Colorado Medicaid
Community Mental Health Services Program

FY 2011–2012 Site Review Report

for

Foothills Behavioral Health Partners, LLC

February 2012

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

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Overview of FY 2011–2012 Compliance Monitoring Activities

The Balanced Budget Act of 1997, Public Law 105-33 (BBA), requires that states conduct a periodic evaluation of their managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs) to determine compliance with regulations and contractual requirements. The Department of Health Care Policy and 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 eighth year that HSAG has performed compliance monitoring reviews of the Colorado Medicaid Community Mental Health Services Program. For the fiscal year (FY) 2011–2012 site review process, the Department requested a review of four areas of performance. HSAG developed a review strategy and monitoring tools consisting of four standards for reviewing the four performance areas chosen. The standards chosen were Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, and Standard IX—Subcontracts and Delegation.

The BHO's administrative records were also reviewed to evaluate implementation of Medicaid managed care regulations related to Medicaid member appeals. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 10 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid appeals that were filed between January 1, 2011, and September 30, 2011. For the record review, the BHO received a score of *M* (met), *N* (not met), or *NA* (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 *U* (unknown) was used and did not impact the overall record review score. Compliance with federal regulations was evaluated through review of the four standards and appeal records. HSAG calculated a percentage of compliance score for each standard and an overall percentage of compliance score for all standards reviewed. HSAG also separately calculated an overall record review score.

This report documents results of the FY 2011–2012 site review activities for the review period—January 1, 2011, through the dates of the on-site review, December 12 and 13, 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 2010–2011 site review activities. Appendix A contains details of the findings for the review of the standards. Appendix B contains details of the findings for the appeals record review. 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 for FY 2011–2012 and the required template for doing so.

Methodology

In developing the data collection tools and in reviewing documentation related to the four 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.

The four standards chosen for the FY 2011–2012 site reviews represent a portion of the Medicaid managed care requirements. Standards that will be reviewed in subsequent years are: Standard I—Coverage and Authorization of Services, Standard II—Access and Availability, Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard VIII—Credentialing and Recredentialing, 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 as outlined in the CMS final protocol.

Objective of the Site Review

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

- The BHO's compliance with federal regulations and contract requirements in the four areas selected for review.
- Strengths, opportunities for improvement, and actions required to bring the BHO into compliance with federal health care regulations and contract requirements in the standard areas reviewed.
- The quality and timeliness of, and access to, services furnished by the BHO, as assessed by the specific areas reviewed.
- Possible interventions to improve the quality of the BHO's services related to the areas reviewed.

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 requirements 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 elements, 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—Compliance Monitoring Tool.

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)
V	Member Information	19	19	17	2	0	0	89%
VI	Grievance System	26	26	24	2	0	0	92%
VII	Provider Participation and Program Integrity	15	15	15	0	0	0	100%
IX	Subcontracts and Delegation	8	7	6	1	0	1	86%
	Totals	**68**	**67**	**62**	**5**	**0**	**1**	**93%**

Table 1-2 presents the scores for **FBHP** for the Appeals Record Review. Details of the findings for the record review follow in Appendix B—Appeals Record Review Tool.

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

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Appeals Record Review	60	59	59	0	1	100%

2. Summary of Performance Strengths and Required Actions

for **Foothills Behavioral Health Partners, LLC**

Overall Summary of Performance

For the four standards reviewed by HSAG, **FBHP** earned an overall compliance score of 93 percent. **FBHP**'s strongest performance was in Standard VII—Provider Participation and Program Integrity, which earned a compliance score of 100 percent. Although scoring only 86 percent for Standard IX—Subcontracts and Delegation, due to the small number of elements scored, **FBHP** performed very well for this standard as it presented only one minor item requiring action. **FBHP**'s scores for Standard V—Member Information, and Standard VI—Grievance System, were 89 percent and 92 percent, respectively. **FBHP** demonstrated strong performance overall and a solid understanding of the federal regulations.

Standard V—Member Information

Summary of Findings and Opportunities for Improvement

FBHP's member handbook was comprehensive and easy to follow, and available in alternative formats and languages. The member handbook included information about the benefits and covered services, included the required definitions of emergency and poststabilization services, and explained how and where to obtain the services. The handbook also included information about advance directives, as required. **FBHP** provided evidence that its welcome packet—which included a copy of the member handbook—was mailed to new members within two to six weeks after receiving notification of enrollment.

FBHP included a comprehensive list of member rights in its member handbook and required that posters containing these rights be displayed in all provider locations. **FBHP** confirmed the posting of member rights at provider locations during its annual compliance reviews. **FBHP**'s policies and procedures stated that members would be given notice of significant changes at least 30 days before the intended date of change. **FBHP** also had processes in place to notify members within 15 days of learning of provider terminations. HSAG reviewed documentation that demonstrated that **FBHP** had informed members of a provider termination.

Summary of Strengths

FBHP demonstrated very strong commitment to making its materials available to all members in an easy-to-understand format and in alternative languages. Printed materials were translated into Spanish and included statements written in Spanish informing members that documents were available in Spanish. Materials also included statements reminding members that documents were available in large type or on audiotape and that interpreter services were available for any language, free of charge. **FBHP**'s member materials had been reviewed by member groups for functionality of the message as well as readability level. The handbook presented difficult concepts in easy-to-understand language. Prior to mailing enrollment packets, the mailing list was sorted so that Spanish-speaking households would receive the packets in Spanish rather than having to request the materials in Spanish.

The **FBHP** Web site could be viewed in Spanish by clicking the En Español button. The Web site also provided all of the required member information, with the ability to follow links to additional information regarding a particular subject. The Web site's Achieve Solutions page also included a large library of member materials and resources.

The Navigation Team at each of the partner mental health centers (PMHCs) was available to assist members in not only understanding the benefits available at the BHO, but also in understanding how to navigate the public benefits system and community resources in general.

Summary of Required Actions

FBHP erroneously depicted the standard appeal resolution time frame as ten *calendar days* in its member handbook. **FBHP** must revise the member handbook to accurately describe the resolution time frame for standard appeals.

The BBA requires BHOs to notify their members at least once a year that the member has the right to ask for information at any time and receive it upon request. Although **FBHP**'s member handbook accurately reflected this requirement, the annual member letter notified its members that they may ask for and receive materials only once a year. **FBHP** must review and/or revise applicable member materials and policies to clarify the requirement for **FBHP** to provide annual notice to members of the right to request information at any time and receive it upon request.

Standard VI—Grievance System

Summary of Findings and Opportunities for Improvement

FBHP had a robust system for processing grievances and appeals. **FBHP** used database programs to document grievances and appeals and generate detailed reports for submission to the quality improvement committee and to the Department, as required. In addition to ValueOptions (VO) processes, **FBHP** had additional tracking and documentation methods to ensure the timeliness of grievance and appeal processing. The on-site review of ten appeal records demonstrated that acknowledgement letters and notices of resolution were sent within the required time frames for all ten records. The record review also demonstrated that individuals who made resolution decisions on the grievances and appeals were not involved previously and had the requisite clinical expertise to do so. Resolution notices reviewed in the records included all of the required information. **FBHP**'s Office of Member and Family Affairs (OMFA) staff worked with members when lacking the required information to decide the appeal and used the extension process in two cases.

Summary of Strengths

FBHP used multiple methods to communicate to members regarding the right to file grievances and appeals, and to request a State fair hearing. It was clear, as evidenced by the record review, that appeals had been filed by members, designated client representatives (DCRs), and providers acting on behalf of the member. **FBHP** used excellent training materials to familiarize new network providers with members' grievance system rights. The on-site record review demonstrated that (1) timelines were met, (2) there was evidence of the OMFA director providing assistance to members during the appeal process, and (3) notices included the required content, were clearly customized to the member's situation, and were written in a way that was easily understood.

Summary of Required Actions

While **FBHP** had a well-organized system for ensuring that individuals who made resolution decisions on appeals were not involved in the previous level of review and had clinical expertise in treating the member's condition, there was one case in the record review in which the decision to deny the expedited process was made by the OMFA director and the grievance coordinator. **FBHP** must ensure that individuals who make clinical decisions related to grievances and appeals have clinical expertise in treating the member's condition or disease.

While **FBHP**'s provider manual addressed each of the required elements, **FBHP** must specifically notify providers that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.

Standard VII—Provider Participation and Program Integrity

Summary of Findings and Opportunities for Improvement

FBHP delegated the responsibility of credentialing potential providers and recredentialing existing providers to VO. VO's processes and procedures were comprehensive and compliant with NCQA requirements. The processes were designed in a way that ensured consistent application of standards and prohibited decisions based on race, national identity, gender, age, sexual orientation, or the type of patient or procedure in which the practitioner specializes.

FBHP performed credentialing and recredentialing for the partner CMHC providers, rather than the CMHCs performing those processes. VO provided primary source verification for partner CMHC (PMHC) providers. VO and **FBHP** used numerous methods to monitor covered services provided by the PMHCs or the independent provider network (IPN). Providers were made aware of the stringent requirements in the provider manual. The procedures included implementing corrective action plans if providers did not meet the standards and follow-up, as needed, until the provider achieved full compliance. In addition to the chart audits performed by VO, **FBHP**'s quality management program included a variety of methods to review performance measures and outcomes measures to evaluate the quality and appropriateness of services furnished.

FBHP provided several documents that clearly stated it would not knowingly employ a director, officer, partner, employee, consultant, or owner who is debarred or excluded from participation in federal programs. **FBHP** demonstrated that it regularly monitored numerous State and federal databases to identify individuals or entities fitting this description with whom **FBHP** had already established or was considering establishing a relationship.

FBHP notified members and providers that members have the right to be informed of treatment options and to participate in treatment decisions including the right to refuse treatment.

Summary of Strengths

VO's use of automated systems through Network Connect proved to be an asset to its ability to manage the provider network on behalf of **FBHP**. The program allowed for cross-referencing of processes with provider files and for tracking and documentation of provider-related information for use in the recredentialing process. VO was able to limit system access to appropriate staff. The program efficiently linked provider functions and information from numerous sources into a single electronic record of all provider information and activity.

FBHP demonstrated an extensive program developed to guard against fraud and abuse. This program included a detailed corporate compliance plan, standards of conduct, and policies and procedures. Review of compliance committee meeting minutes demonstrated timely response to suspected fraud and abuse and communication to the department, as required.

Summary of Required Actions

There were no corrective actions required for this standard.

Standard IX—Subcontracts and Delegation

Summary of Findings and Opportunities for Improvement

FBHP had policies and procedures in place that addressed the delegation of specific BHO tasks and included all of the required information. There was evidence that **FBHP** had a signed, executed agreement with each delegate that included most of the required provisions.

FBHP provided evidence that it completed the predelegation review prior to entering into the delegation agreement with ValueOptions (VO) in 2009.

Summary of Strengths

FBHP demonstrated clear oversight and ultimate responsibility of delegated tasks, as evidenced by multiple methods of ongoing monitoring and formal review. Ongoing monitoring included regular review of reports submitted by VO and regular meetings between **FBHP** and VO. Formal review included review or audit of records including policies, procedures and an annual on-site contract compliance audit. **FBHP** provided evidence that monitoring of VO resulted in requests for corrective action.

Summary of Required Actions

The two agreements between **FBHP** and VO presented each of the required provisions except the provision to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. **FBHP** must revise its agreement with VO to address this requirement.

3. Follow-Up on FY 2010–2011 Corrective Action Plan

for **Foothills Behavioral Health Partners, LLC**

Methodology

As a follow-up to the FY 2010–2011 site review, each BHO that received one or more *Partially Met* or *Not Met* scores was required to submit a corrective action plan (CAP) to the Department addressing those requirements found not to be fully compliant. If applicable, the BHO was required to describe planned interventions designed to achieve compliance with these requirements, anticipated training and follow-up activities, the timelines associated with the activities, and documents to be sent following completion of the planned interventions. HSAG reviewed the CAP and associated documents submitted by the BHO and determined whether 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 2010–2011 compliance monitoring site review.

Summary of 2010–2011 Required Actions

During the 2010–2011 site review, 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** was required to clarify its member handbook to provide information consistent with its policies.

Summary of Corrective Action/Document Review

FBHP submitted its CAP in May 2011. HSAG and the Department approved the CAP, as written. **FBHP** submitted its revised member handbook in August 2011. HSAG and the Department determined that **FBHP** successfully completed the required action in September 2011.

Summary of Continued Required Actions

There were no required actions continued from 2010–2011.

The completed compliance monitoring tool follows this cover page.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor provides all enrollment notices, informational materials and instructional materials relating to members in a manner and format that may be easily understood. ◆ The Contractor makes written information available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency and informs members of how to access those formats. *42CFR438.10(b)(1),(d)* *Contract: II.F.4.a, d, g*	**Documents Submitted:** 1. FBHP Policy Member Info rev FY12.docx 2. FBHP Member Handbook 101811.pdf (p. 10, paragraph 3 – miscellaneous folder) 3. FBHP Large Print Member Handbook.pdf (miscellaneous folder) 4. Simple Word Thesaurus.xlsx (entire document) **Description of Process:** The FBHPartners Office of Member and Family Affairs (OMFA) is responsible for all Member Information. The OMFA includes a Director and two Client and Family Advocates—one at each Partner Mental Health Center (PMHC. OMFA uses the publication *Centers for Medicare and Medicaid Services Writing and Designing Print Materials for Medicaid Beneficiaries-A Guide for State Medicaid Agencies* for guidance in developing the Member Handbook and other Member materials. Other tools such as the Simple Word Thesaurus included in this folder are also used to write the Member materials in easy to understand language and at a 5th grade reading level. For Member mailings, the database is sorted by Spanish speaking and non-Spanish speaking households, avoiding the need for Spanish speakers to have to call for FBHP for Spanish language copies. In addition, all Member materials include a header in Spanish telling members how to obtain a copy in Spanish. In addition, the inside cover of the Member Handbook and a header on all other materials mailed to FBHP Members include a statement in Spanish telling the recipient how to obtain a copy in Spanish. The Member Handbook includes on its inside cover: a header in Spanish telling Members how to obtain the Handbook in Spanish and a footer in	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	large print telling Members how to obtain copies in large print, audiotape and how to get interpreter services.	
Findings: The FBHP Member Information policy stated that the FBHP Office of Member and Family Affairs (OMFA) is to ensure that the member handbook includes all of the information required by federal and State regulations and that all member materials are written in a format that is easily understood. The FBHP Member Handbook stated that the handbook would be available in Spanish, large print, or audio format or could be interpreted into another language and included a telephone number for such requests. In addition, a statement written in Spanish at the front of the handbook informed members that the handbook would be available in Spanish. FBHP provided the FBHP Member Handbook in large print as an example of an alternative format.		
Required Actions: None.		
2. The Contractor has in place a mechanism to help members understand the requirements and benefits of the plan. ◆ The Contractor educates members on: • The availability and use of the mental health system. • Appropriate preventative health care procedures. • Self care. • Appropriate health care utilization. • How to navigate the mental health system. • How to locate information and updates to the Colorado Prescription List (PDL) program. *42CFR438.10(b)(3)* *Contract: II.F.4.b, h*	**Documents Submitted:** 1. FBHP Policy Member Info rev FY12.docx (entire policy) 2. FBHP Member Handbook 101811.pdf (pp 4-8, p.25 bullets 3,4, & 7; pp 14 & 15, beginning "How much does it cost to get mental health services" on p 14 covers bullets 1,4 and 5 – miscellaneous folder) 3. FBHP Member Handbook 101811.pdf (pp 27 & 28, entire pages; covers bullet 2 and 3 – miscellaneous folder) 4. FBHP Emer Serv flyer JCMH Span rev 7-17-09.doc; FBHP Emer Serv flyer JCMH Eng rev 11-23-10.doc; FBHP Emer Serv flyer MHP Span rev 10-17-11.doc; FBHP Emer Serv flyer MHP Eng rev 10-17-11.doc (bullets 1-5, entire documents) 5. FBHP EPSDT letter Eng Jan 09.doc; FBHP EPSDT letter Span Jan 09.doc; FBHP EPSDT Contacts 2009 Eng.doc, FBHP EPSDT Contacts 2009 Span.doc (bullets 1 – 4 entire documents) 6. FBHP PCP letter Eng 7-17-09.doc and FBHP PCP letter Span 7-17-09.doc included in monthly new enrollee mailings (bullets 2-4, entire documents) 7. FBHP Member Handbook 101811.pdf (bullet 6 pp 13 & 14, section titled "How do I get my medications?" – miscellaneous folder)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	8. See Landing Page for FBHP specific Achieve Solutions website https://www.achievesolutions.net/achievesolutions/en/fbhp/Home.do 9. Achieve Solutions Screen Shot Espanol.png (entire document) 10. MHP Navigation Services Flyer.doc (example of services offered by a PMHC to help Members navigate the system) 11. JCMH Client Welcome Packet-Client Rights-HIPAA Notice (entire packet-example of information provided to new clients by a PMHC) **Description of Process:** The FBHPartners' OMFA is responsible for helping members understand the Member Handbook, answering any questions Members or family have about the Medicaid mental health system, helping Members and families navigate the system, and helping with any problems Members and families might have with the system or services. We do this by having an OMFA Client and Family Advocate based at each of our two mental health centers, where the majority of our Members receive services. There are OMFA posters at all the sites of each mental health center with the name and phone number of the OMFA advocate. Additionally, the Member Handbook gives the phone numbers of the OMFA advocates. The OMFA Director's phone number is in the Member Handbook, on the web site and on many other FBHP materials for Members who do not receive services at the mental health centers and for new enrollees. Providing information and helping Members navigate the mental health system as well as providing information about community resources and other Medicaid services are a major focus of the OMFA.	
Findings: The FBHP Member Information policy described the role of the OMFA advocates, located at each Partner Mental Health Center (PMHC) and the director of FBHP's OMFA. The policy stated that it is the responsibility of the OMFA to manage information in the member handbook, place additional flyers in the welcome packet, and maintain staff availability at each PMHC and via telephone contact. The policy also described the process for arranging for interpreter services when needed.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
The FBHP Member Handbook stated that members may receive services from one of the FBHP mental health centers or an independent network provider, provided telephone numbers for the FBHP partner mental health centers, and directed members to the independent provider listing, available in hard copy in the enrollment packet and on the FBHP Web site. The handbook also described the core covered services, provided a listing of additional covered community-based services, and explained benefit limitations on services. The handbook also provided instructions on how to access mental health and physical health emergency services. The Office of Member and Family Affairs (OMFA) section of the handbook and the FBHP Web site described the role of the OMFA staff and provided contact information for OMFA staff. The handbook also described the Colorado Prescription Drug program, including how to obtain information on drugs requiring approval, and provided the Colorado Department of Health Care Policy & Financing's (the Department's) Web site address, and contact information for the Department's pharmacy liaison and FBHP's member services department. FBHP educated members regarding preventive and self care services through the following materials: ♦ The Achieve Solutions program, available through the FBHP member Web site, provided numerous articles regarding depression and schizophrenia, family relationships, stressors and fears, health and wellness, substance abuse, financial and legal issues, self-advocacy, and other mental health subjects. ♦ The FBHP enrollment packet included: ▪ The member handbook. ▪ The provider directory. ▪ Letter describing the EPSDT program and rights under Medicaid distributed in the enrollment packet. ▪ Letter reminding the member that he/she does not have a PCP and how to choose one (distributed in the enrollment packet). ▪ EPSDT Services flyer. ▪ Ombudsman flyer. ♦ The PMHC-specific welcome packet, received at the intake appointment at PMHCs, included the following informational handbooks/flyers: ▪ Additional copy of the member handbook (Jefferson Center for Mental Health [JCMH] and Mental Health Partners [MHP]) ▪ What to do in case of a Mental Health Emergency (JCMH and MHP) ▪ Recovery from Mental Illness (JCMH) ▪ Navigation—description of services available to help the member navigate obtaining public health benefits (JCMH and MHP) ▪ EPSDT Services (JCMH) ▪ How to Access Non-Emergency Transportation through Logisticare (JCMH) ▪ Five Wishes—Advance Directives information (JCMH) ▪ Ombudsman for Medicaid Managed Care (JCMH and MHP) ▪ HIPAA Rights (JCMH)		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
3. The Contractor makes its written information available in the prevalent non-English languages in its particular service area and notifies its members that written information is available in prevalent non-English languages and how to access those materials. *42CFR438.10(c)(3) and (5)* *Contract: II.F.4.c*	**Documents Submitted:** 1. FBHP Policy Member Info rev FY12.doc (p. 2, I.H. 1.&2.) 2. FBHP Member Handbook 101811.pdf (inside front cover, top of page, statement "Si usted necessita una copia de esta informacion en espanol, por favor llame al 1 800-245-1959" (If you need a copy of this information in Spanish, please call….-miscellaneous folder) 3. FBHP Span MemHBK not formatted.doc "Manual de miembro" (entire Manual - Misc. folder) 4. FBHP Spanish Website at http://www.fbhpartners.com/espanol.htm 5. FBHP Member Handbook 101811.pdf (p. 10, paragraph 3 – miscellaneous folder) 6. OMFA poster MHP Span.pdf (example of Spanish language poster at a mental health center) 7. FBHP Cult Comp Plan.doc (outlines our goals towards linguistically and culturally effective services--entire document.) **Description of Process:** FBHPartners has a Cultural Competency Plan which guides and affirms our commitment to provide culturally and linguistically effective services to our Members. The Plan requires Partner Mental Health Centers to adopt compatible Cultural Competency Plans) Spanish is the prevalent non-English language in Colorado. All FBHPartners' materials, for example, Member Handbook, Grievance and Appeal Guide, annual letter) have a statement in the header in Spanish telling Spanish speakers how to obtain a copy of the document in Spanish. Each outpatient site at our Provider Mental Health Centers have a poster in Spanish giving Spanish speakers the phone number of the OMFA Client and Family Advocate who can help them access services. Member mailings, such as the annual letter and monthly mailings of materials to new enrollees, are sorted by non-Spanish speaking and	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Spanish speaking households so that Spanish speakers receive the information in their language.	
Findings: The FBHP Member Information policy described the OMFA role in ensuring that all member materials are to be made available in Spanish. The policy also stated that new enrollee mailings are to be sorted by Spanish-speaking households to minimize the number of members calling to request Spanish materials. The introductory page of the FBHP Member Handbook included a statement that interpreter services would be available for member materials; and a statement written in Spanish informed members that the handbook would be available in Spanish, with a contact number for requests. FBHP provided examples of member materials written in Spanish, including the Annual Member Letter, the FBHP Member Handbook, the Emergency Services Flyer, the EPSDT Letter, and the PCP Letter. The FBHP Web site member pages were available in Spanish by clicking the ESPANOL button.		
Required Actions: None.		
4. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. *42CFR438.10(c)(4)&(5)* *Contract: II.F.4.c, f*	**Documents Submitted:** 1. FBHP Member Handbook 101811.pdf (p. 10 top of page, "What if I have a disability, special need, or need help speaking or understanding English?" all three paragraphs in this section – miscellaneous folder) 2. FBHP Member Handbook 101811.pdf (p. 16, Your Rights as a Medicaid Member, bullets 4 and 6 – miscellaneous folder) 3. FBHP Member Handbook 101811.pdf (inside cover, bottom of page – miscellaneous folder) 4. FBHP Cult Comp Plan.doc (p.3, 3rd paragraph beginning "Through the contractual process….") 5. FBHP Policy Member Info rev FY12.doc (p.2 I.H.4) 6. See mental health center training materials: JCMH Annual Training 11-11-2011.ppt (p.6 bullet 3) JCMH New Employee Training 11-11-2001.ppt (p 5, bullet 1 MHP New Employee Training 11-11-2011.ppt (p. 3, bullet 2) MHP Annual Training 11-11-2011.ppt (p.6, bullet 3) 7. FBHP Language Line Instructions.doc	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: Partner Mental Health Centers (PMHCs) are required to arrange for oral interpretation for all non English languages with needed, either through a telephonic interpreter services or in-person interpreters. Instructions on using the AT&T Language Line are provided to staff at FBHPartners and PMHCs. IPN providers are instructed to contact FBHP's Provider Network Delegate, ValueOptions, in order to secure interpreter services.	
Findings: The Member Information policy stated that the OMFA would arrange for oral interpretation for all member materials through a telephonic language line or in person through the use of interpreters. During the on-site interview, FBHP staff members stated that all PMHC staff were being trained to use the language line and were provided a copy of the language line instructions for quick reference. Staff clarified that the language line was typically being used for non-therapy situations and that during therapy sessions, there would typically be an interpreter present. The Cultural Competency Plan described FBHP's policies regarding providers' provision of services using interpreters and provider training regarding cultural competency. The FBHP Member Handbook, available in both English and Spanish, informed members of interpreter services availability and the use of the AT&T Language Line, free of Charge. The introductory page of the member handbook provided a contact number for members who need interpreter services. In addition, the handbook described the use of Relay Colorado or a teletype writer (TTY) line, as well as sign language interpreters for the deaf or hard-of-hearing.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
5. The Contractor notifies all members (at least once a year) of their right to request and obtain the required information, upon request [information required at 438.10(f)(6) and 438.10(g)(and (h)]. *42CFR438.10(f)(2)* *Contract: II.F.4.m*	**Documents Submitted:** 1. FBHP Policy Member Info rev FY12,doc (p.2, I. I.) 2. FBHP Annual Letter Eng Dec 2011.pdf (entire document) 3. FBHP Annual Letter Span Dec 2011.pdf (entire document) 4. FBHP Member Handbook 10-18-11.pdf (p. 26, last paragraph—misc folder) 5. BHO_Annual Letter_HCPFapproval2011_email (documents HCPF approval of material and language level of annual letter) **Description of Process:** The annual letter which includes all of the required information is mailed to all members in December. The mailing is sorted by Spanish speaking households and all others, so that Spanish speakers receive a copy in their own language and do not have to call FBHP for a copy.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Findings:
The Member Information policy stated that the annual member mailing explained members' rights to receive information about their mental health benefits and how to obtain that information. The FBHP Annual Member Letter summarized the type of information available in the FBHP Member Handbook, and provided telephone and Web site contact information for members to obtain a copy of the handbook; however, the letter stated that members had a right to receive information once a year. The letter also notified members that the handbook would be available in alternative formats, including audio, large print, and Spanish, and that FBHP would provide interpreter services, at no charge, for non-English speaking or hard-of-hearing members.

The member handbook stated that every year, FBHP would notify members in writing of their right "to ask for all of the information" in the member handbook. The handbook also provided the telephone number for the FBHP OMFA to obtain information about FBHP.

Required Actions:
FBHP must review and/or revise the annual member letter to clarify the requirement for FBHP to provide annual notice to members of the right to request information at any time and receive it upon request.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
6. The Contractor gives written notice of any significant change (as defined by the State) in the information [required at 438.10(f)(6) and 438.10(g)] provided to members at least 30 days before the intended effective date of the change. *42CFR438.10(f)(4)* *Contract: II.F.4.k*	**Documents Submitted:** 1. FBHP Policy Member Info rev FY12.doc (p2, J.) 2. FBHP Member Handbook 101811.pdf (p. 8, "How will I know if there are changes in my mental health coverage or benefits?" – miscellaneous folder) **Description of the Process:** The OMFA Director is responsible for ensuring that written notice is provided when necessary.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Information policy stated that it is the responsibility of the OMFA to notify members of any significant changes (as defined by the Department) at least 30 days before the intended effective date of the change. The FBHP Member Handbook stated that members would receive written notification of any major change in coverage or benefits at least 30 days prior to the date of the change and that any changes would be posted on the FBHP and partner CMHCs' Web sites. During the on-site interview, FBHP staff members stated that when the Colorado rule changed the grievance and appeal filing time frames from 20 calendar days to 30 calendar days, OMFA staff immediately changed the grievance and appeal help guides (distributed in notices of action) and the information on the FBHP Web site, and printed insert pages for the member handbooks that had already been printed.		
Required Actions: None.		
7. The Contractor makes a good faith effort to give written notice of termination of a contracted provider within 15 days after the receipt or issuance of the termination notice, to each member who received his or her primary mental health care from, or was seen by, the terminated provider. *42CFR438.10(f)(5)* *Contract: II.F.4.l*	**Documents Submitted:** 1. FBHP Policy Member Info rev FY12.doc (p.3. I.K) **Description of the Process:** The OMFA Director ensures that FBHPartners' Provider Network Delegate ValueOptions makes a good faith effort to give Members written notice of the termination of an Independent Provider within the required timeframe.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Information policy stated that it is the responsibility of the OMFA to notify members within 15 days of receipt or issuance of a termination notice of a network provider. The FBHP Member Handbook stated that members would receive written notification of changes involving the person or place of their services and that FBHP would make efforts to provide notice 15 days ahead of time. The handbook also stated that any changes would be posted on the FBHP and partner CMHCs' Web sites. VO (as the delegate for provider network management) provided a template letter to inform members of the termination of providers.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
Required Actions: None.		
8. The required information (438.10(f)(6) and 438.10(g) is furnished to members within a reasonable time after notification from the State of the recipient's enrollment and includes: ◆ Notice that the member has been enrolled in the Community Mental Health Services Program operated by the Contractor and that enrollment is mandatory. ◆ The Contractor's hours of operation. *42CFR438.10(f)(3)* *Contract: II.F.4.i, j*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p.1 "Welcome"—misc folder) 2. FBHP Span Mem Hbk Not Formatted (p.1 "Bienvenidos"—misc folder) 3. Mailings_member_numbers_FBHP_Jan2010-Aug 2011.xls (entire document) **Description of the Process:** The OMFA Director ensures that the Member Handbook (sorted by Spanish and non-Spanish language households) is mailed within a reasonable time after receiving the monthly enrollment data from HCPF.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Information policy stated that member materials are to be mailed each month to new enrollees within 21 days of receipt of the new enrollees list from the State. The policy stated that the new enrollment mailing is to include the member handbook, as well as additional informational flyers. The member handbook included notice of automatic enrollment in FBHP due to residing in the FBHP service area. The handbook provided office hours for the OMFA and the 24-hour telephone numbers (local and toll-free). Mailing of enrollment notices was being delegated to VO. VO staff members explained that, at the end of each month, VO would take the list of new enrollees for the month and "clean" the list by screening for multiple members in a household and for members who were on and off Medicaid enrollment recently. Staff stated that the mailing list would typically be finalized by the 15th of the following month. HSAG reviewed member mailing reports and mailing receipts and verified that monthly mailings were tracked and completed two to three weeks after the list was finalized.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
9. The member information materials sent following enrollment include: ◆ Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers, including identification of providers who are not accepting new patients. ◆ Any restrictions on freedom of choice among network providers. *42CFR438.10(f)(6)(i) and (ii)* *Contract: II.F.4.i.1, 2*	**Documents Submitted:** 1. ProviderDirectory_Report_BHOs_2011Oct15_PR.pdf (bullet 1 entire directory) 2. FBHP Member Handbook 101811.pdf (bullet 1 p. 4 second paragraph from bottom beginning "Our provider list is easy…." – miscellaneous folder) 3. FBHP Member Handbook 101811.pdf (bullet 4 p.4; bullet 3, 3rd paragraph from bottom beginning "you may choose to get your …." – miscellaneous folder) **Description of the Process:** The OMFA Director ensures that monthly mailing to new enrollees include this information.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP Provider Directory listed names, addresses, telephone numbers, languages spoken, and any specialty areas of all contracted providers. The FBHP Member Handbook stated that members may choose from either of the network mental health centers or contracted independent providers and provided a listing of partner CMHCs with locations and contact information. The handbook referred members to the FBHP Web site link to *Referral Connect* to access a searchable database of network providers. The handbook also instructed members to call the member services telephone number to request a provider directory. During the on-site interview, FBHP staff members reported that the hard copy provider directory was being included in the enrollment mailing. VO staff members stated that the listing was being printed from the VO database and was reflective of the most recent list. VO staff stated that providers not accepting new patients were being removed from the active list, rather than using a notation that they were not accepting new patients. Staff members reported that the active list was being updated monthly and printed from the database for each monthly mailing. Staff also reported that the Web site provider listing was also being updated monthly.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
10. The member information materials sent following enrollment include the following member rights and protections as specified in 42CFR438.100(b)(2)–(3) and in the Medicaid managed care contract. Members have the right to: ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her health care, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. ◆ Request and receive a copy of his or her medical records, and request that they be amended or corrected. ◆ Be furnished health care services in accordance with federal healthcare regulations for access and availability, care coordination and quality. ◆ Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the Contractor, its providers, or the State Medicaid agency treats the member. *42CFR438.10(f)(6)(iii)* *Contract: II.F.4.i.3*	**Documents Submitted:** 1. FBHP Policy Member Rights Rev. 7_1_11.doc (p.1. I.B. and entire policy) 2. FBHP Member Handbook 101811.pdf (pp. 16 "Your Rights as a Medicaid Member", "Member Rights and Responsibilities" See bullet 1 on p. 16 See bullet 2 on p. 16 See bullet 7 on p. 16 See bullet 10 on p. 16 See bullet 21 on p. 16 See bullet 3 on p. 16 See bullet 16 on p. 16 **Description of Process:** The FBHP Policy on Member Rights requires that the member Rights be included in the Member Handbook mailed monthly to new enrollees. The Policy ensures that Member Rights are respected by FBHPartners and its providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP Member Rights policy stated that member rights were to be included in the member handbook, as well as distributed in a variety of additional methods. The Member Rights section of the FBHP Member Handbook listed each of these rights in easy-to-understand language.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
Required Actions: None.		
11. The member information materials sent following enrollment include the following additional member rights. Members have the right to: ◆ Have an independent advocate. ◆ Request that a specific provider be considered for inclusion in the provider network. ◆ Receive a second opinion. ◆ Receive culturally appropriate and competent services from participating providers. ◆ Receive interpreter services for members with communication disabilities or for non-English speaking members. ◆ Prompt notification of termination or changes in services or providers. ◆ Express an opinion about the Contractor's services to regulatory agencies or the media without the Contractor causing any adverse effects upon the provision of covered services. *Contract: II.F.4.j.3*	**Documents Submitted:** 1. FBHP Policy Member Rights Rev. 7_1_11.doc (entire policy) 2. FBHP Policy Second Opinions Rev. 7_1_11,doc (entire policy) 3. FBHP Member Handbook 101811.pdf (pp. 16 "Your Rights as a Medicaid Member" "Member Rights and Responsibilities"- misc folder) See bullet 15 on p. 16 See bullet 11 on p. 16 See bullet 9 on p. 16 See bullet 5 on page 16 See bullet 6 on page 16 See bullet 12 on page 16 See bullet 19 on page 16 **Description of Process:** The OMFA Director ensures that these rights are included in the list of Member Rights included in the Member Handbook and mailed monthly to new enrollees.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Member Rights section of the FBHP Member Handbook listed each of these rights in easy-to-understand language.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
12. Members are informed in these materials about: ◆ Assistance available through the Medicaid Managed Care Ombudsman program. ◆ Appointment Standards for routine, urgent and emergency situations. ◆ Procedures for requesting a second opinion. ◆ Procedures for requesting accommodation for special needs. ◆ Procedures for arranging transportation. ◆ Information on how members will be notified of any changes in services or service delivery sites. ◆ Procedures for requesting information about the contractor's quality improvement program. ◆ Information on any member and/or family advisory board(s) the contractor may have in place. *Contract: II.F.4.j.4–11*	**Documents Submitted:** 1. FBHP Member Handbook 101811.pdf (bullet 1 pg. 16 Your Rights as a Medicaid Member, bullet 15 – miscellaneous folder) 2. FBHP Member Handbook 101911.pdf (bullet 1,p. 24 "Ombudsman for Medicaid Managed Care" section – misc folder) 3. FBHP Member Handbook 101811.pdf (bullet 1, phone number for Ombudsman, back cover, lower left hand corner – misc folder) 4. FBHP Ombuds Flyer Eng 5-12-08.doc (bullet 1, entire document) 5. FBHPartners Member Handbook 101811.pdf (bullet 2 p. 5 "When will I be seen?" – misc folder) 6. FBHPartners Member Handbook 101811.pdf (bullet 3 p.14 "What if I want a second opinion about my treatment or diagnosis?" – misc folder) 7. FBHPartners Member Handbook 101811.pdf (bullet 3 p. 16 "Your Rights as a Medicaid Member" bullet 9 – misc folder) 8. FBHPartners Member Handbook.101811.pdf (bullet 4,p. 10 "What if I have a disability, special need, or need help speaking or understanding English?" – misc folder) 9. FBHPartners Member Handbook 101811.pdf (bullet 5 p. 15 "How can I get transportation to appointments?"- misc folder) 10. FBHPartners Member Handbook 101811.pdf (bullet 6 p. 8 "How will I know if there are changes in my mental health coverage or benefits?" – misc folder) 11. FBHPartners Member Handbook 101811.pdf (bullet 7 pp. 25 and 26, last paragraph under "Quality Improvement Program" – misc folder) 12. FBHPartners Member Handbook 101811.pdf (bullet 8 p. 26 "Member Advisory Committees" – misc folder	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: The FBHPartners' monthly mailing to new enrollees includes the required Member Handbook, HIPAA letter, Provider Directory, and Ombudsman flyer. In addition, FBHPartners includes flyers about EPSDT, Emergency contacts and how to get help finding a Primary Care Provider from Health Colorado.	

Findings:
The FBHP Member Handbook defined the role of the Medicaid ombudsman as a free service to assist members with resolving health care issues, including filing grievances and appeals, and included a prominent display of contact information for the ombudsman. The member handbook described appointment standards as seven days for a routine visit, 24 hours for an urgent situation, and within one hour (two hours if rural) for an emergency. The handbook also included an extensive description of how to access emergency services.

The FBHP Member Handbook described services available for members with special needs, such as disabilities, deaf or hard-of-hearing, or non-English-speaking members, and directed members to the member services telephone number to request assistance. In addition, the handbook provided the member services telephone number to obtain second opinions, transportation to appointments, or any other special services offered.

The member handbook stated that members are to receive written notification of any major change in coverage of benefits or change with the provider or provider location. In addition, the handbook described, in easy-to-understand language, the components of the FBHP Quality Improvement program and instructed members to contact the director of quality improvement (telephone number provided) to request more information about quality programs or to receive a copy of the Quality Plan.

The handbook also explained that the purpose of Member/Family Advisory Committees is to provide feedback to FBHP on "how they are doing" and provided contact telephone numbers for members to obtain more information.

Required Actions:
None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
13. The member information materials sent following enrollment also include the following information regarding the grievance, appeal, and fair hearing procedures: ◆ The right to file grievances and appeals. ◆ The requirements and time frames for filing a grievance or appeal (including oral filing). ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing, and the rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by phone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing, and the service authorization has not expired. • The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The right that providers may file an appeal on behalf of the member with the member's written consent. *42CFR438.10(f)(6)(iv) and438.10 (g)(1)(i–vii)* *Contract: II.F.4.i.4 and II.F.4.i.13*	**Documents Submitted:** 1. FBHP Member Handbook 101811.pdf (bullet 1,pp. 19-24 "What if I Have Problems with my Services or My Rights Are Not Being Respected?" entire section – misc folder) 2. FBHP Member Handbook 101811.pdf (bullet 2, pp. 19-24, "What if I Have Problems with my Services or My Rights Are Not Being Respected?", especially p..20, 3rd paragraph from bottom of page and pp. 22 -24, beginning "What are the time frames for filing an appeal?' and ending at top of p. 24 – misc folder) 3. FBHP Member Handbook 101811.pdf (bullet 3 pp. 21 – 24, Details about State Fair Hearing interspersed throughout – misc folder) 4. FBHP Member Handbook 101811 (bullet 4 pp19- 24, interspersed throughout – misc folder) 5. FBHP Member Handbook (bullet 4 pp19- 24, interspersed throughout – misc folder) 6. FBHP Member Handbook 101811.pdf (bullet 5 pp. 20, top of page; p 21 middle of page under "How do I file an appeal [Appeal of an Action] , p 24 "Ombudsman for Medicaid Managed Care" top half of page – misc folder) **Description of the Process:** Throughout the Member Handbook members are reminded to call the OMFA if they have any questions about their rights or the grievance and appeal system.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**

Findings:

The FBHP Member Handbook informed members of the right to file a grievance or an appeal and how to do so orally or in writing. The handbook stated that the Office of Member and Family Affairs could assist with the process and included the local and toll-free telephone numbers. The handbook stated that a designated client representative, which could include the provider, could file on behalf of the member with the form signed. The handbook provided easy-to-understand definitions of action, notice of action, appeal, designated client representative, grievance, and state fair hearing. The handbook outlined the procedures for filing and processing grievances and appeals. The handbook also provided the time frames for requesting a State fair hearing, stated that the request must be in writing, and provided the address to do so. In addition the handbook informed members that they may represent themselves, or have someone else represent them, and may provide more information at the hearing to support their case.

The member handbook included the 30-calendar-day filing time frame for grievances and appeals and for requesting a State fair hearing. The handbook informed members that grievances and appeals may be filed orally or in writing, that an oral request for an appeal would be considered the date of the appeal and that oral appeals must be followed in writing. The handbook also described FBHP's responsibilities in processing the grievances and appeals. The time frame for resolving expedited appeals was stated as three calendar days, consistent with FBHPs policies and other member materials; however, the time frame for resolving standard appeals was listed as 10 *calendar* days. During the on-site interview, FBHP staff members confirmed FBHP's policy to decide appeals and notify members within 10 *working* days from the receipt of the appeal.

The member handbook addressed the provision to continue previously authorized services during the appeal or State fair hearing, accurately describing the process, the time frame for filing the appeal if requesting continued services, and the duration of those services.

Required Actions:

FBHP must revise the member handbook to accurately state the resolution time frame for standard appeals.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
14. The member information materials sent following enrollment include: ◆ The amount, duration and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled. ◆ Procedures for obtaining benefits including authorization requirements. ◆ The extent to which and how members may obtain benefits, from out-of-network providers. *42CFR438.10(f)(6)(v) through (vii)* *Contract: II.4.i.5–7*	**Documents Submitted:** 1. FBHP Policy Member Info rev FY12 (entire policy) 2. FBHP EPSDT letter Eng Jan 09.doc; FBHP EPSDT letter Span Jan 09.doc; FBHP EPSDT Contacts 2009 Eng.doc FBHP EPSDT Contacts 2009 Span.doc (entire documents flyers included with monthly new enrollees mailing) 3. FBHPartners Member Handbook 101811.pdf (p.1 "Welcome"; pp. 4-17 and p. 25. See especially pp. 4-6 "Choosing and Getting Services"; p. 7 "What mental health services can I get" table; p. 8 "Other required services"; p. 10 "What if I have a disability ….."; pp. 11- 12 "Emergencies"; pp. 13-15 "Other Things You Should Know about Your Services"; pp. 16-17 "Your Rights as a Medicaid Member" entire list of rights and responsibilities – misc folder) **Description of Process:** Throughout the Member Handbook members are encouraged to call the OMFA if they have any questions about their benefits or obtaining a provider.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP Member Handbook described the types of mental health services available, which included inpatient hospital services, outpatient treatment, residential treatment, emergency care, case management, medication management, and school-based services. The handbook outlined the limitations on number of outpatient therapy sessions and inpatient days. The handbook described the FBHP approval of services based on medical necessity, clinical criteria, least restrictive setting, and provider determination, and directed members to contact FBHP for a copy of the clinical guidelines used. In addition, the handbook provided a list of community-based services.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
15. The member information materials sent following enrollment include the extent to which and how after hours and emergency coverage are provided, including: ◆ What constitutes an emergency medical condition, emergency services, and post-stabilization care services with reference to the definitions in 42CFR438.114(a). ◆ The fact that prior-authorization is not required for emergency services. ◆ The process and procedures for obtaining emergency and post-stabilization services, including the use of the 911-telephone system or its local equivalent. ◆ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services. ◆ The fact that the member has the right to use any hospital or other setting for emergency care. *42CFR438.10(f)(6)(viii)* *Contract: II.F.4.i.8*	**Documents Submitted:** 1. FBHP Member handbook 101811.pdf (bullet 1, pp 11 & 12 See "What if I have an Emergency" p 11; bullet 2 & 5, p. 11 2nd paragraph; bullet 1 & 3 p. 11 "What happens when the emergency is over?" bullet 4 p. 36 Appendix B Hospitals – misc folder) 2. FBHP Emer Serv flyer JCMH Span rev 7-19-09.doc (entire document, example of flyer included in the monthly new enrollee mailing) 3. FBHP Emer Serv flyer MHP Eng rev 10-17-11.doc (entire document, example of above flyer in Spanish) **Description of Process:** In addition to information about emergency services in the Member Handbook the monthly mailing includes flyers on how to contact the local community mental health center emergency service.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Emergencies section of the FBHP Member Handbook included the definition of emergency medical condition in easy-to-understand terms and described what to do in both a mental health and physical health emergency. Members were directed to use 911 or go to the nearest emergency facility, and were informed that authorization is not required for emergency services. The handbook stated that members can receive care from any emergency facility, stated that only emergency services were to be covered when the member was out of the service area, that the member should go to the nearest emergency facility, and that FBHP would work with the emergency room or hospital to move the member back to his or her mental health provider. The member handbook also defined post-stabilization services and stated that there is to be no charge to keep the member stable following the emergency.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
16. The member information materials sent following enrollment include the poststabilization care services rules at 422.113(c) and include: ◆ The contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are pre-approved by a plan provider or other plan representative. ◆ The contractor's financial responsibilities for poststabilization care services obtained within or outside the organization that are not pre-approved by a plan provider or other plan representative. ◆ That charges to members for poststabilization services must be limited to an amount no greater than what the organization would charge the member if he or she had obtained the services through the Contractor. ◆ That the organization's financial responsibility for poststabilization services it has not approved ends when: • A plan physician with privileges at the treating hospital assumes financial 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; or • The member is discharged. *42CFR438.10(f)(6)(ix) and 42CFR422.113(c)* *Contract: II.F.4.i.9*	**Documents submitted:** 1. FBHP Member Handbook 101811.pdf (p 11, last paragraph – misc folder) 2. FBHP UM delegation policy 2011.doc (entire policy—Provider Participation and Program Integrity folder) **Description of the Process:** The OMFA Director ensures that Member Handbook defines poststabilization services and clearly states that there is no charge to the Member for poststabilization services. FBHPartners delegates Utilization Management (UM) to ValueOptions and the FBHPartners Medical Director ensures that the delegates UM activities are in compliance with federal and state regulations.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: The FBHP Member Handbook defined poststabilization services as services provided just after an emergency to help the member stay stable or improve. The handbook stated that there would be no charge for these poststabilization services. Both utilization management activities and provider network management were being delegated to VO. The VO Emergency and Post-Stabilization Services policy stated that: ♦ ValueOptions Colorado (VO CO) does not hold a member liable for payment of subsequent screening and treatment after an emergency that is needed to diagnose or stabilize the member, or for poststabilization services, regardless of whether these services were in or out of network. ♦ VO CO allows the treating provider to determine when the member is sufficiently stabilized for transfer or discharge. ♦ VO CO does not require preauthorization for any poststabilization services. ♦ VO CO is financially responsible for poststabilization care services obtained within or outside the network that are either pre-approved or not pre-approved but meet the conditions as specifically outlined in 42 CFR 422.113(c).		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
17. The member information materials sent following enrollment include: ◆ Policies on referral for specialty care and other services not provided by the member's care provider. ◆ That no fees will be charged for covered mental health services provided to members. ◆ How and where to access any benefits available under the State plan but not covered under the Medicaid managed care contract including how transportation is provided. *42CFR438.10(f)(6)(x) through (xii)* *Contract: II.F.4.i.10–12*	**Documents Submitted:** 1. FBHP Member Handbook 101811.pdf (bullet 1, p. 4 third paragraph from bottom; bullet 2, p. 4 last paragraph; bullet 3, p 13 "How do I get my medication," p. 15 "How can I get transportation to appointments?", pp. 27-30, all – misc folder) 2. FBHP EPSDT letter Eng Jan 09.doc; FBHP EPSDT letter Span Jan 09.doc; FBHP EPSDT Contacts 2009 Eng.doc; FBHP EPSDT Contacts 2009 Span (entire documents) **Description of Process:** Members receive this required information in the Member Handbook as well as receiving additional information on EPSDT in the monthly mailing to new enrollees. The Member Handbook encourages Members to call OMFA if they have any questions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP Member Handbook stated that FBHP would refer members to a specialist, if needed. The handbook stated that there are to be no charges or co-pays for mental health services and that members should contact FBHP if they receive a bill. The handbook described other Medicaid health care benefits that the member may receive outside of the BHO, including physical health care benefits, EPSDT services, and a number of Medicaid waiver programs for special needs individuals. The handbook directed members to contact Medicaid Customer Service or Health Colorado for more information and provided contact numbers and the Web site addresses for both. The handbook also stated that FBHP could assist members with finding a medical doctor by calling the OMFA telephone number. The handbook also provided the telephone number for Logisticare and described circumstances under which the member may receive transportation services.		
Required Actions: None.		

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
18. Advance directives requirements: The Contractor maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the BHO. Advance directives policies and procedures include: ◆ A clear statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience. • The difference between institution-wide conscientious objections and those raised by individual physicians. • Identification of the State legal authority permitting such objection. • Description of the range of medical conditions or procedures affected by the conscientious objection. ◆ Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. ◆ Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated. ◆ Procedures for documenting in a prominent part of the member's medical record whether the member has executed an advance directive. ◆ The provision that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based	**Documents Submitted:** 1. FBHP Member Handbook (bullets 8,9,12,13,15, p. 18, "Advance Directives"- misc folder) 2. FBHP Policy Advance Directives rev 7_1_11.doc References bullets at left: 1. NA 2. NA 3. NA 4. NA 5. Policy p. 2, III.B.1 6. Policy p. 2, III.B.2 7. See: Policy p.2, I. B.4; p2, III. C. & D.; JCMH screenshot Adv Dir.docx MHP screenshot Adv Dir.doc 8. Policy p.2,I.B.5 9. Policy (entire) 10. Policy p. 2, II 11. See examples of mental health center training materials: JCMH Annual Training 11-11-2011.ppt, p 4, bullet 3 JCMH New Employee Training 11-11-2001.ppt, p 4, bullet 5 MHP Annual Training 11-11-2011.ppt, p. 4, bullet 4 12. FBHP Member Handbook (misc folder) p. 18 entire page, also JCMH Five Wishes Advance Directives.pdf 13. FBHPartners Member Handbook (misc folder) "Advance Directives" , entire section 14. FBHPartners Member Handbook (misc folder), Paragraph in middle of page beginning "your mental health provider will ask…." contains statement that member does not have to have an Advance Directive to get mental health care and that member can call FBHP for a copy of FBHP's policy on Advance Directives.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
on whether they have executed an advance directive. ◆ Provisions for ensuring compliance with State laws regarding advance directives. ◆ Provisions for informing members of changes in State laws regarding advance directives no later than 90 days following the changes in the law. ◆ Provisions for the education of staff concerning its policies and procedures on advance directives. ◆ Provisions for community education regarding advance directives that include: • What constitutes an advance directive. • Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. • Description of applicable state law concerning advance directives. The member information materials regarding advance directives include: ◆ The member's right under the State law to make decisions regarding medical care and to formulate advance directives, including the right to accept or refuse medical or surgical treatment. ◆ The Contractor's policies respecting implementation of advance directives. ◆ The fact that complaints concerning noncompliance with the advance directive requirements may be filed with the Colorado Department of Public Health and Environment. *42CFR438.10(g)(2) and 42CFR422.128* *Contract: II.F.4.i.14*	15. FBHP Member Handbook (misc. folder) p. 18, bold print near bottom of page **Description of Process:** FBHPartners providers are required to ask Members about Advance Directives at intake. Providers at the Partner Mental Health Centers are prompted to do so in the electronic medical record intake screen. Outpatient providers in the IPN are also required to ask if a Member has and Advance Directive and wants it included his/her record. The Member Handbook explains Advance Directives to Members and tells them how they can get more information about Advance Directives. The Handbook also encourages Members to work with their therapist to develop a crisis plan for themselves.	

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**

Findings:

The FBHP Advance Directives policy stated that:

- It was FBHP policy that FBHP and its providers give adult members written information on advance directives and applicable State laws.
- Upon intake, FBHP providers inquire whether the member has an advance directive and whether the member wants the advance directive placed in her or her mental health record. If the member chooses, the provider is required to place the advance directive information in the legal section of the member's record.
- If a member is incapacitated at the time of admission to mental health service, providers are required to ask the family or DCR if the member has an advance directive, and if not, provide advance directive information to the family member or DCR. The provider then gives the same information to the member once he or she is no longer incapacitated.
- Neither FBHP nor the provider will make any attempts to persuade a member to revoke or alter an existing advance directive, that provision of services is not conditioned on the presence or absence of an advance directive, and that members are not discriminated against based on whether an advance directive has been executed, amended, or revoked. FBHP staff members reported that PMHC staff and providers are trained at initial orientation and annually regarding provider responsibilities related to advance directives.
- Advance directives information is to be distributed to members via the FBHP member handbook
- FBHP will notify members of any changes in State law concerning advance directives no more than 90 days after the effective date of the change
- That new employee orientations and annual trainings for FBHP employees, PMHC providers and the independent provider network (contracted through VO) include information about advance directives.
- The medical record chart audit tool includes evaluation of provider compliance regarding advance directives requirements

The FBHP Advance Directives policy also described the types of advance directives recognized by State law.

The Advance Directives section of the FBHP Member Handbook included a statement that members have the right to formulate advance directives, a definition of advance directives in easy-to-understand language, and the types of advance directives recognized by Colorado law. The handbook provided direction to members to talk to their PCP about advance directives. The handbook also stated that members may provide a copy of an advance directive to place in their mental health record if they choose. The handbook also included contact information for the Colorado Department of Public Health and Environment for filing a complaint about provider noncompliance with advance directives. The handbook also stated that mental health advance directives were not required by law, but that a mental health crisis plan could be developed that would allow members to have more control over their decisions in a mental health crisis.

The VO Provider Manual outlined provider expectations related to advance directives. Advance directive information was also available on FBHP's Web site.

Required Actions:

None.

Standard V—Member Information		
Requirement	**Evidence as Submitted by BHO**	**Score**
19. The member information materials sent following enrollment include: ◆ Notice that additional information that is available upon request, includes information on: • The structure and operation of the Contractor. • Physician incentive plans. *42CFR438.10(g)(3)* *Contract: II.F.4.i.15*	**Documentation Submitted:** 1. FBHP Member Handbook (Misc. folder) p. 26 "How do I get more information about Foothills Behavioral Health Partners?" covers bullet 1 2. FBHP Member Handbook (Misc. folder) p. 4, last paragraph covers bullet 2 **Description of Process:** This information is included in the Member Handbook which is mailed to all new enrollees. The Handbook provides contact information for the OMFA in several places, should Members have any questions about anything in the Handbook. The Handbook also provides a link to the FBHPartners website.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP Member Handbook instructed members to contact the Office of Member and Family Affairs to obtain information on the structure of FBHP and how FBHP conducts business. The Member Handbook informed members that FBHP physicians do not have incentive plans in the section, "Getting and Choosing Services."		
Required Actions: None.		

Results for Standard V—Member Information							
Total	Met	=	17	X	1.00	=	17
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	19	**Total Score**		=	17

Total Score ÷ Total Applicable	=	89%

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has a system in place that includes a **grievance** process, an **appeal** process, and access to the **State fair hearing** process. *42CFR438.402(a)* *Contract: II.F.10* *Grievance and Appeal State Rule (version 11—January 2011): 8.209*	**Documents Submitted:** 1. FBHP Policy Griev & Appeal rev 7_1_11.doc (entire policy) 2. FBHP Member Handbook 10-18-11.pdf (pp.19-24-misc folder) 3. FBHP Griev Appeal Guide rev 7_1_11.doc (entire document) **Description of Process:** FBHP's policy on Grievances and Appeals outlines the process followed by OMFA to ensure that members have full access to the grievance, appeal and state fair hearing process per federal regulations and the state contract. The OMFA includes a Director and two Client and Family Advocates, one based at each Partner Mental Health Centers (PMHC). Having an Advocate at each PMHC ensures their visibility and availability to members. In general, the OMFA Director coordinates all appeals while the Advocates handle all grievances, although all three are cross trained and cover for one another when one is out of the office. The FBHP Manager of Administrative Services and the FBHP Receptionist are also cross trained on the grievance and appeal process in the event of unexpected absences of two or more of the OMFA staff. The OMFA works closely with the Ombudsman for Medicaid Managed Care when so requested and will often suggest a member contact the Ombudsman for support and guidance.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP Grievance System: Grievances and Appeals policy (grievances and appeals policy) described FBHP's grievance process, appeal process, and access to the State fair hearing process. Members were informed via the Foothills Behavioral Health Partners Member Handbook (member handbook) about the grievance and appeal process and how to access the State's fair hearing process. Providers were informed about the processes via the provider manual. The FBHP Medicaid Grievance and Appeal Guide (the grievance and appeal guide) also described FBHP's processes related to the grievance system. During the on-site interview, FBHP staff members reported that members would receive the grievance and appeal guide with the notice of action, as well as with the grievance and appeals acknowledgement letters.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
2. The Contractor defines Action as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole, or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the time frames for resolution of grievances and appeals. ◆ For a resident of a rural area with only one MCO or PIHP, the denial of a Medicaid member's request to exercise his or her rights to obtain services outside of the network under the following circumstances: • The service or type of provider (in terms of training, expertise, and specialization) is not available within the network. • The provider is not part of the network, but is the main source of a service to the member—provided that: o The provider is given the opportunity to become a participating provider. o If the provider does not	**Documents Submitted:** 1. FBHP Policy Griev & Appeal rev 7-1-11.doc (p.1 under "Definitions") 2. FBHP Griev Appeal Guide rev 7-1-11.doc (p.1 & p7 "Definitions" address bullets 1-5) 3. FBHP Member Handbook 101810.pdf (p.19 " Definitions" addresses bullets 1-5---misc folder.(Bullet 6 does not apply to the FBHP area.) 4. FBHP NOA requested service_2011FEB17 (second paragraph with options for checking the type of Action) 5. Delegation Agreement_FY12_FBHP & VO_2011 August 29_Executed.doc (Delegation Subcontracts folder), Exhibit A. (p. 8) section 2. Clinical and Utilization Management Services, items h. and i. 6. FBHP Policy UM delegation policy 2011.doc (entire policy – Provider Participation and Program Integrity) 7. Provider Manual_2011OCT01_FBHP_PR.pdf (pp.31-32 "Definitions: Actions"; p.80 "Actions"-miscellaneous folder) **Description of Process:** FBHPartners does not have any areas meeting the criteria for "rural" areas. The FBHPartners OMFA Director is responsible for ensuring that all Member materials concerning the Grievance System accurately define and describe the Grievance System and that the materials are written for ease of understanding at a sixth grade level.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
choose to join the network or does not meet the BHO's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days. *42CFR438.400(b)* *(42CFR438.52(b)(2)(ii)* *State Rule: 8.209.2*		
Findings: The grievances and appeals policy included the definition of action, which was consistent with the Medicaid managed care definition, as was the definition in the provider manual, the member handbook and the grievance and appeal guide. The VO Grievance/Appeals PowerPoint Training (used for the independent provider network) included good examples of actions. FBHP staff members stated that the member advocates, on-site at the PMHCs, would train PMHC providers using materials consistent with the VO PowerPoint presentation.		
Required Actions: None.		
3. The Contractor defines Appeal as a request for review of an Action. *42CFR438.400(b)* *State Rule: 8.209.2*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (middle of p. 19 under "Definitions"; Glossary p. 31 —misc folder) 2. FBHP Griev Appeal Guide rev 7_1_11.doc (bottom half of p. 1; middle of p. 7) 3. FBHP Policy Griev & Appeal rev 7_1_11 (under "Definitions" p. 1) **Description of Process:** The FBHP OMFA Director is responsible for ensuring that all Member materials accurately define and describe the Grievance System.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The definitions of appeal in the grievances and appeals policy as well as the member handbook, and the grievance and appeal guide were all consistent with the Medicaid managed care definition of appeal. The provider manual and the training PowerPoint were also consistent.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
4. The Contractor defines Grievance as an oral or written expression of dissatisfaction about any matter other than an Action. *42CFR438.400(b)* *State Rule: 8.209.2*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (middle of p. 19 under "Definitions"; Glossary p. 31—misc folder) 2. FBHP Griev Appeal Guide rev 7_1_11.doc (bottom half of p. 1; middle of p. 7) 3. FBHP Policy Griev & Appeal rev 7_1_11 (under "Definitions" pp. 1 & 2) **Description of Process:** The FBHP OMFA Director is responsible for ensuring that all Member materials accurately define and describe the Grievance System.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: Grievance was defined in the grievances and appeals policy as an oral or written expression of dissatisfaction about any matter other than an action. The member handbook and the grievance and appeal guide both included a definition of grievance that was consistent with the policy definition and at the required readability level. The provider manual and the training PowerPoint presentation both included an accurate definition of grievance.		
Required Actions: None.		
5. The Contractor has provisions for who may file: ◆ A member may file a grievance, a BHO-level appeal, and may request a State fair hearing. ◆ A provider may file a grievance on behalf of a member, given that the State permits the provider to act as the member's authorized representative. ◆ A provider, acting on behalf of the member and with the member's written consent may file an appeal. ◆ A provider may request a State fair hearing on behalf of a member, given that the State permits the provider to act as the member's authorized representative.	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (pp. 16-17 " "Member Rights and Responsibilities" bullets 14, 17 & 18 address bullets 1; p. 20 middle of page paragraph beginning "You can ask someone else to file a grievance for you" and p. 21, 2nd paragraph from bottom of page, "You can ask someone else to file an appeal…" address bullets 2 and 3; p. 23 2nd paragraph from bottom of page, "If you think that waiting…." addresses bullet 3—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 2 "If you want to File a Grievance" and p. 2 "If you want to Appeal an Action" address bullet 1; p. 2 "If you want to appeal an Action" bullet 3 addresses bullets 3 and 4 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.1 "Designated Client Representative" under "Definitions"; p 3 II.M; p.6 IV.B.2) **Description of Process:** The OMFA assists members or their Designated Representatives in filing grievances and appeals and ensures that a provider wishing to file on behalf of a member has been named a Designated Representative by the member.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
42CFR438.402(b)(1) *State Rule: 8.209.2*		
Findings: The member handbook informed members that they or a DCR may file a grievance or an appeal and informed members of the availability of the State's fair hearing process. The handbook also informed members that their provider may be the DCR if the member designates the DCR in writing. Providers were informed via the provider manual of the grievance and appeal processes and that they may act as a member's DCR. There were examples in the on-site appeals record review of members and DCRs having filed appeals.		
Required Actions: None.		
6. The Contractor accepts grievances orally or in writing. *42CFR438.402(b)(3)(i)* *State Rule: 8.209.5.D*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 20, middle of page "You can file your grievance in person…."---misc folder) 2. FBHP Griev & Appeal rev 7_1_11..doc (p.2 "If you want to file a Grievance") 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.5 IV.A.1) **Description of Process:** The OMFA ensure that members can file grievances orally or in writing. If the member wishes, OMFA will help the member articulate his/her grievance or put it in writing.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy stated that any oral or written expression of dissatisfaction is acknowledged and responded to in writing and tracked in the grievance database. The member handbook and the grievance and appeal guide informed members that they may file grievances by telephone, in person, by writing a letter, or using a grievance form. During the on-site interview, FBHP staff members explained that member advocates would be available on-site at each partner CMHC to accept grievances in person, or by telephone, and that either the VO service center (Colorado Springs) telephone line or the OMFA director at the FBHP office would typically receive calls from members with providers that were part of the independent provider network (IPN), wishing to file a grievance.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
7. Members have 30 calendar days from the date of the incident to file a grievance. *42CFR438.402(b)(2)* *State Rule: 8.209.5.A*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 20 middle of page, "You can file you grievance in person…"—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 2, middle of page, "If you want to File a Grievance") 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.5 IV.A.1) **Description of Process:** Members are advised in several documents that grievances must be submitted within 30 days of the incident.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy stated that the member would have 30 calendar days from the date of the event to file a grievance. The member handbook and the grievance and appeal guide informed members of the 30-calendar-day filing time frame in easy-to-understand language. The grievance and appeal guide also informed members of the grievance filing time frame.		
Required Actions: None.		
8. The Contractor sends written acknowledgement of each grievance within two working days of receipt. *42CFR438.406(a)(2)* *State Rule: 8.209.B*	**Documents Submitted:** 1. FBHP Member Handbook 101811.pdf (p. 20 second paragraph from bottom—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 2, middle of page, "If you want to File a Grievance") 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.5 IV.A.2) 4. OMFA Medicaid Grievance Tracking Sheet 7_1_11.doc 5. FBHP Griev Ack letter rev 7_1_11.doc **Description of Process:** OMFA staff have procedures and tracking sheets to ensure that timelines are met. Staff are cross trained to assist one another during unexpected absences.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy included the process for the OMFA advocates to send a grievance acknowledgement letter within two working days of the receipt of the grievance. Members were informed via the member handbook and the grievance and appeal guide about the grievance process, including the process of sending the grievance acknowledgement letter. FBHP provided a grievance acknowledgement letter template. During the on-site interview, FBHP		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
staff members reported that the OMFA director would track due dates for sending the acknowledgment letter by using a cover sheet for each grievance file. Staff members stated that each member advocate would send the cover sheet for each grievance filed to the OMFA director for review. In addition, staff members stated that each grievance would be entered into the VO grievance database by the individual who received the grievance, and that the database would be used for completing reports for the Department and trending information.		
Required Actions: None.		
9. The Contractor must dispose of each grievance and provide notice of the disposition in writing as expeditiously as the member's health condition requires, not to exceed 15 working days from the day the BHO receives the grievance. *42CFR438.408(b)(1) and (d)(1)* *State Rule: 8.209.5.D.1, 8.209.5.F*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p.20 last two paragraphs—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p.2 middle of page "If you Want to File a Grievance") 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.5 IV.A.4) 4. OMFA Medicaid Grievance Tracking Sheet 7_1_11.doc **Description of Process:** OMFA staff have procedures and tracking sheets to ensure that timelines are met. Staff are cross trained to assist one another during unexpected absences.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy described the process for investigation and resolution of grievances within 15 working days of the receipt of the grievance. The member handbook and the grievance and appeal guide informed members of the grievance process, including the process to send written notice of resolution within 15 working days of receipt of the grievance. FBHP staff members described the role of the OMFA director in oversight of the advocates and tracking time lines for resolution of grievances.		
Required Actions: None.		
10. The written notice of grievance resolution includes: ◆ The results of the disposition/resolution process. ◆ The date it was completed. *State Rule: 8.209.5.G*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 20 last two paragraphs—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 2, "If you want to File a Grievance" 2nd paragraph) 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p5. IV.A.5) 4. FBHP Griev Dec Letter template rev 7_1_11.doc	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: OMFA's template for decision letters includes all of the information required by federal and state regulations.	
Findings: The grievances and appeals policy stated that grievance resolution letters would include the disposition of the grievance, the date the decision was made, the right to request a review of the decision by the Department, that the OMFA would be able to help with that request, and that the Department's decision would be final. The grievance decision letter template included all of the required information.		
Required Actions: None.		
11. Members may file an appeal within 30 calendar days from the date of the notice of action. *42CFR438.402(b)(2)* *State Rule: 8.209.4.B*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 22 "What are the time frames for filing an appeal?" 2nd bullet—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 4 top of page "To file and Appeal of an Action" 2nd bullet) 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.6 IV.B.1.b.) **Description of Process:** The OMFA Director handles appeals and ensures that they are filed with required timeframes. On occasion, a member may call the Grievance Coordinator at ValueOptions, FBHP's UM Delegate, to file an appeal. In that case, the VO Grievance Coordinator acknowledges the appeal and informs the OMFA Director so that the Director can track the appeal.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy included the provision that members may file an appeal within 30 calendar days of the date of the notice of action. The VO Grievance/Appeals PowerPoint training also included the 30-calendar-day filing time frame. Members were notified of the filing time frame via the member handbook. The notice of action template letters and the grievance and appeal guide also included the 30-calendar-day filing time frame.		
Required Actions: None		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
12. The member may file an appeal either orally or in writing, and must follow the oral request with a written, signed appeal (unless the request is for expedited resolution). *42CFR438.402(b)(3)(ii)* *State Rule: 8.209.4.F*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 21 first paragraph "How do I file an appeal (Appeal an Action)?" –misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 4 "To file an Appeal of an Action" paragraph in middle of page beginning "You can file an appeal by phone….") 3. FBHP Grievance and Appeal Policy rev 7_1_11.doc (p. 5 IV.B.1.) **Description of Process:** The OMFA Director ensures that timelines are followed and informs the member that the Director will accept the appeal orally in order to establish the earliest filing date, but that the member must follow up in writing in order for the appeal to be processed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy stated that members may file appeals orally or in writing, and that OMFA advocates assist members with putting oral requests for an appeal in writing. Members were informed via the grievance and appeal guide (sent with notices of action and acknowledgement letters) and the member handbook that appeals may be filed orally or in writing. The on-site appeal record review included appeals that had been filed orally and in writing.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
13. In handling grievances and appeals, the Contractor must give members reasonable assistance in completing any forms required, putting oral requests for a State fair hearing into writing, and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42CFR438.406(a)(1)* *State Rule: 8.209.4.C*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (pp. 19-22, entire section but see p. 20 paragraph beginning "You can file your grievance in person…" and p.21 paragraph beginning "If you disagree with an Action…" for information re interpreters—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (entire document, but especially pp 1 & 2 "If you need help") 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p. 5 IV.A.2. and p. 4 III.B. 2-5, 9,10 & 12) **Description of Process:** The FBHP OMFA is well staffed to assist members with grievances and appeals. In general, the Client and Family Advocates at the Partner Mental Health Centers handle grievances, while the OMFA Director handles appeals. OMFA staff also have access to a telephonic Language Line, TTY Line, Relay Colorado and interpreters if needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy described the reasonable assistance provided by FBHP OMFA advocates, including completing forms and providing interpreter services. The VO Grievance/Appeals PowerPoint training and the Complaints/Grievance PowerPoint training both used for the IPN and the training materials used for training PMHC providers stated that the grievance and appeals coordinator's or member advocate's role included providing assistance to members to put appeals in writing and to secure translators and interpreters. The member handbook informed members of the availability of assistance filing an appeal, requesting a state fair hearing, and arranging for interpreter services. The notice of action template letter offered "help" putting the appeal in writing. The on-site appeals record review included examples and evidence of FBHP staff assisting members with the appeal process.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
14. The Contractor sends the member a written acknowledgement of each appeal within two working days of receipt, unless the member or the designated client representative (DCR) requests an expedited resolution. *42CFR438.406(a)(2)* *State Rule: 8.209.4.D*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 23 "What other things do I need to know about appeals?"—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p.4, second to the last paragraph 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p. 6 IV.B.3) 4. FBHP Appeal Tracking Sheet 7_1_11.doc 5. FBHP Appeal Ack letter template 7_1_11.doc 6. FBHP Denial of Request for Expedited Appeal_2010NOV30.doc **Description of Process:** The OMFA Director is responsible for managing this process. Any decision to deny a request for an expedited Appeal is made in consultation with an appropriate licensed person and the Member is advised that he/she can file a Grievance about this decision.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy included the provision to send the member a written appeal acknowledgement letter within two working days of receipt of the verbal or written appeal. The member handbook informed members about the appeal process including the process to send a written acknowledgement within two working days of receipt of the appeal. FBHP provided an appeal acknowledgement letter template. The on-site appeals record review demonstrated that acknowledgement letters were sent within two days of receipt of the appeal in 10 of 10 records reviewed.		
Required Actions: None.		
15. The Contractor's appeal process must provide: ◆ That oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date). ◆ The member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The contractor must inform the member of the limited time	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (pp. 21 & 22 "How do I file an appeal (Appeal of an Action)?"—misc folder) First paragraph in this section addresses bullet 1 P. 23 subsection "What other things do I need to know about appeals" addresses bullet 2 P. 24 first paragraph addresses bullet 2 and bullet 4 P. 21 second paragraph for bottom beginning "You can ask someone else…" addresses bullet 4 P. 23 "What other things do I need to know about appeals?" second paragraph addresses bullet 3	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
available for this in the case of expedited resolution.) ◆ The member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents considered during the appeals process. ◆ That included, as parties to the appeal, are: • The member and his or her representative; or • The legal representative of a deceased member's estate. *42CFR438.406(b)* *State Rule: 8.209.4.G, 8.209.4.H, 8.209.4.I*	2. FBHP G&A Guide pp.4-6, but especially P. 4 middle of page, paragraph beginning "You can file an appeal by phone…" addresses bullet 1 P. 5 top of page paragraph beginning "FBHPartners will give you the chance…." Addresses bullet 2 P. 5 top of page paragraph beginning, "Also, FBHPartners will let you and your DCR…." Addresses bullet 3 P. 4 second to last paragraph addresses bullet 4 P.5 top of page, paragraph beginning "Also, FBHPartners will let you and your DCR…" addresses bullet 4 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.4 III.B.2 addresses bullet 1; p.4 III B.3,9,10 and p.6 IV.B.4.b first bullet address bullet 2; p. 4 III B.10 addresses bullet 3; p. 3. II. N. addresses bullet 4) **Description of Process:** The OMFA Director communicates directly with the Member or his/her Designated Representative to ensure that the Member is afforded all of his/her rights in the Appeal process.	
Findings: The member handbook informed members that appeals may be filed by telephone, and that the member must follow-up in writing. The handbook stated that the OMFA will help with putting appeals in writing. The grievances and appeals policy stated that the OMFA director treats oral inquiries as appeals to establish the earliest possible filing date. The policy stated that the OMFA director would forward any additional information from the member to the reviewer and would ensure that the member would have the opportunity to review his or her file and any records used by the reviewer in reaching the decision. The policy described parties to the appeal, as required. The member handbook informed members of the right to provide additional information. The grievance and appeal guide informed members of the short time available to provide additional information if requesting an expedited resolution. The notice of action template letters informed members of the right to review their file and any information the reviewer would use in making his or her decision.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
16. The Contractor must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: ◆ For standard resolution of appeals, within 10 working days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three working days after the Contractor receives the appeal. ◆ For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42CFR438.408(b)(2)&(d)(2)* *State Rule: 8.209.4.J, 8.209.4.L*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 23 "What other things do I need to know about appeals?" entire section—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 5 "Timeframes for a Decision on Your appeal" , first paragraph under "Standard resolution/decision of an Appeal" addresses bullet 1; p.5 "Timeframes for a Decision on Your appeal", all three paragraphs under "Expedited (quicker) resolution of an Appeal" address bullets 2 and 3 3. FBHP Policy Griev & Appeals rev 7_1_11.doc (p. 6 & 7 IV. B.4.a and b addresses all 3 bullets.) **Description of Process:** The OMFA Director ensures that these procedures and timeframes outlined in the FBHP Griev & Appeal Guide are met.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy included the 10-working-day time frame for resolving standard appeals and the 3-calendar-day time frame for resolving expedited appeals. The policy included the provision to make reasonable efforts to verbally notify the member for expedited resolution of appeals. The member handbook included the 3-calendar-day time frame for resolving expedited appeals; however, the handbook stated that the standard resolution time frame for standard appeals is 10 calendar days. (See the Member Information standard, Requirement 13, for scoring specific to the member handbook information about appeal resolution time frames.) The member handbook notified members that FBHP would also try to call the member for notice of resolution for expedited appeals. The on-site appeals record review demonstrated that in each of the 10 records reviewed, the appeal was resolved with notice provided to the member within the required time frames. There were no expedited appeals in the records reviewed.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
17. The written notice of appeal resolution must include: ◆ The results of the resolution process and the date it was completed. ◆ For appeals not resolved wholly in favor of the member: • The right to request a State fair hearing, and how to do so. • The right to request that benefits while the hearing is pending, and how to make the request. • That the member may be held liable for the cost of these benefits if the hearing decision upholds the Contractor's action. *42CFR438.408(e)* *State Rule: 8.209.4.M*	**Documents Submitted:** 1. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 5 middle of page, paragraph beginning "The letter giving you our decision….") 2. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.6 IV.B. 4.a. entire section) 3. Management Services Agreement_FY12_FBHP & VO_2011 August 29_Management Services Agreement Executed.doc (Delegation Subcontracts folder) Exhibit A, Member & Family Affairs, items a. through e. (p. 16) addresses all bullets 4. Delegation Agreement_FY12_FBHP & VO_2011 August 29_Executed.doc (Delegation Subcontracts folder), Exhibit A. (p.8 & 9) section 2. Clinical and Utilization Management Services, item i. Addressees all bullets 5. FBHP Decision on Appeal_2010NOV30.doc **Description of Process:** The OMFA Director is responsible for ensuring that the Appeal Resolution letters include the required information and are written for ease of understanding and at a sixth grade level. A Resolution letter template is used to ensure that this occurs.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy included the required content of appeal resolution letters. As the UM delegate for FBHP, VO provided examples of resolution template letters, demonstrating that separate letters were used for appeals related to the termination of previously authorized services, and for appeals related to new requests for services. Each template included the required information, as applicable. The resolution letters reviewed during the on-site appeals record review included the required information.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
18. The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: ◆ Were not involved in any previous level of review or decision-making. ◆ Have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. *42CFR438.406(a)(3)(ii)* *State Rule: 8.209.4.E, 8.209.5.C*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 20 second paragraph from bottom—misc folder) FBHP Griev & Appeal Guide rev 7_1_11.doc (p.2 "If you want to file a Grievance" first paragraph; pp. 4&5 "To file an Appeal of an Action", last paragraph on p 4 and top of page 5) 2. FBHP Grievance and Appeal Policy rev 7_1_11.doc (p.2. I.G. addresses all bullets; p.4 III.B.8 addresses reviewers on Appeals; p.5 IV.A.2 & 3 addresses decision-makers on grievances) **Description of Process:** The OMFA Director is responsible for ensuring that grievance reviewers were not previously involved and that an appropriately licensed staff, also not previously involved make decisions about grievances. The FBHP Medical Director is responsible for ensuring that ValueOptions, under its Management Services Agreement with	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy stated that the OMFA director, in coordinating grievance and appeal processing, would ensure that individuals who make decisions on grievance and appeals were not involved in the issue previously and have the necessary clinical expertise to make the decision. Members were informed of the process in the member handbook. While the on-site appeals record review demonstrated that individuals who had made resolution decisions on the appeals reviewed had not been involved in the previous decision and had the requisite clinical expertise to do so, one case reviewed indicated that the individuals who made the decision to deny an expedited review did not have clinical expertise in treating the member's condition.		
Required Actions: FBHP must ensure that individuals who make clinical decisions related to grievances and appeals have clinical expertise in treating the member's condition or disease.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
19. The contractor may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: ◆ The member requests the extension; or ◆ The Contractor shows that there is need for additional information and how the delay is in the member's interest. ◆ If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay. *42CFR438.408(c)* *State Rule: 8.209.4.K, 8.209.5.E*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 20 "How do I file a grievance (complaint)?" last two paragraphs on page; p. 23 "What other things do I need to know about appeals" second and third paragraphs—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p.. 2 "If you want to file a Grievance", second paragraph; p. 3 "When does FBHPartners send you a Notice of Action?" entire section) 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.6 IV.B.4.a.) 4. FBHP Griev Dec Extension letter rev 7-1-11.doc 5. FBHP Extension of Decision Date on Appeal_2010NOV30.doc **Description of Process:** The OMFA Director works closely with the Grievance Coordinator of ValueOptions (the Administrative Service Organization and UM Delegate) to ensure that timelines are met and requirements followed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy included the provision to extend the time frames for resolution of grievances and for standard and expedited appeals. The grievance extension letter template and the appeal extension letter template contained fields for including the reason for the extension. Members were informed of the extension process via the member handbook. There were two appeal resolutions extended in the on-site appeals record review. In both cases, the FBHP staff member sent the member notice of the extension and the reason for the delay.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
20. A member need not exhaust the Contractor's appeal process before requesting a State fair hearing. The member may request a State fair hearing within 30 calendar days from the date of the notice of action. *42CFR438.402(b)(2)(ii)* *State Rule: 8.209.4.N*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (pp. 21 & 22 "How do I file and appeal (Appeal of an Action)?" last paragraph on p. 21 and first 2 paragraphs on p. 22—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 2"If you want to Appeal an Action, bullet 5; p. 4 "To file an Appeal of an Action" bullet 2 and fourth paragraph from bottom of page, "Because appealing to FBHPartners might….") 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.8 VA.) **Description of Process:** The OMFA Director advises Members early in the appeal process that they contact the ALJ rather than wait until receiving the FBHP resolution letter. The OMFA Director also frequently recommends that the Member contact the Ombudsman for Medicaid Managed Care for help and guidance filing an appeal with the ALJ.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy stated that members may appeal directly to the administrative law judge (ALJ) without first appealing to FBHP. The member handbook informed members of the 30-calendar-day filing time frame for each and stated that the member may want to appeal to the ALJ at the same time. The appeal decision template letters also provided the time frame and method for requesting a State fair hearing.		
Required Actions: None.		
21. The Contractor maintains an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to regain maximum function. The Contractor's expedited review process includes: ◆ The Contractor ensures that punitive action is not taken against a provider	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf ("What other things do I need to know about appeals?" third paragraph—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 2 "If you want to appeal an Action" bullet 7; p. 5 "Expedited (quicker) resolution of an Appeal" entire section) 3. FBHP Policy Griev & Appeals rev 7_1_11.doc (pp. 6 & 7, IV.B.4.b) **Description of Process:** The OMFA Director assists members who request an expedited appeal and ensures that the correct procedures and timelines are followed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
who requests an expedited resolution or supports a member's appeal. ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: • Transfer the appeal to the time frame for standard resolution. • Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice. *42CFR438.410* *State Rule: 8.209.4.P–.R*		
Findings: The grievances and appeals policy described the expedited appeal process and included each of the required provisions. The Practitioner Agreement Template stated that VO (used for independently contracted practitioners) shall not terminate a practitioner that advocated for a member or filed an appeal or a complaint. The template letter for denial of the expedited process explained the reason for denying expedition and provided the date the appeal would be decided using the standard time frame. Members were informed about the expedited appeal process via the member handbook. There were no examples of expedited reviews in the appeals record review.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
22. The Contractor provides for continuation of benefits while the BHO-level appeal and the State fair hearing are pending if: ◆ The member or the provider files timely*—defined as on or before the later of the following: • Within 10 days of the Contractor mailing the notice of action. • The intended effective date of the proposed action. ◆ The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. ◆ The services were ordered by an authorized provider. ◆ The original period covered by the original authorization has not expired. ◆ The member requests extension of benefits. **This definition of timely filing only applies for this scenario–i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.* *42CFR438.420(a) and (b)* *State Rule: 8.209.4.S*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (pp. 22 & 23 "What are the time frames for filing an appeal?" and "What if I want my services to continue during my appeal" –misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 2 "If you want to Appeal an Action" bullet 8; p. 4 "To file an Appeal of an Action" bullet 1; p. 6 "Special Situation for Previously Authorized Services") 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.7. IV.B.5.a) **Description of Process:** The OMFA Director works with members to help them understand this process and ensures that coordination occurs with providers and the UM Delegate, where needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy accurately described the provision for continuation of previously authorized services during the appeal or the State fair hearing. The grievance and appeals guide and the member handbook clearly described the provisions for continuing previously authorized services during an appeal or State fair hearing, in easy-to-understand language.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
23. If, at the member's request, the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten days pass after the Contractor mails the notice providing the resolution (that is against the member) of the appeal, unless the member (within the 10-day time frame) has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached. ◆ A State fair hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. *42CFR438.420(c)* *State Rule: 8.209.4.T*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (pp. 22 "What are the time frames for filing an appeal?" and What if I want my services to continue during my appeal?"—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (pp. 6 & 7 "Special Situation for Previously Authorized Services") 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p. 7 IV.B.5.b., c., and d.) **Description of Process:** The OMFA Director works with members to help them understand this process and ensures that coordination occurs with providers and the UM Delegate, where needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy included the provision for continuation of previously authorized services during the appeal or the State fair hearing and contained the correct information regarding the duration of continued services. The grievance and appeals guide and the member handbook clearly described the duration of continued services during an appeal or State fair hearing in easy-to-understand language.		
Required Actions: None.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
24. Effectuation of Appeal Resolution: ◆ If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the Contractor must pay for those services. ◆ If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. *42CFR438.420(d), 42CFR438.424* *State Rule: 8.209.4.U–W*	**Documents Submitted:** 1. FBHP Member Handbook 10-18-11.pdf (p. 23 top part of page "Important Note: If your appeal …." addresses bullet 1—misc folder) 2. FBHP Griev & Appeal Guide rev 7_1_11.doc (p. 2 "If you want to Appeal an Action" bullet 9, addresses bullet 1; p. 5 Timeframes for a Decision on your Appeal, third bullet, addresses bullet 1; p.7 "If the Hearing Office rules in your favor", addresses bullet 2 & 3) 3. FBHP Policy Griev & Appeal rev 7_1_11.doc (p. 7. IV.B.5.d) **Description of Process:** The OMFA Director works with members to help them understand this process and ensures that coordination occurs with providers and the UM Delegate, where needed.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The grievances and appeals policy included the required effectuation of the appeal resolution provisions. Members were informed via the member handbook that they may have to pay for services that were continued during the appeal or the State fair hearing if the final decision is not in favor of the member.		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
Required Actions: None.		
25. The Contractor maintains records of all grievances and appeals and submits quarterly reports to the Department. *42CFR438.416* *State Rule: 8.209.3.C*	**Documents Submitted:** 1. FBHP Griev Dbase screenshot pt. 1.png 2. FBHP Griev Dbase screenshot pt. 2.png 3. FBHP Appeal Database Screenshot.docx 4. StRpt_Analysis_FINAL_FBHP_Q1FY12_2011_2011Oct31_OMFA.doc—quarterly report example 5. StRpt_FBHPGriev State Report FINAL_Q1FY12_OMFA.xls—quarterly report example 6. FBHP Policy Griev & Appeal rev 7_1_11.doc (p.2, I.B and E). 7. Management Services Agreement_FY12_FBHP & VO_2011 August 29_Management Services Agreement Executed.doc (Delegation Subcontracts folder) Exhibit A, p. 6 Member & Family Affairs, item b **Description of Process:** The FBHP Grievance Database is maintained by ValueOptions and FBHP OMFA staff enter grievances throughout the quarter; at the end of the quarter, the OMFA Director and ValueOptions Grievance Coordinator work together to develop the quarterly grievance data and narrative report. The FBHP Appeal Database is maintained by FBHP on its server and the OMFA Director enters appeals in the database and at the end of the quarter provides the data and narrative to the VO Grievance Coordinator. The VO Grievance Coordinator assembles the Quarterly Report and submits it electronically to HCPF and copies the OMFA Director. The OMFA Director keeps copies of the Quarterly Report on the FBHP server and provides them to the FBHP QI Director.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: FBHP provided screen shots of VO's grievances and appeals databases. The FBHP OMFA director reported that she would review grievance cover sheets prepared by the member advocates (for grievances) and prepare cover sheets to track appeals (as the UM tasks related to appeal processing are delegated to VO). The Quarterly Grievance and Appeal reports submitted to the Department demonstrated FBHP's documentation and reporting of grievances and appeals. In addition, VO produced more detailed grievance and appeal trending reports for internal use and presentation to the quality management		

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
committees as evidenced by review of reports and Quality Improvement Committee meeting minutes. The on-site appeals record review demonstrated FBHP's record-keeping for appeals.		
Required Actions: None.		
26. The Contractor must provide the information about the grievance system specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing. • The rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. • If benefits continue during the	**Documents Submitted:** 1. FBHP Provider Network delegation policy 2011.doc (entire policy – Provider Participation and Program Integrity folder) 2. VOStd_Practitioner Agmt_0809_final_20100708.pdf (pg 5 Sec 2.10 – VO folder Standard VII) 3. Co MedicaidAddendum_2011OCT01_PR.pdf (pg 1 Sec B.5 – VO folder) 4. Provider Manual_2011Oct01_PR.pdf (pg 27-33 Sec 9 & pg 79-81 Sec 15 – miscellaneous folder) 5. FBHP Policy Griev & Appeals rev 7_1_11.doc (p.2.I.F.) 6. FBHP Policy Delegation of BHO Respon_final 7_1_11.doc (pg 2 Sec VI-Delegation Subcontracts folder) **Description of Process:** FBHPartners delegates Provider Network functions to ValueOptions. At the time of contracting ValueOptions reviews the contract sections that reference that the Provider must abide by policies and procedures within the Provider Manual. The Provider Manual describes the Grievance system in two sections, which are referenced. FBHPartners informs subcontractors, at the time of contracting, about the grievance procedure, as described in our grievance policy and the FBHP Policy Delegation of BHO Responsibilities	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard VI—Grievance System		
Requirement	**Evidence as Submitted by BHO**	**Score**
appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The member's right to have a provider file a grievance or an appeal on behalf of the member, with the member's written consent. *42CFR438.414* *State Rule: 8.209.3.B*		
Findings: The provider manual included detailed information about the grievance system and FBHP's processes, except to notify the provider that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.		
Required Actions: FBHP must ensure that providers are notified that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.		

Results for Standard VI—Grievance System							
Total	Met	=	24	X	1.00	=	24
	Partially Met	=	2	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	26	**Total Score**		=	24

Total Score ÷ Total Applicable	=	92%

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor has a robust and thorough process, described in written policies and procedures, to evaluate potential providers before they provide care to members, and to reevaluate them periodically thereafter. The Contractor has adopted NCQA credentialing and recredentialing standards and guidelines for provider selection. *42CFR438.214(a)* *Contract: II.G.3.a, Exhibit O: I.A, I.B.3*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02c & pg 9-10 sec 3-Delegation Subcontracts folder 2. FBHP Credentialing Delegation Policy 2011.doc (entire policy) 3. N203_FacilityCredentialingPolicy_2011OCT01_PR (entire policy – VO folder Standard VII) 4. N201_PracCredentialingPolicy_2011OCT01_PR(entire policy – VO folder Standard VII) 5. N501_PracRecrePolicy_2011OCT01_PR (entire policy-VO folder Standard VII) 6. N502_FacilityRecrePolicy_2011OCT01_PR (entire policy-VO folder Standard VII) 7. N101_OverviewNNS_2011OCT01_PR (entire policy – VO folder Standard VII) 8. 2011 FBHP Credentialing Manual PMHCs.doc (entire manual) 9. FBHP Policy Credentialing Program 2011.doc (entire policy) 10. FBHP Policy_Provider_Monitoring 2011.doc (pg 1, sec I) **Description of Process:** FBHPartners delegates credentialing and re-credentialing to ValueOptions. ValueOptions reviews providers upon initial credentialing and recredentialing to evaluate providers who participate in the Colorado Medicaid Network. Recredentialing occurs on a 3 year, or 36 month cycle. ValueOptions' process meets NCQA guidelines and is reviewed annually to ensure compliance.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	In addition FBHPartners maintains a credentialing and recredentialing program to review all partner mental health center (PMHC) providers upon initial credentialing and, for licensed providers, recredentialing to evaluate PMHC individual providers. ValueOptions is delegated primary source verification for the FBHPartners credentialing program. Recredentialing occurs on a 3 year, or 36 month cycle. The FBHPartners' credentialing program meets NCQA guidelines.	

Findings:
During the on-site interview, staff members explained that provider credentialing functions had been delegated by FBHP to VO for independent providers. Staff members also stated that FBHP would credential the CMHC providers, and that VO would also perform primary source verification for the CMHC providers credentialed by FBHP. The final delegation agreement between FBHP and VO (July 2011) specified that FBHP delegated credentialing and recredentialing functions to ValueOptions for the independent provider network. Delegated activities included gathering and entering data on network providers into the credentialing database, reviewing and processing credentialing applications in accordance with NCQA standards, conducting licensure and sanction checks on all providers, conducting credentialing committee meetings, and ensuring provider contracts and site visits were completed. The FBHP Credentialing and Recredentialing—Delegation Oversight policy stated that FBHP, through the annual audit and report review process, would verify that all activities of the VO credentialing and recredentialing program includes the necessary policies and procedures to ensure compliance with applicable standards and regulations. The policy outlined the criteria for the annual evaluation of the delegate (VO).

The VO Overview of National Network Services policy described the role and responsibilities of the corporate level national network services department in the development and management of a national network of providers, which included credentialing and monitoring of network adequacy. The VO Practitioner Credentialing policy outlined the detailed operational procedures for processing a provider application, including the organization and verification of information in the credentialing file by staff, documentation of all information in the Network Connect Credentialing module, administrative review of file information, forwarding of clean files to the medical director, and recommendations to the National Credentials Committee for final determination. The policy specified that the administrative review of file information was based on discipline-specific criteria. The VO Discipline Specific Credentialing Criteria policy outlined the specific licensure, education, and experience requirements for each practitioner discipline (e.g., psychiatrist, social worker). The VO Practitioner Recredentialing policy specified that recredentialing applications would be sent to the provider four months prior to the recredentialing date, which is tracked through the Credentialing module. The policy described, in addition to the operational procedures outlined in the VO Provider Credentialing policy, that a Credentialing Specialist would gather and review provider-specific utilization management indicators, quality indicators, and complaints for consideration by a peer reviewer and the National Credentials Committee, as necessary.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
The FBHP Partner Mental Health Center Credentialing Manual (FBHP credentialing manual) and the FBHP Credentialing and Recredentialing policy described FBHP's processes for credentialing and recredentialing PMHC providers, consistent with NCQA guidelines. The manual stated that FBHP delegates primary source verification for PMHC providers to VO, and described the responsibilities of the FBHP credentialing committee and the FBHP medical director. The VO Facility Credentialing policy and the VO Facility Recredentialing policy outlined the procedures related to the credentialing of organizational providers. The policies described the administrative procedures for preparation and verification of applicant information which were similar to that outlined in the VO Practitioner Credentialing and Recredentialing policy, with the following exceptions: the organizational accreditation status is verified, an on-site visit is performed for non-accredited facilities, and the administrative review of the file is based on criteria specific to organizational providers. The VO Credentialing Criteria for Facility/Organizational Providers outlined requirements for licensure and certifications, accreditation, malpractice history, liability insurance, and program-specific criteria. All credentialing and recredentialing policies stated that approvals would be communicated in writing to the provider within 60 days of determination, sending an executed provider contract, and that denials would be communicated in writing within 5 days of determination, including the reason for denial and information concerning the provider appeal process.		
Required Actions: None.		
2. The Contractor has policies and procedures that describe methods of ongoing provider monitoring and that include: ◆ The frequency of monitoring. ◆ How providers are selected to be reviewed. ◆ Scoring benchmarks. ◆ The way record samples will be chosen. ◆ How many records will be reviewed. (The Department encourages a survey checklist for the actual provider visits.) *Contract: Exhibit O: I.A.2*	**Documents Submitted:** 1. FBHP Policy_Provider_Monitoring 2011.doc (entire policy) 2. FBHP MHC checklist 2011.xlsx (entire document) 3. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02b & pg 8-9 sec 2-Delegation Subcontracts folder 4. FBHP UM delegation policy 2011.doc (entire policy) 5. 259LEnhancedCLMgmtof OPService_Policy_SC_Cl (2).docx (entire policy – VO folder Standard VII) 6. FBHP Policy QAPI program revised 2011.doc (entire policy) 7. FBHP Policy Qual Care Concerns FY '12.doc (entire policy) 8. FBHP Policy Critical Incidents revised FY '12.doc (entire policy) 9. FBHP Policy NCF_ACF Services Revised 7_1_11.doc	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	(entire policy) 10. FBHP Policy Medical Records Maintenance Revised 2011.doc (entire policy) 11. 3 BHO Medical Record Audit tool final 121610.xls.(entire document) 12. FBHP Policy Monitoring of Encounter Record Accuracy Final 7_1_11.doc (entire policy) **Description of Process:** FBHPartners' policies and procedures outline the methods used for ongoing provider monitoring including frequency of monitoring, as noted in the FBHP Policy on Provider Monitoring or in Attachment A in the FBHP Policy Medical Records Maintenance; how providers are selected, as noted, for example, in the FBHP Medical Record Maintenance Policy, scoring benchmarks such as in the 3 BHO Medical Record Audit tool; and how and how many medical records are chosen, as noted in the FBHP Policy Medical Record Maintenance Attachment A. In addition, FBHPartners utilizes a procedure of monitoring individual provider outlier care processes, through FBHPartners delegation of Utilization Management, called "Enhanced Clinical Management." which provides information on care quality as well as provider utilization.	

Findings:
The VO Practitioner Recredentialing policy and the FBHP credentialing manual stated that recredentialing will be conducted for each provider every three years and included review of data related to utilization, quality, and grievances.

The FBHP provider monitoring described a variety of monitoring activities, both aggregate and provider-specific. The policy stated that monitoring of care provided will occur through the Quality Assessment and Performance Improvement Program, through performance measure quarterly reporting and performance improvement projects. The policy stated that patient-specific monitoring will occur as needed, as often as daily through follow-up on quality of care concerns and VO's enhanced clinical management program. The VO Enhanced Clinical Management of Outpatient Services policy described monitoring of provider treatment records for justification of services beyond a specified number of treatments or clinical evidence to support the diagnosis for several pre-defined categories of patients. The criteria and methods of selecting records for review were outlined.

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Requirement	**Evidence as Submitted by BHO**	**Score**
	The FBHP Medical Record policy described FBHP's medical record documentation requirements and performance of medical record audits to ensure compliance. The policy described the sampling method for providers selected for review and for specific records for both the PMHCs and the independent provider network. The policy also described methods for determining the number of records reviewed each year and the frequency of audits for each provider based on compliance. Attachment A to the policy described the criteria for review and the scoring benchmark to determine how often the provider will be subject to repeat medical record audits. The BHO Chart Audit Tool included fields to evaluate the presence and accuracy of documentation. FBHP staff members stated that the PMHCs would conduct chart audits to ensure compliance with medical record requirements, and oversight of PMHC chart audits would be accomplished through the quality improvement program. The Monitoring of Encounter Record Accuracy policy described the random sampling and procedures for annually auditing 411 encounter records for errors. The policy also addressed procedures for investigation and follow-up to ensure accurate encounter submission by providers. The FBHP 411Audit Summary report included sample records for mental health centers and the independent provider network. The report included analysis of incomplete or inaccurate records (by type), evaluation of medical records documentation to substantiate the claim, and a comparison to the previous year's results. The report also included a summary findings and corrective action plans. The FBHP Quality of Care Concerns policy stated that the Quality of Care Committee was composed of medical directors and quality improvement directors of the three BHOs who delegate provider network management to VO as well as VO representatives. During the on-site interview, staff stated that the committee would provide peer review for quality of care concerns. Staff also stated that if issues arose through review of grievances, UM data, medical record audits, or adverse incident reports, the concern might be reviewed by the committee, investigated further, or flagged for CAP request.	
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
3. The Contractor monitors covered services rendered by provider agreements for: ◆ Quality ◆ Appropriateness ◆ Patient outcomes ◆ Compliance with: • Medical record requirements • Reporting requirements • Applicable provisions of the BHO's contract with the Department. *Contract: II.G.10.a.3–4*	**Documents Submitted:** 1. FBHP Policy_Provider_Monitoring 2011.doc (entire policy) 2. FBHP MHC checklist 2011.xlsx (entire document) 3. FBHP Policy QAPI program revised 2011.doc (entire policy) 4. QI Work Plan FBHP FY '12 final.docx (entire document) 5. QI program evaluation FY '11.doc (entire document) 6. MHSIP_YSS-F Survey Report FY '11 final.doc (entire document) 7. 3rd Qtr report FY '11.doc (entire document) 8. Performance Indicator Report 4th Qtr FY '11.pdf (entire document) 9. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02b & pg 8-9 sec 2-Delegation Subcontracts folder 10. FBHP UM delegation policy 2011.doc (entire policy) 11. 259LEnhancedCLMgmtof OPService_Policy_SC_Cl (2).docx (entire policy – this is an update to a policy in the VO folder – Standard VII) 12. ECM_Prov_Cover_Letter_IPN_3BHO.pdf (entire document – VO Folder Standard VII) 13. ECM_Prov_Report_Template_2011Sep27_3BHO.pdf (entire document – VO Folder Standard VII) 14. ECM2_FBHP.pdf (entire document) 15. FBHP Policy Qual Care Concerns FY '12.doc (entire policy) 16. FBHP Policy Critical Incidents revised FY '12.doc (entire policy) 17. FBHP Policy NCF_ACF Services Revised 7_1_11.doc (pg 2, Sec IV) 18. FY12_ACF_NCF_survey report_MHP_2011.doc (entire	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
	document – example of survey report) 19. FBHP Policy Medical Records Maintenance Revised 2011.doc (entire policy) 20. 3 BHO Medical Record Audit tool final 121610.xls.(entire document) 21. Medical Record Review Report FY '11.doc (entire document) 22. IPNChartAudResults_Report Q2 FY11_FBHP_2011.docx (entire document, example of routine IPN medical record audits) 23. FBHP Policy Monitoring of Encounter Record Accuracy Final 7_1_11.doc (entire policy) 24. FBHP 411 audit FY '11.docx (entire document) 25. AdverseIncident_FBHP FY112Q1.pdf (entire document – tracking reporting of adverse incidents) 26. FBHPQ4FY11_IPNEmergency AccesstoCare_Calls_2011May.QM.xlsx (entire document) 27. CCARUpdate_Letter_FBHP_2011Sept27_QM.pdf (entire document) 28. DBAuditResults_Report_VO_2011Aug09_QM.doc (entire document) **Description of Process:** FBHP procedures for monitoring provider quality, appropriateness, patient outcomes, and compliance with medical records, reporting, and other contractual requirements are outlined in the FBHP Policy on Provider Monitoring and other policies submitted. More specifically, provider quality, appropriateness, and outcomes are monitored through FBHPartners QAPI Department including annual QI Plan activities, monitoring of quality of care concerns and critical incidents, as well as delegated monitoring through ValueOptions UM ECM process. Compliance with medical record	

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Requirement	**Evidence as Submitted by BHO**	**Score**
	requirements, reporting, and other BHO contract requirements are also monitored by the QAPI Department staff, utilizing PMHC peer review audits, IPN audits, the MHC checklist, Adverse Incident reports, etc., to assess reporting and other BHO requirements.	

Findings:
The FBHP Medical Record policy and the Provider Monitoring policy described the frequency and type of monitoring of provider performance through medical record audits and contract compliance audits. The policies also described the Quality Improvement/Utilization Management (QI/UM) Committee's role in reviewing data and reports and for determining appropriate initiatives. The Quality Assessment and Performance Improvement (QAPI) policy described the components addressed within the QAPI program. The FY12 Quality Assessment and Performance Improvement and Outcomes (QAPIO) Program Description described review of five dimensions of monitoring: Access to Care, Member and Family Service and Satisfaction, Care Quality and Appropriateness, Outcomes of Care, and Care Coordination and Integration. The program description described committee review of access data, performance improvement projects, Mental Health Statistics Improvement Program (MHSIP) results, utilization data, performance measure data and reports related to the five dimensions of monitoring. The FY 11 3rd Quarter QAPI Report (Jan—March 2011) provided an example of a quarterly report providing results of monitoring activities for the quarter.

The FBHP Utilization Management policy and the Delegation Agreement between FBHP and VO (the delegate) described monitoring of utilization management activities performed by VO and oversight of VO by FBHP.

The MHC Checklist was the contract compliance audit tool which evaluated PMHC's compliance with the following areas: Member Rights, OMFA responsibilities, cultural competency, access to care, cooperation with the QAPI program, coordination of care, practice guidelines, and reporting requirements. The Clinical Chart Audit tool was used for medical record audits and included assessment of the presence of specific documentation required in medical records. The FY11 Medical Record Audit Report provided results for the annual medical record audits conducted for MHP, JCMH, and for the IPN and described the corrective action plans and education plans that were requested from the PMHCs and certain independently contracted providers.

Other examples of provider monitoring included:

- A Discharge Audit Report, which was a review of a sample of discharge summaries (residential treatment) for evidence of a follow-up appointment having been scheduled. VO completed this audit.
- A sample of a reminder letter to an independent provider regarding the need to update a member's Colorado Client Assessment Record (CCAR).
- The Annual QI Program Evaluation provided analysis of quality improvement activities and data related to:
  - Review of performance indicators
  - Members having a behavioral health home
  - Member and family satisfaction results

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Requirement	**Evidence as Submitted by BHO**	**Score**
▪ Grievance and appeal review ▪ Quality and appropriateness of care ▪ Over and underutilization of services ▪ Care coordination activities ▪ Outcomes and effectiveness of care ▪ Access to care ▪ Improvement in symptom severity ▪ Analysis of performance improvement project and focus study results		
Required Actions: None.		
4. If the Contractor identifies deficiencies or areas for improvement, the Contractor and the provider take corrective action. *Contract: II.G.10.a.5*	**Documents Submitted:** 1. FBHP Policy_Provider_Monitoring 2011.doc (pg 2 SecIIB3 & IIID) 2. FBHP Policy Qual Care Concerns FY ’12.doc (pg 2 Sec IIIB) 3. QI Work Plan FBHP FY’12 final.docx (pg 20 – recidivism project and access to care-MI Waiver project) 4. QOC report FY ’11.doc (entire document – example of QOC CAPs requested in fiscal year) 5. FBHP CAP Request 03-11 executed.pdf (entire document - example of CAP request to provider) 6. CAP-03-11 JCMH.doc (entire document - example of CAP from provider) 7. LasaterN_Fail_FBHP_2011Aug30_QM.doc (entire document – example of CAP request) 8. LasaterN_CAP Not Accepted_FBHP_2011Oct 14_QM.doc (entire document – example of CAP request) 9. LasaterN_CAP Submitted_FBHP_2011_Oct07_QM.pdf (entire document) 10. LasaterN_CAPSubmitted_FBHP_2011_Oct28_QM.pdf (entire document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: FBHPartners, when there are provider deficiencies, takes corrective action, through implementation of performance improvement projects, educational materials, and requests for corrective action. Examples of corrective action requests include an annual QOC report describing both an educational letter and a corrective action request, and two examples of corrective action plan requests regarding medical record documentation issues.	
Findings: The Provider Monitoring policy included the provision to request corrective action for deficiencies as determined through medical record audits or other provider monitoring. FBHP provided letters to a provider in the independent provider network, letters to a PMHC requesting a corrective action plan, and the responses from these two providers as examples of FBHP's corrective action process. The required corrective actions resulted from the FY11 annual chart audit that was performed. The QAPI description and work plan described QAPI initiatives resulting from review of utilization and access data through the QI/UM committee meetings. The FBHP Quality of Care Concerns report summarized the two quality of care concerns reviewed by the Quality of Care (QOC) committee and FBHP's response, including whether to request corrective action.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
5. The Contractor's provider selection policies and procedures include provisions that the Contractor does not: ◆ Discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. ◆ Discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42CFR438.12(a)(1) and (2)* *42CFR438.214(c)* *Contract: II.G.3.b, II.G.4.a*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02e & pg 11-12 sec 5-Delegation Subcontracts folder 2. FBHP Provider Network Delegation Policy 2011.doc (entire document) 3. N101_OverviewNNS_2011OCT01_PR (pg 1 & 2 – VO folder Standard VII) 4. COMedicaidAddendum_2011OCT01_PR.pdf (pg 1 – VO folder Standard VII) 5. N401_PrimarySourceVerif_2011OCT01_PR (pg 1 &2 – VO folder Standard VII) **Description of Process:** FBHPartners delegates Provider Network functions to ValueOptions. ValueOptions does not discriminate against providers for acting within the scope of their license or providing services to members that require costly treatment.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP Provider Network policy and the FBHP/VO Delegation Agreement described FBHP's delegation of provider network management to VO. The VO Overview of National Network Services (NNS) policy stated that NNS was responsible on a corporate level for credentialing, network adequacy and quality monitoring of a national provider network. The policy stated that provider credentialing and eligibility determinations would be based on objective, non-discriminatory requirements for education, licensure, professional standing, service availability, quality and utilization performance, and would not be based on race, national identity, gender, age, sexual orientation, or the type of procedure or patient in which the practitioner specializes. The policy outlined monitoring procedures for nondiscriminatory credentialing decisions and stated that the National Credentialing Committee members were required to sign a statement of non-discrimination. The VO Primary Source Verification policy described processes used to ensure that the credentialing and recredentialing processes are nondiscriminatory. The Colorado Medicaid Addendum stated that VO would not prohibit or restrict providers from acting on behalf of the member, including those providers serving high-risk members or specialized conditions that may be costly.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
6. The Contractor does not prohibit, or otherwise restrict health care professionals, acting within the lawful scope of practice, from advising or advocating on behalf of the member who is the provider's patient, for the following: ◆ The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered. ◆ Any information the member needs in order to decide among all relevant treatment options. ◆ The risks, benefits, and consequences of treatment or non-treatment. ◆ The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. *42CFR438.102(a)* *Contract: II.E.1.h.1*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02e & pg 11-12 sec 5-Delegation Subcontracts folder 2. FBHP Provider Network Delegation Policy 2011.doc (entire document) 3. VOStd_Practitioner Agmt_0809_FINAL 20100708.pdf (pg 8 – VO Folder Standard VII) 4. COMedicaidAddendum_2011OCT01_PR.pdf (pg 1 – VO Folder Standard VII) 5. N101_OverviewNNS_2011OCT01_PR (pg 1 & 2 – VO Folder Standard VII) 6. FBHP Member Handbook 101811.pdf (Member Rights pg. 16 & 17 – miscellaneous folder) **Description of Process:** FBHPartners delegates Provider Network functions to ValueOptions. ValueOptions does not discriminate against providers who act within the scope of his/her license for advising or acting on the behalf of members. FBHPartners ensures members, through the FBHP member handbook, receive information about their rights to receive information from providers on treatment related issues	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The Provider Network policy described the provider network management activities delegated to VO. The VO Practitioner Agreement stated that the practitioner would always exercise best medical judgment in the treatment of members and that VO would not prohibit or penalize communication between the provider and member regarding treatment options and medically necessary care. The VO Colorado Medicaid Addendum to the practitioner agreement stated that VO would not prohibit or restrict a provider, acting within the scope of his/her license and practice, from advising or advocating on behalf of the member. The FBHP Member Handbook's list of member rights included the rights to obtain information about treatment choices, participate in treatment decisions, and the right to refuse treatment.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
7. If the Contractor objects to providing a service on moral or religious grounds, the Contractor must furnish information about the services it does not cover: ◆ To the State. ◆ To member before and during enrollment. ◆ To members within 90 days after adopting the policy with respect to any particular service. *42CFR438.102(b)* *Contract: II.E.1.h.2*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02e & pg 11-12 sec 5-Delegation Subcontracts folder 2. FBHP Provider Network Delegation Policy 2011.doc (entire document) 3. FBHP Member Handbook 101811.pdf (pg 9 under Clinical Guidelines – miscellaneous folder) 4. 310L_NonDiscrimination_SC.doc (entire document – VO folder Standard VII) **Description of Process:** FBHPartners delegates Provider Network functions to ValueOptions. ValueOptions does not deny services on moral or religious grounds. Any discrimination is covered under policy 310L_NonDiscrimination_SC.doc. FBHPartners ensures, through the Member Handbook, that members are aware of this policy.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Non-Discrimination of Member policy stated that VO staff members and providers would not deny a member any covered service based on the grounds of race, color, creed, religion, age, sex, military status, national origin, marital status, sexual orientation, or physical or mental disability. The FBHP Member Handbook stated that FBHP will not deny services based on moral or religious grounds.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
8. The Contractor does not employ or contract with providers excluded for participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act (This requirement also requires a policy). *42CFR438.214(d)* *Contract: II.G.3.e*	**Documents Submitted:** 1. FBHP Policy Excluded Indiv or organizations revised 7_1_11.doc (entire policy) 2. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02c.e; pg 9-10 sec 3,pg 11-12 sec 5- Delegation Subcontracts folder 3. FBHP Provider Network Delegation Policy 2011.doc (entire document) 4. FBHP Credentialing Delegation Policy 2011.doc (entire document) 5. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf (pg 13 – VO Folder Standard VII) 6. COMedicaidAddendum_2011OCT01_PR.pdf (pg 2 – VO Folder Standard VII) 7. N401_PrimarySourceVerif_2011OCT01_PR (pg 4 – VO Folder Standard VII) 8. Provider_SanctionCheck_1.pdf (entire document) 9. Provider_SanctionCheck_2.pdf (entire document) 10. CMHCStaff_SanctionCheck_1.pdf (entire document) 11. CMHCStaff_SanctionCheck_2.pdf (entire document) 12. FBHP CorpCompProgram Final FY 12 (pg 10 Sec #3) **Description of Process:** FBHPartners delegates Provider Network and Credentialing/Recredentialing functions to ValueOptions. ValueOptions and FBHPartners (see FBHP Corporate Compliance Plan) does not employ or contract with providers who are excluded for participation in federal healthcare programs. Through credentialing and re-credentialing procedures, ValueOptions staff conducts the Primary Source Verification (PSV) process where providers are checked for any sanctions in relation to participation	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
	of federal healthcare programs on a monthly basis. Also – on a monthly basis all FBHPartners employees and Board Members are checked for exclusion or disbarment.	
Findings: The FBHP Excluded Individuals or Organizations policy stated that VO, as the delegate for provider network management and credentialing and recredentialing, will query national databases for sanction activities prior to the VO contracting, or FBHP hiring processes. The Primary Source Verification policy stated that VO will query the following databases to ensure that applicants have not been excluded from federal health care participation, or federal procurement or nonprocurement activities: ♦ Office of Inspector General (OIG) ♦ Excluded Parties List System (EPLS) ♦ Office of Foreign Assets Control (OFAC)		
Required Actions: None.		
9. The Contractor may not knowingly have a director, officer, partner, employee, consultant, or owner (owning 5 percent or more of the contractor's equity) who is debarred, suspended, or otherwise excluded from participating in procurement or nonprocurement activities under federal acquisition regulation or Executive Order 12549. *42CFR438.610* *Contract: II.G.6*	**Documents Submitted:** 1. FBHPartners CorpComp Program (pg 10, #3) 2. FBHP Policy Exclusion Federal Procurement Participation revised 7_1_11.doc (entire document) **Description of Process:** FBHPartners has in place a procedure where all principals (defined in the FBHP Policy Exclusion Federal Procurement Participation) must complete, sign, and faithfully complete the two attached forms to the policy and all principals are checked against the HHS Office of Inspector General's "List of Excluded Individuals/Entities" before assuming their responsibilities with FBHPartners and monthly thereafter.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: During the on-site interview, FBHP confirmed that all FBHP board members and FBHP employees were being screened by VO using the above processes.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by BHO**	**Score**
10. If the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. *42CFR438.12(a)(1)* *Contract: II.G.4.b*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02e & pg 11-12 sec 5-Delegation Subcontracts folder 2. FBHP Provider Network Delegation Policy 2011.doc (entire document) 3. CLCCDenyPreApp_Ltr_BHO_2011Jan01_PR.pdf (entire document – VO Folder Standard VII) 4. EmailClarification_HCPF_2011OCT01_PR.pdf (entire document) **Description of Process:** FBHPartners delegations Provider Network functions to ValueOptions. All provider requests to join the network are evaluated by ValueOptions. Should ValueOptions decline to include the provider in the network, then a letter indicating the reason for the decision is sent to the provider. The Department has indicated they do not wish to receive copies of notifications to providers unless there is a complaint or concern expressed directly to the Department (Attached email).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
During the on-site interview, staff members reported that the VO provider relations department, as the FBHP delegate, would perform a pre-credentialing network adequacy assessment of each practitioner application to determine whether the provider contributes to the expertise of the network, the geographic coverage of the network, and is willing to meet Medicaid requirements. If the provider applicant did not meet these criteria, the Local Credentialing Committee would notify the practitioner in writing that there is not an access need in the network. Staff also stated that if there was a problem in the credentialing screening process which resulted in denial of the application, the provider would be notified in writing of that reason as well. The VO Colorado Medicaid Provider Network Assessment and Recruitment Workflow diagram described the process for pre-credentialing assessment following receipt of a provider application. Pre-credentialing assessment consisted of evaluation for network need based on the specialty, cultural experience, language, and location of the applicant compared to existing network area providers. A sample provider notification letter (September 2011) indicated pre-application review by the local credentialing committee and described the reason for denying inclusion in the network.

Required Actions:
None.

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Requirement	**Evidence as Submitted by BHO**	**Score**
11. The Contractor must have administrative and management arrangements or procedures that are designed to guard against fraud and abuse and include: ◆ A mandatory compliance plan approved by the Contractor's CEO and Compliance officer. ◆ Submission of the compliance plan to the Department for review. ◆ Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards. ◆ Provisions for internal monitoring and auditing. ◆ Provision for prompt response to detected offenses and for development of corrective action initiatives. ◆ Effective mechanisms to identify and report suspected instances of Medicaid fraud, waste, and abuse including mechanisms to identify and report suspected instances of upcoding and unbundling of services, identifying services never rendered, and identifying inflated bills for services and/or goods provided. ◆ The designation of a compliance officer and a compliance committee that are accountable to senior management. ◆ Effective training and education for the compliance officer and the Contractor's employees. ◆ Effective lines of communication between the compliance officer and the Contractor's employees ◆ Enforcement of Standards through well-publicized disciplinary guidelines. ◆ Effective processes to screen all provider claims, collectively and individually, for potential fraud	**Documents Submitted:** 1. FBHPartners CorpComp Prog Final FY 12 (bullet 1 entire document; bullet 4 pg 13; bullet 5 pg 12 and pg 14 Sec 7; bullet 6 pg 13 [monitoring systems]; bullet 7 pg 8-9 [program oversight]; bullet 8 pg 10-11; bullet 9 pg 11 [Reporting Mechanisms and Prohibition Against Retaliation]; bullet 10 pg 13 [Disciplinary Systems], pg 14 [Prompt Response]; bullet 12 pg 12-13 [Reporting]) 2. FBHP Policy Detection of Fraud and Abuse final 7_1_11.doc (bullet 3 entire document; bullet 4 pg 2-3 Sec II; bullet 6 pg 2-3 Sec II; bullet 8 pg 1 & 2 Sec I; bullet 9 pg 3 II.E.; bullet 10 pg 1-2 Sec I; bullet 11 pg 2 Sec IIA-C 3. JCMH CAP request DOD 10_4_11.doc (example of procedures for detection of potential fraud and abuse) 4. FBHP Policy Investigation-Reporting Fraud Abuse final 7_1_11.doc (bullet 3, entire document; bullet 5 pg 2, Sec III & IV; bullet 12 reporting pg 2 Sec IV) 5. FBHP Policy Exclusion Federal Procurement Participation revised 7_1_11.doc (bullet 3 & 4 entire document) 6. FBHP Policy Conflict of Interest 7_1_11.doc (bullet 3 & 4 entire document) 7. FBHP Policy Excluded Indiv or organizations revised 7_1_11.doc (bullet 3 & 4 entire document) 8. FBHP Policy Monitoring of Encounter Record Accuracy Final 7_1_11.doc (bullet 3 entire document; bullet 4 pg 1, Sec I, bullet 5 pg 2, bullet 6 pg 1 Sec I and pg 2 Sec III; bullet 11 entire policy) 9. FBHP Policy_Provider_Employee Incentive final 7_1_11 (bullet 3 entire document) 10. Email Marceil Case re: Corp Compl Program Approval.pdf (bullet 2 entire document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by BHO**	**Score**
waste or abuse. • Reporting: o The Contractor immediately reports indications or suspicions of fraud by giving a verbal report to the Contract manager. The Contractor shall then investigate its suspicions and submit its written findings to the contract manager within three business days of the verbal report. If the investigation is not complete within three business days, the Contractor shall continue to investigate and submit a final report within 15 business days (further extension may be approved by the contract manager). o The Contractor reports known, confirmed intentional incidents of fraud and abuse to the contract manager and to the appropriate law enforcement agency, including the Colorado Medicaid Fraud Control Unit. *42CFR438.608* *Contract:II.G.5.d, II.G.5.g–l*	**Description of Process:** FBHPartners has in place a comprehensive Corporate Compliance Program and relevant Policies and Procedures that actively prevents and/or detects possible fraud and abuse, allows for immediate investigation and timely reporting according to required reporting guidelines.	

Findings:
The FBHP Corporate Compliance Program Plan was approved by the FBHP Board of Directors and the FBHP Board of Managers, as evidenced by review of board of managers and board of director meeting minutes for calendar year 2011. FBHP provided e-mail communication regarding Department approval of the Corporate Compliance Plan. The plan described the purpose of the compliance program, which included prevention, detection, and reporting of known or suspected fraud or abuse, or other forms of misconduct, and to promote self-auditing and voluntary disclosure of violations. The plan also included standards of conduct and a description of program oversight by the corporate compliance committee and duties of the corporate compliance officer. Duties of the corporate compliance officer included communication and visibility to encourage employees to report any concerns.

The Corporate Compliance Plan and the Detection of Fraud and Abuse policy stated that FBHP providers, employees, and board members are to be trained annually regarding the plan, receive a copy of the plan, and sign a statement acknowledging receipt of the plan and agreement to become familiar with its

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
requirements. The plan included a hotline telephone number for reporting violations. The Corporate Compliance Plan, as well as the Investigation and Reporting of Fraud and Abuse policy described procedures for reporting suspected fraud, which included: ♦ Immediate verbal reporting to the Department of suspected fraud ♦ An initial written report within 3 business days ♦ A final written report of findings within 15 business days ♦ Reporting confirmed violations to the appropriate legal authorities including the Colorado Medicaid Fraud Control Unit. The Detection of Fraud and Abuse policy described VO's responsibilities, as FBHP's delegate for management of information technology, to conduct automated and manual edits on encounter data to identify inappropriate billing and coding, duplicate encounters, unbundling, or false claims. Additional monitoring described in the plan included: ♦ Annual encounter data audit ♦ Review of UM data for patterns that may indicate waste, abuse, or poor quality of care ♦ Review of member grievances and appeals for content that may indicate unusual practice patterns The plan described enforcement of the compliance program including corrective action or disciplinary action, as appropriate. FBHP provided an example corrective action plan related to the annual audit of encounter data. Review of Compliance Committee meeting minutes demonstrated implementation of FBHP's compliance plan.		
Required Actions: None.		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
12. The Contractor provides that Medicaid members are not held liable for: ◆ The Contractor's debts in the event of the Contractor's insolvency. ◆ Covered services provided to the member for which the State does not pay the Contractor. ◆ Covered services provided to the member for which the State or the Contractor does not pay the health care provider that furnishes the services under a contractual, referral, or other arrangement. ◆ Payments for covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount that the member would owe if the Contractor provided the services directly. *42CFR438.106* *Contract: II.G.11*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02e & pg 11-12 sec 5-Delegation Subcontracts folder 2. FBHP Provider Network Delegation Policy 2011.doc (entire document) 3. Provider Handbook (pg 12 Sec 3 – Miscellaneous Folder) 4. COMedicaidAddendum_2011OCT01_PR.pdf (pg 3 – VO Folder Standard VII) 5. VOStd_PractitionerAgmt_0809_FINAL_20100708.pdf (pg 21 – VO Folder Standard VII) **Description of Process:** FBHPartners delegates Provider Network functions to ValueOptions. ValueOptions' provider agreements and the BHO/ValueOptions Provider Handbook clearly state Members cannot be held liable for payments for covered services or for the BHO's debts.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:
The Compensation Amounts and Responsibility section and the No Balance Billing section of the VO Practitioner Agreement stated that under no circumstances, including non-payment by VO/payor, insolvency of VO/payor, or breech of the Agreement, will the provider seek payment for covered services from the member or member representatives. The agreement specified that VO has the right to take action, such as offsetting provider reimbursement or legal action, for violations. The VO Provider Manual, which is incorporated in full into the VO Practitioner Agreement, stated that Medicaid members are not to be subject to co-payments and that any collection of fees, including fees for non-covered services or missed appointments, from a member may result in provider termination. The FBHP Member Handbook stated that there is to be no charge or co-pay for covered Medicaid services, and instructed members to call FBHP (contact information provided) if they receive a bill for any services.

During the on-site interview, FBHP staff members stated that the FBHP OMFA director would review the content of each grievance and could identify providers who may be billing members inappropriately. VO staff reported that if the provider was a contracted provider, provider relations staff members would contact the provider and remind him or her of the terms of the contract and the need to refund monies to the member.

Required Actions:
None.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
13. The Contractor has a written agreement with each provider. *Contract: II.G.10.a.2*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02e & pg 11-12 sec 5-Delegation Subcontracts folder) 2. FBHP Provider Network Delegation Policy 2011.doc (entire document) 3. COMedicaidAddendum_2011OCT01_PR.pdf (entire document – VO Folder Standard VII) 4. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf (entire document – VO Folder Standard VII) **Description of Process:** FBHPartners delegates Provider Network functions to ValueOptions. All providers are contracted and enter into an agreement with ValueOptions in order to provide services to eligible Medicaid Members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Practitioner Agreement and the Facility Service Agreement template stated that the term of the contract is to be one year with automatic one-year renewals until either party chooses to terminate the contract. The Colorado Medicaid Addendum, incorporated into all practitioner and facility agreements, included additional provisions applicable to the Colorado Medicaid program. FBHP provided signed facility service agreements for Jefferson Center for Mental Health and for Mental Health Partners (previously the Mental Health Center Serving Boulder and Broomfield Counties).		
Required Actions: None.		

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
14. Written provider agreements specify: ◆ The activities to be performed by the provider. ◆ Reporting responsibilities of the provider. ◆ Provisions for revoking the provider agreement or imposing other sanctions if the provider's performance is inadequate. ◆ Provisions for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53 *Contract: II.G.10.a.2,7*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02e & pg 11-12 sec 5-Delegation Subcontracts folder 2. FBHP Provider Network Delegation Policy 2011.doc (entire document) 3. COMedicaidAddendum_2011OCT01_PR.pdf (entire document, pg 2 for the DHHS – VO Folder Standard VII) 4. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf (entire document, pg 6 &19 for the DHHS – VO Folder Standard VII) **Description of Process:** FBHPartners delegates Provider Network functions to ValueOptions. Written provider agreements specify the activities to be performed by the provider, the responsibility of reporting, what may constitute as revocation of the agreement, and the provision of access to records of the DHHS,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Findings:

The VO Practitioner Agreement and the Facility Service Agreement, together with the Colorado Medicaid Addendum to the agreements described:

- The activities to be performed by the provider, including the provision of covered mental health and substance abuse services to members, which are non-discriminatory, within the scope of the practitioner's license, medically necessary, and in accordance with VO policies and procedures. Additional activities included maintenance of medical records, claims filing per requirements, and compliance with quality, utilization, and grievance and appeals procedures.
- Reporting responsibilities, which included any legal actions involving the provider, licensure actions and renewals, loss of privileges, changes in credentialing information, and reporting of data to comply with quality management and other VO policies and procedures.
- The provision for timely access to records by DHHS, OIG, Government Accountability Office (GAO), CMS, or other regulatory agencies or their designees.
- Provisions for termination, including for breach of Agreement, loss of licensure, or for criminal or credentialing issues.
- Actions which may be taken against the provider for failure to carry out provisions of the agreement or cooperate with VO policies and procedures.

The VO Provider Manual, incorporated in its entirety into the provider agreements, also included a description of provider activities, reporting responsibilities, and access to records.

Required Actions:

None.

Standard VII—Provider Participation and Program Integrity		
Requirement	**Evidence as Submitted by BHO**	**Score**
15. The Contractor provides a copy of its claims filing requirements to every participating provider upon acceptance of the provider into the Contractor's network, and to every provider within 15 calendar days after any change in the standard form or requirements. *Contract: II.G.10.c.17*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2 section 2.02e & pg 11-12 sec 5-Delegation Subcontracts folder 2. FBHP Provider Network Delegation Policy 2011.doc (entire document) 3. COMedicaidAddendum_2011OCT01_PR.pdf (pg 4 – VO Folder Standard VII) 4. VOStd_PractitionerAgmt_0809_FINAL 20100708.pdf (pg 5 & 6 – VO Folder Standard VII) 5. Provider Handbook (Section 13, Pg 42-73 – Miscellaneous Folder) **Description of Process:** Providers are given the claims filling requirements as per their contract with ValueOptions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The VO Practitioner Agreement and the Colorado Medicaid Addendum to the Practitioner Agreement stated the requirement for the submission of clean claims (components defined) within a specified time period, and according to the guidelines specified in the provider manual. The agreements stated that compensation would be made by VO in accordance with the Medicaid rate schedule, which was attached. The VO Provider Manual outlined claims filing requirements, including required forms and formats, time frames for filing, required fields, submission methods, detailed instructions for completion of each field on the claim form, coding definitions, claims appeal processes, claims adjustment, and resubmission instructions. During the on-site interview, staff members stated that there had been no changes in claims filing requirements during the audit period.		
Required Actions: None.		

Results for Standard VII—Provider Participation and Program Integrity							
Total	Met	=	15	X	1.00	=	15
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	15	**Total Score**		=	15

Total Score ÷ Total Applicable	=	100%

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. *42CFR438.230(a)(1)* *Contract: II.B.1*	**Documents Submitted:** 1. FBHP Policy Delegation of BHO Respon final 7_1_11.doc (entire policy) 2. FBHP Policy Monitoring of Delegates final 7_1_11.doc (entire policy) 3. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2-3, 3.01 Monitoring and Review; pg 4-5 Article V; pg 13-15 Reports for Monitoring Delegation) 4. FBHP Pre-delegation Site Questions Value Options.doc (set of questions FBHP used to assess VO in 2009) 5. Desk Audit Tool – FBHP 6_14_11.docx (entire document) 6. Delegation Review Summary 2011.docx (entire document) 7. VO Delegation Annual Evaluation FY 11.doc (FY '11 evaluation - entire document) 8. CAP_Delegation_BHO_2011OCT3.docx (entire document; FY '11 VO CAP) 9. CAP VO re: NOA 3-14-11.pdf (entire document – example of CAP request for delegated responsibilities) 10. NOALetter_CAP_FBHP_2011April01_CLN(2).docx (entire document – example of CAP response) 11. CAP request VO12-21-2101.pdf (entire document – example of CAP request for delegated responsibilities) 12. CAP VO 2_7_11.pdf (entire document – example of CAP response) **Description of Process:** The CEO and QAPI Department are responsible for overseeing the delegate. The CEO and Board of Managers are responsible for entering into a delegation contract and the QAPI Department	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
	is responsible for oversight. Oversight includes an annual evaluation of the delegate and their effectiveness in completing requirements of the delegated area and on-going monitoring of the delegate's responsibilities, including requesting a corrective action plan for areas that are deficit.	

Findings:
The FBHP Monitoring of Delegates policy described FBHP's methods of monitoring delegated activities and clearly articulated FBHP's intent to maintain responsibility for the tasks. The Management Services Agreement between FBHP and VO clearly described FBHP's responsibility and methods of oversight and monitoring of VO's performance of delegated functions. FBHP provided several examples of ongoing communication between FBHP and VO demonstrating FBHP's oversight and responsibility for delegated activities. BHO responsibilities to be delegated to VO included:

- Distribution of member materials
- Utilization management including notice to members of authorization decisions and preparation of UM reports for committee review.
- Provider network development and management including credentialing and recredentialing and provider orientation and training and monitoring
- Claims processing
- Data management and reporting

On-site, FBHP staff members confirmed that no tasks would be delegated to the partner CMHCs.

Required Actions:
None.

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
2. Before any delegation, the Contractor evaluates (and documents in writing that it has) the prospective subcontractor's ability to perform the activities to be delegated. *42CFR438.230(b)(1)* *Contract: II.B.2, Exhibit S—II.A*	**Documents Submitted:** 1. FBHP Policy Delegation of BHO Respon final 7_1_11.doc (pg 1-2 Sec I-III) 2. FBHP Pre-delegation Site Questions Value Options.doc (set of questions FBHP used to assess VO in 2009) 3. FBHP BOM Minutes 090922.doc (pg 3 "Pre-delegation site visit) **Description of Process:** FBHP executive staff conducted a site visit and requested specific documentation with ValueOptions to assess their abilities as a delegate for Utilization Management, Provider Network, Credentialing/Recredentialing, Reporting, and Claims Processing. A recommendation was provided to the BOM and the BOM approved.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: The FBHP Delegation of BHO Responsibilities policy described FBHP's process to conduct a predelegation evaluation of a potential delegate. The process to determine that the delegate has demonstrated the capacity and competency to perform that activity included a review of references, reports, equipment, personnel rosters, external evaluations, and a query of the OIG database to verify the delegate's eligibility for federal health care participation. FBHP's list of Pre-delegation Site Visit Questions demonstrated FBHP's process for evaluating ValueOptions (VO) in 2009 prior to entering into a delegation agreement with VO for the performance of UM, claims processing, provider network management, credentialing, and data management and reporting. FBHP Board of Managers meeting minutes for September 22, 2009, demonstrated board review of the predelegation evaluation and approval of delegation to VO.		
Required Actions: None.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
3. The Contractor has written policies and procedures for the monitoring of subcontractor performance, monitors the subcontractor's performance on an ongoing basis, and subjects it to a formal review according to the schedule established by the State. *42CFR438.230(b)(3)* *Contract: II.B.2, Exhibit S—I.A, IV.A*	**Documents Submitted:** 1. FBHP Policy Delegation of BHO Respon final 7_1_11.doc (entire policy) 2. FBHP Policy Monitoring of Delegates final 7_1_11.doc (entire policy) 3. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 2-3, 3.01 Monitoring and Review; pg 4-5 Article V; pg 13-15 Reports for Monitoring Delegation) 4. FBHP Pre-delegation Site Questions Value Options.doc (set of questions FBHP used to assess VO in 2009) 5. Deck Audit Tool – FBHP 6_14_11.docx (entire document) 6. Delegation Review Summary 2011.docx (entire document) 7. VO Delegation Annual Evaluation FY 11.doc (FY '11 evaluation - entire document) 8. CAP_Delegation_BHO_2011OCT3.docx (entire document; FY '11 VO CAP) 9. CAP VO re: NOA 3-14-11.pdf (entire document – example of request for CAP for delegated responsibilities) 10. NOALetter_CAP_FBHP_2011April01_CLN(2).docx (entire document – example of CAP response) 11. CAP request VO12-21-2101.pdf (entire document – example of CAP request for delegated responsibilities) 12. CAP VO 2_7_11.pdf (entire document – example of CAP response) **Description of Process:** The CEO and QAPI Department are responsible for overseeing the delegate. Oversight includes an annual evaluation of the	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
	delegate and their effectiveness in completing requirements of the delegated area and on-going monitoring of the delegate's responsibilities, including requesting a corrective action plan for areas that are deficit.	

Findings:
The FBHP Monitoring of Delegates policy stated that a schedule of ongoing monitoring activities, to occur no less than quarterly, is to be developed with each delegate. The policy also stated that formal review is to consist of a query of the OIG database for status regarding federal health care participation, review of licensure status, review of performance in specific delegated functions, and follow-up on complaints, if applicable. FBHP's delegation agreement with VO specified that FBHP is to engage in ongoing monitoring by:

- Review of reports submitted to FBHP by VO
- Regular meetings between FBHP and VO
- Review of the performance of VO managers and directors responsible for providing services to FBHP

The agreement also specified that FBHP is to engage in formal review by:

- Review or audit of VO records
- Annual on-site visit of VO and a documentation or record review

Exhibit B to the delegation agreement listed the regular reports due to FBHP.

The completed VO Delegation Annual Evaluation and the Delegation Review Summary provided the results for FBHP's annual site visit and formal evaluation of VO's performance of delegated activities. Additional corrective action requests and responses demonstrated ongoing monitoring of VO's performance of delegated activities. During the on-site interview, FBHP staff members stated that reports submitted by VO are to be reviewed by the QI director and the QI committee. Staff also stated that follow-up to CAPs submitted by VO would also be accomplished by the FBHP QI director. Review of QI/UM committee meeting minutes demonstrated review of regular reports submitted by VO, which included a variety of UM reports and member outcomes information. Review of calendar year 2011 board of directors meeting minutes demonstrated board review of VO financial management of the partnership and approval of revisions to the VO management services and delegation agreements. Review of calendar year 2011 board of managers meeting minutes demonstrated review and oversight of the administrative services organization (ASO) tasks performed by VO.

Required Actions:
None.

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
4. The Contractor ensures that work further subcontracted by a subcontractor is monitored by the delegating subcontractor. *Contract: II.B.2, Exhibit S—IV.B*	**Documents Submitted:** 1. FBHP Policy Monitoring of Delegates final 7_1_11.doc (entire policy – stated specifically in policy statement) **Description of Process:** FBHP monitors any work further subcontracted by a delegate similar to our procedures for monitoring the delegate.	☐ Met ☐ Partially Met ☐ Not Met ☒ N/A
Findings: The delegation agreement stated that none of the delegated services are to be assigned or transferred by the contractor without written consent of the other party. The FBHP Monitoring of Delegates policy stated that FBHP is to monitor its delegates' subcontracted activities. During the on-site interview, FBHP staff confirmed that currently, VO has not subcontracted any activities that it is responsible to perform for FBHP.		
Required Actions: None.		
5. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action. *42CFR438.230(b)(4)* *Contract: II.B.2, Exhibit S—IV.C*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (pg 4-5 Article V) 2. FBHP Policy Monitoring of Delegates final 7_1_11.doc (Sec IIB) 3. VO Delegation Annual Evaluation FY 11.doc (FY '11 evaluation - entire document) 4. CAP_Delegation_BHO_2011OCT3.docx (entire document; FY '11 VO CAP) 5. CAP VO re: NOA 3-14-11.pdf (entire document – example of CAP request for delegated responsibilities) 6. NOALetter_CAP_FBHP_2011April01_CLN(2).docx (entire document – example of CAP response) 7. CAP request VO12-21-2101.pdf (entire document- example of CAP request for delegated responsibilities) 8. CAP VO 2_7_11.pdf (entire document – example of CAP response)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
	Description of Process: The FBHP policy on monitoring delegates and the Delegation agreement describe the process for implementing corrective action. Attached are two incidents in which a formal corrective action plan was requested.	
Findings: The FBHP Monitoring of Delegates policy included provisions for submission and review of corrective action plans when needed. The delegation agreement delineated the process of requiring corrective action plans and timelines for submission. FBHP provided evidence of having requested corrective action plans and VO having submitted plans in response to the FBHP request. The corrective actions were in response to the annual audit as well as to issues arising during ongoing monitoring. CAPs were related to encounter data accuracy, the required content of notices of action, and requirements related to credentialing and provider relations.		
Required Actions: None		
6. There is a written agreement with each delegate. *42CFR438.230(b)(2)* *Contract: II.B.2, Exhibit S—III.A*	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (entire document) 2. FBHP&VO.2011 Aug 29_Managment Services Agreement Executed doc.pdf (entire document) **Description of Process:** FBHP has both a Management Services agreement with ValueOptions, covering overall contractual requirements and a delegation agreement specific to any delegated functions. Both are revised and/or updated annually. Attached is the FBHP Management Services Agreement and Delegation Agreement with ValueOptions for FY '12	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
Findings: FBHP provided the signed and executed management services agreement as well as the signed and executed delegation agreement between VO and FBHP.		
Required Actions: None.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
7. The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. ◆ Specifies that the subcontractor shall comply with the standards specified in the Contractor's agreement with the Department. ◆ Requires at least semi-annual reporting of progress and findings to the Contractor. ◆ Describes the process which the Contractor will use to evaluate the subcontractor's performance. ◆ If the subcontractor will perform utilization management, the agreement provides that the compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services (reference 42CFR438.12(e). ◆ Includes a provision that the subcontractor shall maintain complete files of all records, documents, communications, and other materials which pertain to the operation of the subcontract or to the delivery of services under the subcontract sufficient to disclose fully the nature and extent of services/goods provided to each member and to document all activities and services under the agreement. ◆ Includes provisions permitting duly authorized agents of the Department, State and federal government to access the subcontractor's	**Documents Submitted:** 1. Delegation Agreement FBHP & VO_2011 August 29_Executed.doc.pdf (bullet 1 pg 2 Article II and all of Exhibit A pg 8-15; bullet 2 pg 5 sec 5.06; bullet 4 pg Exhibit B pg 13-15; bullet 5 pg 2-3 Article III; bullet 6 pg 4 Sec 4.05; bullet 8 pg 5 Sec 6.01; bullet 9 pg 5 Sec 6.01) 2. FBHP&VO.2011 Aug 29_Managment Services Agreement Executed doc.pdf (bullet 2 pg 6-7 Sec 6.2 e.& f; bullet 3 pg 1-2 Sec 1.1 and 1.2; bullet 7 pg 4; Sec 5.2) **Description of Process:** All elements specified in #7 are included in the FBHP Management Services Agreement with ValueOptions, which includes all overall FBHP & ValueOptions contract elements, or in the FBHP Delegation Agreement with ValueOptions, a subset agreement under the Management Services Agreement.	☐ Met ☒ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
premises during normal business hours to inspect, audit, monitor, or otherwise evaluate the quality, appropriateness, timeliness, or any other aspect of the subcontractor's performance of subcontracted services. ◆ Provides for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. ◆ Requires the subcontractor and any other subrecipients to notify the Department when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000. *42CFR438.230(b)(2)* *Contract: II.B.2, Exhibit S—III.B–M*		
Findings: Between the two agreements between FBHP and VO, each of the required provisions were present except the provision to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.		
Required Actions: FBHP must revise delegation agreements to require reporting of federal expenditures from all sources equal to or in excess of $500,000.		

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
8. The Contractor provides a description of the grievance, appeal and fair hearing procedures, approved by the Department, and time frames to all Subcontractors at the time the subcontractor enters into a contract with the Contractor. The description includes: ◆ The member's right to file grievances and appeals. ◆ The requirements and time frames for filing grievances and appeals. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers that the member can use to file a grievance or an appeal by telephone. ◆ The member's right to a State fair hearing for appeals: • The method to obtain a State fair hearing • The rules that govern representation at the hearing ◆ The fact that, when requested by the member: • Benefits will continue if the member files an appeal or a request for a State fair hearing within the time frames specified for filing. • The member may be required to pay the cost of services furnished while the appeal is pending if the final decision is adverse to the member. *Contract: II.B.2, Exhibit S–V*	**Documents Submitted:** 1. FBHP Policy Delegation of BHO Respon final 7_1_11.doc (pg 2 Sec V) 2. FBHP Policy Griev & Appeal rev 7_1_11 (pg 1 Sec I.F. – Grievance System folder) **Description of Process:** At the time that FBHP enters into a subcontract the Director of the Office of Client and Member Affairs (OMFA) ensures the delegate is familiar with the FBHP Grievance and Appeal Policy and Procedures.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard IX—Subcontracts and Delegation		
Requirement	**Evidence as Submitted by BHO**	**Score**
Findings: As the ASO for FBHP, VO had prepared and distributed the provider manual and the member handbook, both of which included information about the grievance system. Each of the partner CMHC's, as providers, also had access to the provider manual and had worked with and distributed the member handbook. (The specific accuracy of the provider manual content related to grievances and appeals is scored in Standard VI, Requirement 26, and the specific content of the member handbook is scored in Standard V, Requirement 13.)		
Required Actions: None.		

Results for Standard IX—Subcontracts and Delegation							
Total	Met	=	6	X	1.00	=	6
	Partially Met	=	1	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	1	X	NA	=	NA
Total Applicable		=	7	**Total Score**		=	6

Total Score ÷ Total Applicable	=	86%

Appendix B. Appeals Record Review Tool

for Foothills Behavioral Health Partners, LLC

The completed record review tool follows this cover page.

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Foothills Behavioral Health Partners, LLC

Review Period:	January 1, 2011–September 30, 2011
Date of Review:	December 12, 2011–December 13, 2011
Reviewer:	Barbara McConnell, MBA, OTR
Participating BHO Staff Member:	Hazel Bond, MA

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
1	*****	8/5/11	8/8/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	8/18/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
2	*****	7/13/11		M☐ N☐	M☐ N☐ U☐	M☐ N☐ U☐	Y☐ N☐	Y☐ N☐		M☐ N☐	M☐ N☐	M☐ N☐
Comments: The member appealed directly to the State fair hearing. There was no FBHP level appeal.												
3	*****	5/23/11	5/25/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	5/31/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
4	*****	9/27/11	9/28/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	10/11/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
5	*****	5/6/11	5/9/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	5/26/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments: FBHP sent an extension letter on 5/18/11 (8 working days after receipt of the appeal). The required time frames were met.												
6	*****	6/14/11	6/15/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	6/28/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
7	*****	6/21/11	NA	NA	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	6/29/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments: The provider, acting as DCR on behalf of the member, requested an expedited appeal on 6/21/11. FBHP notified the DCR that the request for expedited review was denied on 6/21/11 and mailed a written denial of the request for expedited review on 6/22/11. The decision to deny the expedited process was made by the FBHP OMFA Director and the VO Grievance and Appeals Coordinator. (See Standard VI, Requirement 18, for scoring related to this.)												
8	*****	3/9/11	3/9/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	3/18/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
9	*****	2/24/11	2/28/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☒ N☐	3/22/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments: FBHP mailed an extension letter on 3/10/11.												
10	*****	3/17/11	3/17/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	3/18/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												

Appendix B. Colorado Department of Health Care Policy & Financing
FY 2011–2012 Appeals Record Review Tool
for Foothills Behavioral Health Partners, LLC

1	2	3	4	5	6	7	8	9	10	11	12	13
File #	Member ID	Date Appeal Received	Date of Acknow-ledgment Letter	Acknow-ledgment Within 2 Working Days	Decision-maker—Previous Level	Decision-maker—Clinical Expertise	Expedited	Time Frame Extended	Date Resolution Letter Sent	Resolved in Time Frame (10 W-days or 3 W-days)	Resolution Notice Includes Required Content	Resolution Notice Easily Understood
11	*****	3/7/11	3/7/11	M☒ N☐	M☒ N☐ U☐	M☒ N☐ U☐	Y☐ N☒	Y☐ N☒	3/18/11	M☒ N☐	M☒ N☐	M☒ N☐
Comments:												
	# Applicable Elements			9	10	10				10	10	10
	# Compliant Elements			9	10	10				10	10	10
	Percent Compliant			100%	100%	100%				100%	100%	100%

Note: M = Met, N = Not met, U = Unknown, Y = Yes, N = No

Total # Applicable Elements	**59**
Total # Compliant Elements	**59**
Total Percent Compliant	**100%**

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

Table C-1 lists the participants in the FY 2011–2012 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**
Hazel Bond, MA	Director, Office of Member and Family Affairs
Tom Clay	Chief Executive Officer
Alan Fine, MD	Medical Director
Lucy Hausner	Consumer/Family Advocate, Jefferson Center for Mental Health
Scott Marmulstein	Quality Analyst II
Linda Runyon	Consumer/Family Advocate, Mental Health Partners
Barbara Smith, PhD, MHSA-RN	Director, Quality Improvement
Elizabeth Strammiello	Director, Corporate Compliance
Department Observers	**Title**
Marceil Case (telephonically)	Behavioral Health Specialist
Russ Kennedy	Quality Compliance Specialist
Jerry Ware (telephonically)	Quality Compliance Specialist

Appendix D. Corrective Action Plan Process for FY 2011–2012

for Foothills Behavioral Health Partners, LLC

If applicable, **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 required action, the BHO should identify the planned interventions and complete the attached CAP template. Supporting documents should not be submitted and will not be considered until the CAP has been approved by the Department. Following Department approval, the BHO must submit documents based on the approved timeline.

Table D-1—Corrective Action Plan Process

Step 1	**Corrective action plans are submitted**
	If applicable, the BHO will submit a CAP to HSAG and the Department within 30 calendar days of receipt of the final 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 to HSAG and the Department. The BHO will submit the CAP using the template provided. 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 or HSAG 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 CAP, 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 or HSAG will inform the BHO as to whether: (1) the documentation is sufficient to demonstrate completion of all required actions and compliance with the related contract requirements or (2) the BHO must submit additional documentation. The Department or HSAG will inform each BHO in writing when the documentation substantiating implementation of all Department-approved corrective actions is deemed sufficient to bring the BHO into full compliance with all the applicable federal Medicaid managed care regulations and contract requirements.

The template for the CAP follows.

Table D-2—FY 2011–2012 Corrective Action Plan *for* FBHP		
Standard V—Member Information		
Requirement	**Findings**	**Required Actions**
Requirement 5: The Contractor notifies all members (at least once a year) of their right to request and obtain the required information, upon request [information required at 438.10(f)(6) and 438.10(g)(and (h)].	The Member Information policy stated that the annual member mailing explained members' rights to receive information about their mental health benefits and how to obtain that information. The FBHP Annual Member Letter summarized the type of information available in the FBHP Member Handbook, and provided telephone and Web site contact information for members to obtain a copy of the handbook; however, the letter stated that members had a right to receive information once a year.	FBHP must review and/or revise the annual member letter to clarify the requirement for FBHP to provide annual notice to members of the right to request information at any time and receive it upon request.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* FBHP		
Standard V—Member Information		
Requirement	**Findings**	**Required Actions**

Requirement 13:
 	
The member information materials sent following enrollment also include the following information regarding the grievance, appeal, and fair hearing procedures:
◆ The right to file grievances and appeals.
◆ The requirements and time frames for filing a grievance or appeal (including oral filing).
◆ The right to a State fair hearing:
• The method for obtaining a State fair hearing, and the rules that govern representation at the State fair hearing.
◆ The availability of assistance in the filing process.
◆ The toll-free numbers the member may use to file a grievance or an appeal by phone.
◆ The fact that, when requested by the member:
  • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing, and the service authorization has not expired.
  • The member may be required to pay the cost of services furnished while the appeal or State fair hearing is pending, if the final decision is adverse to the member.
◆ The right that providers may file an appeal on behalf of the member with the member's written consent.
	The member handbook listed the time frame for resolving standard appeals as 10 *calendar* days. During the on-site interview, FBHP staff members confirmed FBHP's policy to decide appeals and notify members within 10 *working* days from the receipt of the appeal.	FBHP must revise the member handbook to accurately state the resolution time frame for standard appeals.

Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* FBHP
Standard V—Member Information
Training Required:
Monitoring and Follow-up Planned:
Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan *for* FBHP		
Standard VI—Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 18: The Contractor ensures that the individuals who make decisions on grievances and appeals are individuals who: ◆ Were not involved in any previous level of review or decision-making. ◆ Have the appropriate clinical expertise in treating the member's condition or disease if deciding any of the following: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues.	The grievances and appeals policy stated that the OMFA director, in coordinating grievance and appeal processing, would ensure that individuals who make decisions on grievance and appeals were not involved in the issue previously and have the necessary clinical expertise to make the decision. Members were informed of the process in the member handbook. While the on-site appeals record review demonstrated that individuals who had made resolution decisions on the appeals reviewed had not been involved in the previous decision and had the requisite clinical expertise to do so, one case reviewed indicated that the individuals who made the decision to deny an expedited review did not have clinical expertise in treating the member's condition.	FBHP must ensure that individuals who make clinical decisions related to grievances and appeals have clinical expertise in treating the member's condition or disease.
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* FBHP		
Standard VI—Grievance System		
Requirement	**Findings**	**Required Actions**
Requirement 26: The Contractor must provide the information about the grievance system specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. The information includes: ◆ The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. ◆ The right to a State fair hearing: • The method for obtaining a State fair hearing. • The rules that govern representation at the State fair hearing. ◆ The availability of assistance in the filing process. ◆ The toll-free numbers the member may use to file a grievance or an appeal by telephone. ◆ The fact that, when requested by the member: • Benefits will continue if the appeal or request for State fair hearing is filed within the time frames specified for filing. • If benefits continue during the appeal or State fair hearing process, the member may be required to pay the cost of services while the appeal or State fair hearing is pending, if the final decision is adverse to the member. ◆ The member's right to have a provider file a grievance or an appeal on behalf of the member, with the member's written consent.	The provider manual included detailed information about the grievance system and FBHP's processes, except to notify the provider that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.	FBHP must ensure that providers are notified that if previously authorized services are continued during the appeal or State fair hearing, the member may have to pay for those services, if the final decision is adverse to the member.
Planned Interventions:		

Table D-2—FY 2011–2012 Corrective Action Plan *for* FBHP
Standard VI—Grievance System
Person(s)/Committee(s) Responsible and Anticipated Completion Date:
Training Required:
Monitoring and Follow-up Planned:
Documents to be Submitted as Evidence of Completion:

Table D-2—FY 2011–2012 Corrective Action Plan *for* FBHP		
Standard IX—Subcontracts and Delegation		
Requirement	**Findings**	**Required Actions**
Requirement 7: 1. The written delegation agreement: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. ◆ Specifies that the subcontractor shall comply with the standards specified in the Contractor's agreement with the Department. ◆ Requires at least semi-annual reporting of progress and findings to the Contractor. ◆ Describes the process which the Contractor will use to evaluate the subcontractor's performance. ◆ If the subcontractor will perform utilization management, the agreement provides that the compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services (reference 42CFR438.12(e). ◆ Includes a provision that the subcontractor shall maintain complete files of all records, documents, communications, and other materials which pertain to the operation of the subcontract or to the delivery of services under the subcontract sufficient to disclose fully the nature and extent of services/goods provided to each member and to document all activities and services under the agreement.	Between the two agreements between FBHP and VO, each of the required provisions were present except the provision to require the subcontractor to report when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.	FBHP must revise delegation agreements to require reporting of federal expenditures from all sources equal to or in excess of $500,000.

Table D-2—FY 2011–2012 Corrective Action Plan *for* FBHP		
Standard IX—Subcontracts and Delegation		
◆ Includes provisions permitting duly authorized agents of the Department, State and federal government to access the subcontractor's premises during normal business hours to inspect, audit, monitor, or otherwise evaluate the quality, appropriateness, timeliness, or any other aspect of the subcontractor's performance of subcontracted services. ◆ Provides for access to all records by the Secretary of the U.S Department of Health and Human Services or any duly authorized representative as specified in 45CFR74.53. ◆ Requires the subcontractor and any other subrecipients to notify the Department when expected or actual expenditures of federal assistance from all sources equal or exceed $500,000.		
Planned Interventions:		
Person(s)/Committee(s) Responsible and Anticipated Completion Date:		
Training Required:		
Monitoring and Follow-up Planned:		
Documents to be Submitted as Evidence of Completion:		

Appendix E. Compliance Monitoring Review 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 to determine the content of the review. ◆ HSAG coordinated with the Department and the BHO to set the dates 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 to discuss the FY 2011–2012 compliance monitoring review process and answer questions as needed. ◆ HSAG assigned staff to the review team. ◆ Prior to the review, HSAG representatives also responded to questions 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 BHOs were prepared for the compliance monitoring review.
Activity 2:	**Obtained Background Information From the Department**
	◆ HSAG used the federal Medicaid managed care regulations (the BBA) and the BHO's Medicaid managed care contract with the Department to develop HSAG's monitoring tool, on-site agenda, record review tool, and report template. ◆ HSAG submitted each of the above documents to the Department for its review and approval. ◆ HSAG submitted questions to the Department regarding State interpretation or implementation of specific managed care regulations or contract requirements. ◆ HSAG considered the Department's responses when determining compliance and analyzing findings.
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 review request via e-mail delivery of the desk review form, the compliance monitoring tool, and an on-site agenda. The desk review request included instructions for organizing and preparing the documents related to the review of the four standards. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and during the on-site document review consisted of the completed desk review form, the compliance monitoring tool with the "evidence as submitted by the BHO" section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ The HSAG review team reviewed all documentation submitted prior to the on-site portion of the review and prepared a request for further documentation and an interview guide to use during the on-site portion of the review.
Activity 4:	**Conducted Interviews**
	◆ During the on-site portion of the review, HSAG met with the BHO's key staff members to obtain a complete picture of the BHO's compliance with contract requirements, explore any issues not fully addressed in the documents, and increase overall understanding of the BHO's performance.
Activity 5:	**Collected Accessory Information**
	◆ During the on-site portion of the review, HSAG collected 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 2011–2012 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 federal Medicaid managed care regulations and associated contract requirements.
Activity 7:	**Reported Results to the Department**
	◆ HSAG completed the FY 2011–2012 Site Review Report. ◆ HSAG submitted the site review report to the BHO and the Department for review and comment. ◆ HSAG incorporated the BHO's and Department's comments, as applicable, and finalized the report. ◆ HSAG distributed the final report to the BHO and the Department.