direct members to obtain a second opinion or access the appeal process, if applicable. The provider manual informed providers that members have the right to a second opinion from an in-network or out-of-network provider at no cost to the member. The member handbook informed members of the right to request a second opinion and how to do so and included the right to a second opinion at no cost on the list of member rights. FBHP provided evidence that CMHC staff members were trained regarding member rights, including the right to obtain a second opinion. During the on-site interview, FHBP staff members stated that FBHP had requests for second opinions occasionally and that the requests have typically come through the Office of Member and Family Affairs (OMFA) or the member's therapist.		
Required Actions: None		
5. If the Contractor is unable to provide necessary services to a member in-network, the Contractor must adequately and timely cover the services out of network for the member, for as long as the Contractor is unable to provide them. *42CFR438.206(b)(4)* Contract: II.E.1.c.3 and II.E.1.d.1	**Documents:** 1. FBHP Policy Provider Network delegation 2010 (entire policy) 2. FBHP UM delegation policy final 2010 (see Utilization Management folder-entire policy) 3. FBHP_VO Delegation Agreement 091206 (Misc folder – Entire doc) 4. VO Colorado 274L Provision of Services through an Out of Network Provider (see Utilization Management folder - Entire policy, especially Page 3, Section IV.A.7) 5. SCA Letter Practitioner with cover (see Utilization Management folder – entire doc)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	6. SCA Letter Facilities with cover (see Utilization Management folder – entire doc) 7. FBHP Provider Manual part 1 of 2(see Misc folder – Page 20, Section V, *Member Choice of Providers*) 8. FBHPartners Member Handbook 102209 (see Misc folder – Page 6 and 16) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions®' policies describe services not available through an in-network provider may be accessible to members through an out-of-network provider at no cost to the member and that all timeframes for authorization decisions must be upheld. Policies outline the approval process and situations in which Single Case Agreements are approved for member services outside of the provider network. In the member handbook, members are informed that they can ask to see a provider who may not be listed in the provider directory. The provider handbook outlines the member's rights regarding choice of providers.	
Findings: The VO Provision of Services Through an Out of Network Provider policy included the provision that if services were unavailable within the network, FBHP/VO made the services available from an out-of-network provider via an SCA. FBHP provided templates for an SCA with an individual provider and for a facility. The provider manual informed providers of the conditions under which members may receive services from an out-of-network provider. The member handbook informed members that they may receive services from an out-of-network provider and may ask that a provider be added to the network, but if they do not obtain approval, members may have to pay for the services.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
6. The Contractor requires out-of-network providers to coordinate with the Contractor with respect to payment and ensures that the cost to the member is no greater that it would be if the services were furnished within the network. *42CFR438.206(b)(5)* Contract: II.E.1.d.2	**Documents:** 1. FBHP Policy Provider Network delegation 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (see Misc folder - Entire agreement) 3. SCA Letter Facilities with cover (see Utilization Management folder – entire doc) 4. SCA Letter Practitioner with cover (see Utilization Management folder – entire doc) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). Single Case Agreements require that out-of-network providers coordinate with ValueOptions® with respect to payment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The SCA templates for individual providers and for facilities required providers to coordinate with FBHP/VO with respect to payment, explained how providers should submit claims, and informed providers that they may not hold members liable for any part of a bill.		
Required Actions: None		
7. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Emergency services are available: • By phone, including TTY accessibility, within 15 minutes of the initial contact, • In-person within one hour of contact in urban and suburban areas, • In-person within two hours of contact in rural and frontier areas. ◆ Urgent care is available within twenty four hours	**Documents:** **Policies/Member Information** 1. FBHP Policy Access to Services Revised FY'11 (entire policy). Describes policy and procedures for providers to meet all access standards. 2. FBHP Policy Provider Network delegation 2010 (entire policy) FBHP delegates provider network to ValueOptions specific to the last bullet regarding provider location/network adequacy 3. FBHPartners Member Handbook 102209 (See Misc folder - p 5, p 11) Provides access standards information for members 4. FBHP Emer Serv flyerJCMH Eng rev 11_23_10 (entire doc).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
from the initial identification of need ◆ Routine services are available upon initial request within 7 business days. ◆ Outpatient follow-up appointments within seven business days of an inpatient psychiatric hospitalization or residential facility. ◆ Providers are located throughout the Contractor's service area, within thirty miles or thirty minutes travel time, to the extent such services are available. *42CFR438.206(c)(1)(i)* Contract: II.E.1.a.6 through II.E.1.a.8	Sent to members monthly/annually re: 24/7 emerg service 5. FBHP Emer Serv flyer MHCBBC Eng 11_23_10 (entire doc). Sent to members monthly/annually re: 24/7 emerg service. **Provider Training/Information** 6. FBHP Prov Manual Pt 1 of 2 (see Misc folder - pg 7,#7, pg 8-10 & pg 34) Provider information on access standards 7. Provider Newsletter_Feb 2010 (pg 2 – section on Access to Care Standards). 8. Provider Newsletter_Jul 10 (pg 4, section on Access to care Standards) 9. 2010 CO Medicaid provider forum_2010 (slide 33 – 5th bullet, required to report date of offered appt; slide 101-102, training on access standards) 10. MHCBBC Access to Care Guidelines (entire document). Information for screening providers at MHCBBC **Monitoring Access/Availability** 11. 1st Qtr report FY '11(2) (Most recent report monitoring of access, pg 3-4; 5,8). 12. Follow-up residential services report Qtr 1, FY '11 (1st Qtr report on monitoring residential follow-up, entire doc). Describes monitoring of residential follow-up 13. QI program eval '10 (pg 2; 4-9; 11-13). Describes FY '10 performance regarding access indicators, including grievances 14. FBHP_EmergAccessIPN_Narrative_Q2FY11 (entire doc) Most recent report on IPN emergency response times. Describes phone call results monitoring IPN emergency response. 15. FBHPartners_ACT_Q1FY11final (entire document). Most recent quarterly Access report to the Department. 16. MHSIP_YSS-F Survey Report FY '10 revised 8_13_10 (pg 6-10, areas related to Access). Describes client survey results regarding access.	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	17. MHCBBC response Lafayette office closure (entire doc). Response to request to follow-up of survey concerns 18. JCMH weekly monitor 2010 – 2011_ATS for_FBHP (entire document). Monitoring report provided to FBHP weekly 19. MHCBBC Access to Care Reports – weekly routine emerg 112210-112810 (email). Monitoring report provided to FBHP weekly 20. 3 BHO Network Adequacy Report Q1FY11(excel sheet labeled "outliers"). **Description of Process:** The FBHP QI Department establishes policies/procedures and monitors provider adherence to all access standards. The FBHP Policy on Access describes the process for ensuring provider adherence to the access standards. FBHP delegates to ValueOptions Provider Network responsibilities which include ensuring network adequacy, such as provider locations within a 30 mile radius. FBHP and its partner MHCs maintain emergency crisis lines 24/7 and the partner MHCs have specified Access and Emergency teams that are regularly trained in the required access standards.	
Findings: The FBHP Access to Services policy included the appointment standards. The FBHP delegation agreement indicated that FBHP delegated monitoring of providers and development of the network adequacy assessment and annual reports. Providers were informed of the timely access standards and provider responsibilities via the provider manual and provider newsletters. Members were informed of the timely access standards via the member handbook. Numerous reports, including the Follow-Up Residential Services report, Emergency Access report, and Access to Care reports, demonstrated FBHP's/VO's oversight and monitoring of its IPN and CMHCs for compliance with timely access standards. The VO Colorado provider forum conducted in fall 2010 included a discussion of timely access standards. During the on-site interview, FBHP staff members reported that they were considering repeating the provider forum via Webinar. Staff also reported that FBHP QI staff monitors training, hours of operation, and access reports submitted by the CMHCs. The PowerPoint presentation used for the fall 2010 provider forum was found on FBHP's Web site under the provider tab.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
8. The Contractor and its providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members. *42CFR438.206(c)(1)(ii)* Contract: II.E.1.a.4	**Documents:** 1. FBHP Policy Access to Services Revised FY'11 (pg 2-3, Sec II). Describes provider requirements related to hours of operation. 2. FBHP Prov Manual Pt 1 of 2 (Misc folder – pg 8, #1; pg 9-10 (#6-8) 3. Extended Hours Report JCMH (entire doc) 4. MHCBBC extended hours support (entire doc) 5. JCMH evening & weekend support (entire doc). Report from JCMH on emerg coverage and weekend program support 6. MHSIP_YSS-F Survey Report FY '10 revised 8_13_10 (pg 6-10, areas related to Access). Describes client survey results regarding access. 7. QI program eval '10 (pg 2; 4-9; 11-13). Describes FY '10 performance regarding access indicators, including grievances **Description of Process:** The FBHP QI Department establishes policies/procedures and monitors provider adherence to all access standards, including ensuring office hour availability and weekend/emerg support. The FBHP Policy on Access and the Provider Manual describe the office hour requirements for providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP Access to Services policy stated that FBHP's delegate ensures that an adequate number of IPN outpatient sites offer hours beyond 8 a.m. to 5 p.m. The provider handbook informed providers of the expectation that they offer hours of operation that are no less than the hours of operation offered to commercial members or that are comparable to Medicaid fee-for-service. Members were informed of the FBHP business office hours and the CMHC business and service hours via the member handbook. During the on-site interview, FBHP staff members confirmed that FBHP/VO providers served all payor types at each location; therefore, the hours of operation for Medicaid members were the same as they were for other payer types.		
Required Actions: None		

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
9. The Contractor makes Services available 24 hours a day, 7 days a week, when medically necessary. *42CFR438.206(c)(1)(iii)* Contract: II.E.1.a.5	**Documents:** 1. FBHP Policy Access to Services Revised FY'11 (pg 2, B.1-2; 2.c; pg 3, II.C.1&2). Describes provider requirements for service availability 24/7. 2. FBHP Prov Manual Pt 1 of 2 (in Misc folder - pg 9, #4; pg 10; pg 11 #1). Describes provider requirements for service availability 24/7 and FBHP 24/7 emergency access for Members. 3. FBHP Emer Serv flyerJCMH Eng rev 11_23_10 (entire doc). Sent to members monthly/annually re: 24/7 emerg service 4. FBHP Emer Serv flyer MHCBBC Eng 11_23_10 (entire doc). Sent to members monthly/annually re: 24/7 emerg service. 5. FBHP_EmergAccessIPN_Narrative_Q2FY11 (entire doc) Most recent report on IPN emergency response times. Describes phone call results monitoring IPN emergency response. 6. Provider Newsletter_JUL 10 (pg 4, section on Access to Care standards). 7. Provider newsletter_Feb 2010 (pg 2, section on Access to Care Standards) 8. 2010 CO Medicaid provider forum_2010 (slide 101-102, Access to Care Standards) 9. JCMH evening & weekend support (entire doc). Annual report from JCMH on emerg coverage and weekend program support 10. MHCBBC extended hours support (entire doc). Annual report from MHCBBC on weekend and after hours support and office hours **Description of Process** The FBHP QI Department establishes policies/procedures and monitors provider adherence to all access standards. The FBHP	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Policy on Access describes the process for ensuring provider adherence to the access standards. FBHP and its partner MHCs maintain emergency crisis lines 24/7 and IPN providers are expected to be available for crisis calls 24/7.	
Findings: The FBHP Access to Services policy included the provision that FBHP and its providers maintain systems for providing emergency services 24 hours per day, seven days per week. Providers were informed of their responsibilities for after-hours coverage via the provider manual. Members were informed of the availability of services 24 hours per day, seven days per week, and were provided the telephone number to contact FBHP 24 hours per day in the member handbook. The FBHP ATC report and the FBHP ER IPN Access report demonstrated oversight and monitoring of the provider network for compliance.		
Required Actions: None		
10. The Contractor has mechanisms to ensure compliance by providers regarding timely access to services, and has mechanisms to monitor providers regularly to determine compliance and to take corrective action if there is failure to comply. *42CFR438.206(c)(1)(iv) through (vi)* Contract: II.E.1.a. 9 through II.E.1.a. 11	**Documents:** **Policies** 1. FBHP Policy Access to Services Revised FY'11 (pg 3-4, sec IV). Describes FBHP methods for monitoring provider adherence to access standards and requirements. 2. FBHP Policy NCF_ACF Services Revised FY '11 (pg 2, IV). Describes procedures for monitoring NCF/ACF member residents access behavioral health services **Provider Training/Information** 1. Provider Newsletter_Feb 2010 (pg 2 – section on Access to Care Standards) 2. Provider Newsletter_July 10 (pg 4, section on Access to Care Standards) 3. 2010 CO Medicaid Provider forum_2010 (slide 33 – 5th bullet, requirement for reporting date offered appt; slide 101-102 Access to Care standard training) **Monitoring Access** 1. QI Work Plan FBHP FY '11 Final (pg 8-9) 2. 1st Qtr report FY '11(2).(Most recent report monitoring of	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	access, pg 3-4; 5,8). 3. Follow-up residential services report Qtr 1, FY '11 (1st Qtr report on monitoring residential follow-up, entire doc). Describes monitoring of residential follow-up 4. QI program eval '10 (pg 2; 4-9; 11-13). Describes FY '10 performance regarding access indicators, including grievances 5. FBHP_EmergAccessIPN_Narrative_Q2FY11(most recent report on IPN emergency response times). Describes phone call results monitoring IPN emergency response. 6. FBHPartners_ACT_Q1FY11final (entire document). Most recent quarterly Access report to the Department. 7. FBHPartners_ACT_Q4FY10 (FY '10 full access report) 8. MHSIP_YSS-F Survey Report FY '10 revised 8_13_10 (pg 6-10, areas related to Access). Describes client survey results regarding access. 9. MHCBBC response Lafayette office closure (entire doc). Response to request to follow-up of survey concerns 10. ACF_NCF_Survey report_FBHP 2010 (entire report). Describes results of an ACF/NCF satisfaction survey on behavioral health service access 11. JCMH weekly monitor 2010-2011_ATS for _FBHP (entire document). Monitoring report provided to FBHP weekly 12. MHCBBC Access to Care Reports – weekly routine emerg 112210-112810 (email). Monitoring report provided to FBHP weekly **Description of Process:** The FBHP QI Department establishes policies/procedures and monitors provider adherence to all access standards. The FBHP Policy on Access describes the process for ensuring provider adherence to timely access, including quarterly monitoring through the QI Plan Access indicators, training for providers in	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	access standards, and weekly monitoring of access standards with partner MHCs. In addition, internal MHSIP/YSS-F surveys are conducted and grievances are monitored for client concerns regarding timely access.	
Findings: FBHP provided numerous reports demonstrating oversight and monitoring of providers for compliance with access-to-care requirements. FBHP also provided examples of a first-time warning letter and request for a corrective action plan when monitoring activities determined that a provider was not complying with requirements. During the on-site interview, FBHP staff members reported that they received access data from the CMHCs weekly to monitor compliance, then received quarterly reports from the CMHCs to use for BHO-level quarterly reporting to the Department. Timely access to IPN providers was monitored using the data from the online or automated access-to-care system.		
Required Actions: None		
11. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Addressing the language and cultural expertise of providers in the network plan, ◆ Ensuring members' right to receive culturally appropriate and competent services from participating providers, ◆ Assessing member demographics, cultural, and racial affiliations, language and reading proficiency, ◆ Evaluating members' cultural and linguistic needs, ◆ Utilizing information gathered [regarding cultural and linguistic needs] in the service plan. *42CFR438.206(c)(2)* Contract: II.E.1.c.1.v; II.F.4.j.3.iv; F.7.d.1; F.7.e.2; and F.9.a	**Documents:** **Policies/Member Information** 1. FBHP Policy Member Rights rev 12_18_09 (entire policy, which includes Member Rights statement) Explains the role of OMFA in ensuring member rights 2. FBHP policy Cultural Competency rev. 12_15_10 (Policy and Purpose section) 3. FBHP language assistance policy (entire policy) 4. FBHPartner Member Handbook 102209 (misc folder – pg 4, second paragraph from bottom; pg 5 second paragraph and last paragraph; pg 6 4th bullet from top; pg 10 under "What if I have a …."; pg 15 bullets 4,5,6) Handbook includes several statements to help members understand their rights to culturally and linguistically appropriate services 5. FBHPartners Cultural Competency Plan adopted 1_20_09 (entire plan) Describes FBHP's commitment to services, regardless of culture or proficiency in English. 6. FBHP Staff Train & Attend 12_17_10 for Cal Yr 2011. Documents FBHP staff training on using language line and on the language access requirements	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	7. Office of Civil Rights Language Access Presentation 12_17_10 (entire PP) Powerpoint presentation by an OCR representative for FBHP staff and PMHCs. **Provider Training/Infor** 1. JCMH Cultural Competency Plan 12_15_10 (entire plan, but especially Goal 1, Organizational Structure, third paragraph, bullets 2-7; Goal IV, first paragraph; Goal VIII Written Materials) 2. MHCBBC Cultural Responsiveness Plan 112_15_10 (entire plan but especially Goals I, II, IV, V, VI and VIII, which track goals in FBHPartners' plan) 3. Intro to Cultural Profiles (entire doc) Describes FBHPartners development of six draft profiles. 4. Deaf & H of H Profiles, 2nd draft (entire doc). Example of one of the six draft profiles 5. Latino Profile, 2nd draft (entire doc) Example of one of the six draft profiles 6. 2010 CO Medicaid provider forum_2010 (slide 109-110; slide 114) 7. Client Right Training MHCBBC 2009 (slide #13 – right to culturally appro service; #17 – right to interpreter service). Annual training for MHCBBC providers 8. JCMH Provider Training Report Final 2010 (cultural competency and client rights[2nd opinion and culturally appro services] under New Employee and Annual Training) 9. MHCBBC New Hire Orientation agenda 02_2010 (consumer rights & confidentiality training – includes culturally appro services and second opinion) 10. MHCBBC 2010 Annual Training Course Listings (course on Client rights, culturally appro services and second opinion) 11. MHCBBC Annual & New Employee Training (bullet on	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	interpreter services) 12. FBHP Prov Manual Pt1 of 2.pdf (pg 86, bullet 4, assess cultural issues) 13. JCMH Rights Annual Trng – clinical-12_10 (slide 4 & 5) 14. Lang line train JCMH (entire doc) 15. Lang Line train MHCBBC (entire doc) **Monitoring** 1. MHSIP_YSS-F Survey Report FY ’10 revised 8_13_10.doc (pg 6, Table 3&4; pg 13, item #18) 2. ValueOptions_CO_Partnerships_Provider Directory (overall directory used to monitor access to language) 3. FBHP Languages_PMHC & IPN (monitoring report on providers with competency in other languages) 4. Ethnicity_Racial Membership_penetration report FY ’10.doc (entire document) Annual report monitoring ethnic/racial access for Members 5. Medical Record Review Report FY ’10 (entire report) Report on provider medical record review including assessing whether cultural/linguistic issues documented in evaluation and addressed in treatment plan. 6. Revised Clinical Peer Review 7_1_09 (Item A1h & T3) Form used in medical record audit including assessing and utilizing cultural/linguistic needs 7. 3BHO Audit tool final 12_16_10 (new audit tool for medical record audits – begin using 1/1/11 – pg 2 item 25) 8. MHCBBC Intake screen cultural.doc (example of MHC EMR intake form that includes cultural issue assessment) 9. Intake Example JCMH (example of MHC EMR intake form that includes cultural issue assessment)	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Description of Process: FBHPartners" Cultural Competency Plan establishes Goals, timelines and responsibilities for ensuring that all members receive culturally sensitive and linguistically appropriate services. A Cultural Competency Committee with representatives from the PMHCs and ValueOptions meets 2-4 times/year. The FBHPartners' Cultural Competency Coordinator identifies subject matter experts as consultants and is also developing profiles of target populations that will be incorporated into FBHPartners' practice guidelines. Both PMHCs are required to develop Cultural Competency plans. In addition, monitors are in place to ensure network adequacy regarding languages, that cultural issues are assessed and addressed in the member medical records, and access is ensured for all ethnicity/racial groups.	

Findings:
FBHP produced a provider language tracking document that indicated the number of providers in the network who speak languages other than English. Languages spoken by providers were included in the provider directory. The FBHP Language Assistance Service to Members policy described the use of the AT&T Language Line, Relay Colorado, and the use of professional interpreters, as needed, for assisting members who speak languages other than English and for members who are deaf or hard of hearing. On the list of member rights in the member handbook and in the FBHP Member Rights policy were the rights to "get information about your treatment choices in a way that you can understand; receive services that are suitable to your culture; and get interpreter services if you have problems communicating or do not speak English." The 3 BHO Audit Tool demonstrated that the BHO monitored for the presence of cultural and linguistic factors in the assessment and the treatment plan (applicable to the IPN). The FBHP cultural competence plan was a comprehensive plan that included goals, objectives, and activities designed to ensure that effective and culturally and linguistically competent mental health services were accessible to members enrolled in FBHP. The FBHP Web site could be translated into Spanish by clicking the "En Espanol" button. FBHP also provided a copy of the member handbook in Spanish. During the on-site interview, staff reported that cultural competence activities completed so far included the service area demographic profiles, staff and CMHC training, and an organizational self-assessment. Staff also reported that the CMHCs in the FBHP service area have completed organizational self-assessments, as well. Annual training topics included use of the language telephone translation line, Relay Colorado, and the Teletype/Telecommunications Device for the Deaf (TDD/TTY).

Required Actions:
None

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
12. The Contactor submits to the State (in a format specified by the State) documentation to demonstrate that the Contractor: ◆ Offers an appropriate range of preventative, primary care, and specialty services that is adequate for the anticipated number of members for the services area, ◆ Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area, ◆ Certifies that the network meets the requirements set forth in 438.206 and 438.207. *42CFR438.207(b)* Contract: II.E1.b.1	**Documents:** 1. FBHP Policy Provider Network delegation 2010 (entire policy) 2. FBHP_VO Delegation Agreement 091206 (Misc folder - Entire doc) 3. 3 BHO Network Adequacy Report Q1FY11 4. 3 BHO Certification of Network Adequacy 5. 3 BHO Email Network Adequacy 2010OCT 6. FY2010 Annual Needs Assessment 7. FBHP Provider Manual pt 1 of 2 (Misc folder - Page 3, Section II, *Continuum of Services*) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions® reviews network adequacy on a quarterly basis and reports the outcomes to HCPF. Included in the submission is a certification that the provider network meets the needs of eligible Medicaid members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The 3 BHO Network Adequacy Needs Assessment and 3 BHO Network Adequacy Report included all requirements. FBHP provided a copy of the e-mail confirming that FBHP sent the report and the network adequacy certification to the Department on October 29, 2010.		
Required Actions: None		

Results for Standard II—Access and Availability							
Total	Met	=	12	X	1.00	=	12
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	12	**Total Score**		=	12

Total Score ÷ Total Applicable	=	100%

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
1. The Contractor has written policies and procedures to ensure timely coordination of the provision of covered services to its members and to ensure service accessibility attention to individual needs and continuity of care to promote maintenance of health and maximize independent living. Contract: II.E.1.g.1	**Documents:** **Policies** 1. FBHP Policy Continuity of Care_Care Coordination revised 7_1_09 (entire document) Describes FBHPartners policy and procedures regarding Coordination and Continuity of Care 2. FBHP Policy Qual Care Concerns Final FY11 (entire policy and pg 5 QOC report, under "Clinical Care" see "failure to coordinate services" as a QOC issue) FBHPs policy on reporting QOC concerns including issues related to coordination of care 3. FBHP Policy Medical Record Maintenance Revised 2010 (see Access folder; Sec I & II). Policy ensuring medical record documentation standards including documentation of coordination of care 4. FBHP Policy Confidentiality and Security of Health Information 12_15_10 **Provider Training/Information** 1. FBHP Prov Manual Pt 1 of 2 (see misc folder, pg 11-12, primary mental health provider role to coordinate; pg 18, #2 – document CC, #4 – document communication with other providers; pg 24 – provider requirements re: EPSDT coordination; pg 25 – provider requirements re: coordination of care) 2. FBHP Prov Manual Pt 2 of 2 (see misc folder – pg 4-5) 3. Training on Coord of Care with PCPs JCMH (entire document) 4. MHCBBC Tx Plan Screen Shot CC (shows section requiring clincians to indicate their CC plan) 5. Provider Newsletter_JUL10 (see Access folder - pg 2- IPN information on care coordination) 6. Provider Newsletter_Feb 2010 (see Access folder – pg 3 section under Coordination of Care)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	7. 2010 CO Medicaid provider forum_2010 (see Access folder – slide 26 – Coordination re hosp discharge; slide 96-100, information on CC with physical health provider) **Provider Monitoring Coordination of Care** 1. Medical Record Review Report FY '10 (see Access folder; Coordination of Care section bottom of pg 1 and top pg 2; CC results under each provider group) 2. Revised Clinical Peer Review 7_1_09 (see Access folder - Item T6, T8, C2, C3) Example of form used in medical record audit including documentation of CC 3. 3BHO Audit tool final 12_16_10. (see Access folder – new form to use 1/1/11 – pg 3, Item #40 & #53) 4. EPSDT Letter request MHCBBC (entire document). Letter to health provider to ensure coordination of care 5. EPSDT to Client-Parent-Guardian MHCBBC (entire document) Handout for parents to promote EPSDT screening 6. EPSDT letter JCMH (entire document) Letter to health provider to promote coordination of care 7. 1st Qtr report FY 11(2) (see Access folder – pg 12 – indicators to monitor access to PCP and CC with PCP) 8. QI Program eval '10 (see Access folder – pg 2-3; pg 16-17; pg 21-22) 9. FBHP Griev & Appeal Report Qtr 1 FY 09-10 (pg 1-2, bottom of page "Discussion of Grievance). Example of follow-up on a coordination of care grievance 10. QI Work Plan FBHP FY11 Final (see Access Folder – pg 17, CC measures; pg 20, CC PIP) 11. QOC report FY '10 (entire doc). Annual report on reported quality of care concerns – many of which were issues related to coordination of care and follow-up after hosp discharge	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Description of Process: The FBHP QI Department is responsible for establishing policies and procedures to ensure timely coordination of services to members. The FBHP Policy Continuity of Care_Care Coordination outlines this policy and procedures, including a description of FBHP's care coordination system, procedures for coordinating with the member's health care provider, ensuring access to a PCP, continuity with a previous care provider or BHO, and procedures for monitoring provider adherence to the policy, including follow-up re: quality of care concerns. Additional policies, including the FBHP Policy Confidentiality describes procedures for maintaining member confidentiality when coordinating care, FBHP Policy Qual Care Concerns describes reporting of quality of care concerns, including not coordinating care, and FBHP Policy Medical Record Maintenance delineates medical record documentation requirements, including coordination of care. Additional documents are provided supporting required provider training and information and monitoring on care coordination.	
Findings: The FBHP Coordination and Continuity of Care policy included procedures for assigning the care coordinator, requirements for documenting coordination needs and activities, and requirements for other processes such as releases of information and communicating with primary care providers (PCPs). The policy also addressed monitoring methods to ensure timely access for members and to ensure the presence of required information in the medical record, including requirements for the assessment and treatment plan. During the on-site interview, FBHP staff members delineated the roles of VO (the CCMs) and FBHP and its CMHCs. Staff members explained that VO was only involved in processing requests through the service center for authorization of services (routine requests from the IPN and requests for intensive levels of care). Coordination of services provided was the responsibility of the primary therapist or care coordinators, or hospital liaisons employed by the CMHCs (for more complex cases).		
Required Actions: None		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
2. Policies and procedures address: ◆ The coordination of services furnished to the member by the Contractor with the services the member receives from any other MCO or PIHP. ◆ The coordination and provision of services in conjunction with other behavioral health care providers, physical health care providers, long term care providers, waiver service providers, pharmacists, county and state agencies, and other organizations that may be providing wrap around services. *42CFR438.208(b)(2)* Contract: II.E.1.g.1 and II.E.1.g.2	**Documents:** **Policies** 1. FBHP Policy Continuity of Care_Care Coordination revised 7_1_09 (pg 1 & 2, Sec I-IV; pg 3, Sec VII) 2. FBHP Policy Medical Record Maintenance Revised 2010.doc (see Access folder; Sec I & II). Policy ensuring general medical record standards including documentation of coordination of care **Provider Training/Information** 1. FBHP Prov Manual Pt 1 of 2 (see misc folder, pg 11-12, primary mental health provider role to coordinate; pg 18, #2 – document CC, #4 – document communication with other providers; pg 24 – provider requirements re: EPSDT coordination; pg 25 – provider requirements re: coordination of care) 2. FBHP Prov Manual Pt 2 of 2 (see misc folder – pg 4-5) 3. Provider Newsletter_Feb 2010 (see Access folder – pg 3 Section on discharge planning hosp) 4. Provider newsletter_Jul 10 (see Access folder – pg 2 Coordination with PCP) 5. 2010 CO Medicaid provider forum_2010 (see Access folder – slide 26, discharge coordination hosp; slide 96-100, coordination with PCP) 6. Training on Coord of Care with PCPs JCMH (entire document) 7. MHCBBC Tx Plan Screen Shot CC (shows section requiring clincians to indicate their CC plan) **Provider Monitoring** 1. 1st Qtr report FY 11(2) (see Access folder – pg 12 – indicators to monitor access to PCP and CC with PCP) 2. QI Program eval ’10 (see Access folder – pg 2-3; pg 16-17; pg 21-22)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	3. QI Work Plan FBHP FY11 Final (see Access Folder – pg 17, CC measures; pg 20, CC PIP) 4. ACF_NCF_survey report_FBHP2010 (see Access folder, pg 2, Table 1, pg 4, Table 2, pg 6, Table 3, pg 8, Table 4, specifically items #6,7,8,&10) 5. Medical Record Review Report FY '10 (see Access folder; Coordination of Care section bottom of pg 1 and top pg 2; CC results under each provider group) 6. Revised Clinical Peer Review 7_1_09 (see Access folder - Item T6, T8, C2, C3) Example of form used in medical record audit including documentation of CC 7. 3BHO Audit tool final 12_16_10 (see Access folder – new form to use 1/1/11 – pg 3, Item #40 & #53) 8. QI_UM min Oct 2010 (see New Business – QI/UM MI Waiver Report) Follow-up of members with an MI Waiver with more than 3 physical health ED visits/12 month period **Description of Process:** The FBHP QI Department is responsible for establishing policies and procedures to ensure timely coordination of services to members, including coordination with an MCO, or other organization that may be providing wrap-around services to assist the Member in remaining in the community. The FBHP Policy Continuity of Care_Care Coordination outlines this policy and procedures, including a description of FBHP's care coordination system, procedures for coordinating with the member's health care provider, ensuring access to a PCP, continuity with a previous care provider or BHO, and procedures for monitoring provider adherence to the policy. Included in the QI Plan are performance indicators monitoring coordination of care, as well as continued work on a coordination of care PIP implemented to improve coordination of care.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Findings: The FBHP Coordination and Continuity of Care policy included procedures for transitioning members to another BHO (related to eligibility service area) and ensuring continuity of care. The policy stated that members may remain with the current BHO for up to 60 days and addressed authorization requirements. The policy described the process for communicating with the PCP via a coordination letter. The medical record documentation audit evaluated for the presence of releases of information for the purpose of coordinating care, documentation of efforts in coordinating with the PCP and other providers, the presence of required forms, and the content of the treatment plan related to coordination of care. Providers were informed of care coordination responsibilities and documentation responsibilities related to care coordination via the provider manual and provider newsletters. In addition, care coordination information was included in a Medicaid provider forum conducted in fall 2010 and available on FBHP's Web site.		
Required Actions: None		
3. The Contractor shares with other health care organizations serving the member with special health care needs, the results of its identification and assessment of that member's needs, to prevent duplication of those activities. *42CFR438.208(b)(3)* Contract: None	**Documents:** 1. FBHP Policy Continuity of Care_Care Coordination revised 7_1_09 (pg 2, IIA2b & IIb2) 2. Medical Record Review Report FY '10 (see Access folder; Coordination of Care section bottom of pg 1 and top pg 2; CC results under each provider group) 3. QI Program eval '10 (see Access folder – pg 17 B; pg 22 1b) 4. MHCBBC PCP letter (entire) Example of letter sent to PCP sharing health information 5. COC Letter jcmh (entire doc) Example of letter sent to PCP sharing health information 6. 1st Qtr report FY 11(2) (see Access folder – pg 12 – indicators to monitor sending CC to PCP) 7. EPSDT Letter JCMH (entire doc) 8. EPSDT letter request MHCBBC (entire doc) 9. FBHP Prov Manual Pt 1 of 2 (see misc folder, pg 11-12, primary mental health provider role to coordinate; pg 18, #2 – document CC, #4 – document communication with other providers; pg 24 – provider requirements re: EPSDT coordination; pg 25 – provider requirements re: coordination of care) 10. FBHP Prov Manual Pt 2 of 2 (see misc folder – pg 4-5)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	11. 2010 CO Medicaid provider forum_2010 (see Access folder – slide 96-100, coordination with PCP) **Description of Process** The FBHP QI Department is responsible for establishing policies and procedures to ensure timely coordination of services to members, including coordination with an MCO, or other organization that may be providing wrap-around services to assist the Member in remaining in the community. The FBHP Policy Continuity of Care_Care Coordination outlines this policy and procedures, including a description of FBHP's care coordination system and, in particular, procedures for coordinating with the member's health care provider. FBHP has procedures for requesting, at intake, a release of information from the client for their PCP, in order to coordinate care with the health care provider. FBHP monitors coordination of care through Medical Record audits and tracking of the CC Letter being sent to the PCP as a performance indicator.	
Findings: The Coordination and Continuity of Care policy addressed sharing diagnostic and medication information with the member's PCP via the PCP care coordination letter. The policy also defined "at-risk members" and stated that at-risk members received more intensive care coordination. The medical record audit form included an evaluation for the presence of communication and coordination with other providers, including medical providers, treatment agencies, or social service agencies. The PCP letter template included diagnostic and medication information, requested the same information from the PCP, and offered further discussion for the purpose of care coordination. During the on-site interview, FBHP staff members reported that the general care coordination letter was sent to the PCP, offering and requesting information at intake and annually, and that the letter requesting Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) information was sent at intake only.		
Required Actions: None		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
4. The Contractor ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E (HIPAA), to the extent that they are applicable. *42CFR438.208(b)(4)* Contract: II.E.1.g.1	**Documents:** **Policies/Member infor** 1. FBHP Policy Continuity of Care_Care Coordination revised 7_1_09 (pg 1, IC) 2. FBHP Policy Confidentiality and Security of Health Information 12_15_10 (entire policy) 3. FBHP HIPAA Guidelines rev 1_16_10 4. FBHP Confidentiality Agreement (entire doc) This agreement must be signed by all FBHP staff and contractors 5. FBHPartners Member Handbook 102209 (see misc folder – pg 15 &16) **Provider/FBHP Training/Infor** 1. FBHPartners Authorization to Release Information, rev 8_1_09 (form used by FBHPartners to obtain Member permission to release protected health information 2. FBHP Privacy Notice English 7_17_09 (entire doc) 3. FBHP HIPAA & HITECH Annual Staff Training 1_27_10 4. FBHP Prov Manual Pt 1 of 2.pdf (see misc folder - pg 25 first paragraph) 5. ROI JCMH (entire doc) Example of MHC release of information form 6. JCMH Provider Training Report Final 2010 (see Access folder confidentiality/HIPAA under New Employee and Annual Training) 7. MHCBBC New Hire Orientation agenda 02_2010 (see Access folder – consumer rights and confidentiality) 8. MHCBBC 2010 Annual Training Course Listings (see Access folder course on confidentiality/HIPAA) 9. MHCBBC Confidentiality Training 03_10 (entire doc)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Description of Process: The FBHP Office of Member and Family Affairs (OMFA) is responsible for establishing policies and procedures and training to ensure that members' privacy under federal and state laws is protected while coordinating care for members. The Policy on Confidentiality outlines the internal procedures for insuring the confidentiality of Protected Health Information (PHI) and notifying members of their right to protection of PHI. (See, for example FBHP Staff Training for cal yr 2011, FBHP Confidentiality Agreement, authorization to release information forms, Member's Privacy Notice, and information in Member Handbook.) The OMFA includes a Director and an advocate at each Partner Mental Health Center (PMHC) who provide annual and new employee training at PMHCs. (See, for example, JCMH Provider Training Report Final 2010 in Access folder and MHCBBC New Hire Orientation agenda 2-2010 and MHCBBC 2010 Annual Training Course Listings in Access folder.) Training for providers in the Independent Provider Network is accomplished by ValueOptions, the Provider Network Delegate, as evidenced by the FBHP Prov Manual Pt 1 of 2, pg.25.	

Findings:
The FBHP Coordination and Continuity of Care policy included the provision that a release of information is obtained at the member's intake session for each provider and agency furnishing services to the member. The FBHP Confidentiality and Security of Health Information policy addressed compliance with confidentiality requirements (such as the Health Insurance Portability and Accountability Act [HIPAA]) via instruction to staff regarding the minimum amount of information required, electronic security measures, and the use of releases of information. The policy also addressed staff training requirements. During the on-site interview, FBHP staff members explained that the HIPAA Guidelines document was used as a handout during staff training. FBHP provided an example of the FBHP release of information. The CMHC new hire and annual training included information and responsibilities related to confidentiality. The provider manual described confidentiality requirements, the HIPAA regulations, and the provider's responsibilities for ensuring the confidentiality of member information. The member handbook explained how protected health information (PHI) was used. The medical record audit form included assessment for the presence of releases of information in the medical records, as applicable. Staff members also explained that the confidentiality agreement was signed by all staff and committee members (the QI Committee, Board of Directors, etc.) annually.

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
Required Actions: None		
5. The Contractor ensures that each member accessing services receives an individual intake and assessment within contractual timeframes for the level of care needed. The individual intake and assessment shall not be performed as part of any group orientation or therapy session. *42CFR438.208(c)(2)* Contract: II.F.7.a and II.F.7.c	**Documents:** 1. FBHP Policy Continuity of Care_Care Coordination revised 7_1_09 (pg 1, IB) 2. FBHP Policy Access to Services Revised FY'11 (see Access folder- pg 1 A1). Describes timelines for intake appt and other intake requirements 3. FBHP Policy Medical Record Maintenance Revised 2010 (see Access folder; Sec I & II). Policy ensuring general medical record standards including individualized assessment documentation 4. FBHP Prov Manual Pt 1 of 2 (see misc folder, pg 86 4th and 5th bullet) Provider information re: assessment requirements 5. FBHPartners_ACT_Q1FY11final (see Access folder- information on routine intake). Most recent quarterly Access report to the Department. 6. FBHPartners_ACT_Q4FY10 (see Access folder - FY '10 full access report – see information on routine intake) 7. Medical Record Review Report FY '10 (see Access folder; Assessment/intake section on pg 1 and results under each provider group) 8. Revised Clinical Peer Review 7_1_09 (see Access folder - Item A1-A7) Example of form used in medical record audit including documentation of assessment 9. 3BHO Audit tool final 12_16_10 (see Access folder – new form to use 1/1/11 – pg 2, Item #18-33) 10. QI Program eval '10 (see Access folder – pg 4-5) 11. 1st Qtr report FY 11(2) (see Access folder – pg 3)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
	Description of Process: The FBHP QI Department is responsible for establishing policies and procedures to ensure members receive a thorough assessment/intake within the required timeline standards. The FBHP policy Continuity of Care_Care Coordination and Access to Care delineate the requirements for the assessment. FBHP QI Department staff monitor the intake timelines and individualized assessment through the QI Plan and quarterly QI Reports as well as through medical record audits.	
Findings: The Member Medical Record policy included procedures for medical record chart auditing to ensure that medical records included all required documentation. The medical record audit form included assessment for the presence and content of the individualized assessment. The July 2010 Provider Newsletter described CCAR processes. The provider manual included the list of medical record documentation standards, which included an individualized assessment of the member needs and what should be assessed. The medical record review report demonstrated that FBHP monitored its CMHC providers for the presence and content of the individualized assessment. The 3 BHO Audit Tool demonstrated monitoring of FBHP's IPN providers for the presence and content of the individualized assessment (conducted by VO, FBHP's delegate).		
Required Actions: None		
6. Each member actively seeking services shall have an individualized service plan (treatment plan), developed by the member and/or the designated member representative and the member's provider or treatment team and: ◆ Utilizes the information gathered in the member's intake and assessment to build a comprehensive plan of service, ◆ Includes measurable goals, strategies to achieve the stated goals and a mechanism for monitoring and revising the service plan as appropriate, ◆ Is signed by the member and reviewing professional. If the member chooses not to sign his/her service	**Documents:** 1. FBHP Policy Continuity of Care_Care Coordination revised 7_1_09 (pg 1, IB) 2. FBHP Policy Medical Record Maintenance Revised 2010 (see Access folder; Sec I & II). Policy ensuring medical record documentation standards including an individualized treatment plan 3. FBHP Prov Manual Pt 1 of 2 (see misc folder, pg 87, service treatment plan section) 4. Medical Record Review Report FY '10 (see Access folder; Treatment Plan section on pg 1 and results under each provider group) 5. Revised Clinical Peer Review 7_1_09 (see Access folder –	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by BHO/Health Plan**	**Score**
plan, documentation is provided in the member's medical record stating the member's reason for not signing the plan, ◆ Service planning occurs annually or if there is a change in the member's level of functioning. *42CFR438.208(c)(3)* Contract: II.F.9	Item T1-U7) Example of form used in medical record audit including documentation of treatment plan 6. 3BHO Audit tool final 12_16_10 (see Access folder – new form to use 1/1/11 – pg 2, Item #36-45) 7. Tx plan JCMH (example of treatment plan EMR screen showing signature areas, goals) 8. Client Right Training MHCBBC 2009 (see Access folder – slide #13, service plan participation; Slide #16, involved in dev service plan). Example of annual training material for MHCBBC providers. 9. QI Program eval '10 (see Access folder – pg 10-11) Monitoring of client response on YSS-F and MHSIP re: treatment plan participation **Description of Process:** The FBHP QI Department is responsible for establishing policies and procedures to ensure members receive an individualize treatment plan. The FBHP Policy on Medical Record maintenance and the FBHP Provider Manual specify the treatment plan requirements and procedures for monitoring providers regarding these requirements through medical record audit. PMHCs and IPN receive annual training on member rights, which includes the right to participate in their developing their treatment plan.	
Findings: The Member Medical Record policy included procedures for medical record chart auditing to ensure that medical records included all required documentation. The medical record audit form included assessment for the presence and content of the individualized service plan. The provider manual included the list of medical record documentation standards, which included an individual service/treatment plan. The medical record review report demonstrated that FBHP monitored its CMHC providers for the presence and content of the individualized treatment plan. The 3 BHO Audit Tool demonstrated monitoring of FBHP's IPN providers for the presence and content of the individualized treatment plan (conducted by VO, FBHP's delegate).		
Required Actions: None		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	6	**Total Score**		=	6

Total Score ÷ Total Applicable	=	100%

Appendix B. Denials Record Review Tool
for Foothills Behavioral Health Partners, LLC

The completed compliance monitoring tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Foothills Behavioral Health Partners, LLC

Review Period:	January 1, 2010–September 15, 2010
Date of Review:	February 17, 2011
Reviewer:	Barbara McConnell
Participating Plan Staff Member:	Amie Adams

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
1	******	12/28/09	1/5/10	8	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☒ N ☐ N/A ☐	Y ☒ N ☐
Comments:											
2	******	1/17/10	1/21/10	4	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
3	******	1/21/10	1/25/10	4	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
4	******	2/10/10	2/11/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
5	******	2/23/10	2/24/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
6	******	2/25/10	3/2/10	5	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
7	******	3/23/10	3/24/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
8	******	4/6/10	4/7/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
9	******	4/21/10	4/22/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
10	******	5/17/10	5/17/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Foothills Behavioral Health Partners, LLC

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
11	******	5/12/10	5/18/10	6	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
12	******	5/27/10	5/28/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
13	******	N/A	6/4/10	N/A	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: This was a claim denial. The decision was made on 6/4/10. The requirement for claim denials was to send the notice of action at the time of any decision affecting the claim.											
14	******	N/A	6/24/10	N/A	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: This was a claims denial. The decision was made on 6/24/10. The requirement for claims denials was to send the notice of action at the time of any decision affecting the claim.											
15	******	N/A	7/7/10	N/A	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: This was a claim denial. The decision was made on 7/7/10. The requirement for claim denials was to send the notice of action at the time of any decision affecting the claim.											
16	******	N/A	7/21/10	N/A	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments: This was a claim denial. The decision was made on 7/21/10. The requirement for claim denials was to send the notice of action at the time of any decision affecting the claim.											
17	******	7/28/10	7/28/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
18	******	8/2/10	8/3/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
19	******	8/12/10	8/13/10	1	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											
20	******	8/30/10	8/30/10	0	Y ☒ N ☐ N/A ☐		Y ☐ N ☐ N/A ☒	Y ☒ N ☐	Y ☒ N ☐	Y ☐ N ☐ N/A ☒	Y ☒ N ☐
Comments:											

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2010–2011 Denials Record Review Tool
for Foothills Behavioral Health Partners, LLC

1	2	3	4	5	6	7	8	9	10	11	12
		Complete if Standard/Expedited Authorization Decision				Complete for Termination, Suspension, or Reduction of Previously Authorized Services		Complete for All Denials			
File #	Member ID	Date of Initial Request	Date Notice of Action Sent	Number of Days for Decision and Notice	Notice Sent w/in Time Frame? (S = 10 C days after request; E = 3 W days after request)	Date Notice Sent	Notice Sent w/in Time Frame? (At least 10 days prior to change in service)	Notice Includes Required Content?	Decision Made by Qualified Clinician?	Requesting Physician Consulted? (if applicable)	Reason Valid?
21	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments: No oversample cases were required to obtain and review 20 cases.											
22	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
23	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
24	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
25	******				Y ☐ N ☐ N/A ☐		Y ☐ N ☐ N/A ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐
Comments:											
# Applicable Elements					20		0	20	20	1	20
# Compliant Elements					20		0	20	20	1	20
Percent Compliant					100%		NA	100%	100%	100%	100%

Total # Applicable Elements	**81**
Total # Compliant Elements	**81**
Total Percent Compliant	**100%**

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

Table C-1 lists the participants in the FY 2010–2011 site review of **FBHP**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Project Director
FBHP Participants	**Title**
Don Bechtold	Medical Director, FBHP
Amie Adams	Clinical Director, ValueOptions
Hazel Bond	Director, Office of Member and Family Affairs, FBHP
Barbara Ryan	Chair, Board of Managers, FBHP
Lucy Hausner	Member and Family Advocate, Jefferson Center
Linda Runyon	Member and Family Advocate, Mental Health Partners
Barbara Smith	Director, Quality Assessment and Performance Improvement, FBHP
Department Observers	**Title**
Marceil Case (telephonically)	Behavioral Health Specialist
Jerry Ware	Quality/Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2010–2011 for Foothills Behavioral Health Partners, LLC

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

Table D-1—Corrective Action Plan Process

Step 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 provided. The Department should be copied on any communication regarding CAPs. For each of the elements receiving a score of *Partially Met* or *Not Met*, the CAP must describe interventions designed to achieve compliance with the specified requirements, the timelines associated with these activities, anticipated training and follow-up activities, and documents to be sent following the completion of the planned interventions.
Step 2	**Prior approval for timelines exceeding 30 days**
	If the BHO is unable to submit the CAP (plan only) within 30 calendar days following receipt of the final report, it must obtain prior approval from the Department in writing.
Step 3	**Department approval**
	Following review of the CAP, the Department will notify the BHO via e-mail whether: ◆ The plan has been approved and the BHO should proceed with the interventions as outlined in the plan. ◆ Some or all of the elements of the plan must be revised and resubmitted.
Step 4	**Documentation substantiating implementation**
	Once the BHO has received Department approval of the plan, the BHO should implement all the planned interventions and submit evidence of such implementation to HSAG via e-mail or the FTP site, with an e-mail notification regarding the posting. The Department should be copied on any communication regarding CAPs.
Step 5	**Progress reports may be required**
	For any planned interventions requiring an extended implementation date, the Department may, based on the nature and seriousness of the noncompliance, require the BHO to submit regular reports to the Department detailing progress made on one or more open elements of the CAP.

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 as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the BHO must submit additional documentation. The Department will inform each BHO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable contract requirements.

The template for the CAP follows.

Table D-2—FY 2010–2011 Corrective Action Plan *for* Foothills Behavioral Health Partners, LLC					
Standard and Requirement	**Required Actions**	**Planned Intervention and Person(s)/Committee(s) Responsible**	**Date Completion Anticipated**	**Training Required/Monitoring and Follow-up Planned**	**Documents to be Submitted as Evidence of Completion**
I. Coverage and Authorization of Services 30. The Contractor is financially responsible for post-stabilization care services obtained within or outside the network that are not pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition within 1 hour of a request to the organization for pre-approval of further post-stabilization care services.	The member handbook stated, "You may need services after the emergency is over to help you stay stable or improve your mental health condition. This is called Post-Stabilization Care. Post-stabilization services are inpatient and outpatient services provided just after an emergency. Your emergency provider must get approval from your BHO for these services after the emergency is over." This statement leads the reader to believe that preauthorization is required for poststabilization care and is in conflict with FBHP policies. FBHP must clarify the member handbook to provide information that is consistent with VO/FBHP's policies.				

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 listed below 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 and a meeting at the Department to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the date of the review. ◆ HSAG coordinated with the Department to determine timelines for the Department's review and approval of the tool and report template and other review activities. ◆ HSAG staff attended Behavioral Health Quality Improvement Committee (BQUIC) meetings and discussed the FY 2010–2011 compliance monitoring review process as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions from the BHO via telephone contact or e-mails related to federal managed care regulations, contract requirements, the request for documentation, and the site review process to ensure that the BHO was prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the BBA Medicaid managed care regulations and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, desk audit request, on-site agenda, record review tool, 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 via delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk audit request included instructions for organizing and preparing the documents related to the review of the three standards. Thirty days prior to the review, the BHO provided documentation for the desk audit, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk audit form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. ◆ The 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 and reviewed additional documents as needed. (HSAG reviewed certain documents on-site due to the nature of the document—i.e., certain original source documents were of a confidential or proprietary nature or were requested as a result of the pre-on-site document review.) ◆ HSAG reviewed additional documents requested as a result of the on-site interviews.
Activity 6:	**Analyzed and Compiled Findings**
	◆ Following the on-site portion of the review, HSAG met with BHO staff to provide an overview of preliminary findings. ◆ HSAG used the FY 2010–2011 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 required of the BHO to achieve full compliance with Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2010–2011 Site Review Report. ◆ HSAG submitted the site review report to the Department for review and comment. ◆ HSAG incorporated the Department's comments. ◆ HSAG distributed a second draft report to the BHO for review and comment. ◆ HSAG incorporated the BHO's comments and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.