Colorado Medicaid
Community Mental Health Services Program

FY 2013–2014 Site Review Report

for

Foothills Behavioral Health Partners, LLC

May 2014

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

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CONTENTS

Introduction

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 federal health care regulations and managed care contract requirements. The Department of Health Care Policy and Financing (the Department) has elected to complete this requirement for Colorado's behavioral health organizations (BHOs) by contracting with an external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG).

This report documents results of the FY 2013–2014 site review activities for the review period of January 1, 2013, through December 31, 2013. This section contains summaries of the findings as evidence of compliance, strengths, findings resulting in opportunities for improvement, and required actions for each of the two standard areas reviewed this year. Section 2 contains graphical representation of results for all 10 standards across two, three-year cycles, as well as trending of required actions. Section 3 describes the background and methodology used for the 2013–2014 compliance monitoring site review. Section 4 describes follow-up on the corrective actions required as a result of the 2012–2013 site review activities. Appendix A contains the compliance monitoring tool for the review of the standards. Appendix B contains details of the findings for the denials record reviews. Appendix C lists HSAG, BHO, and Department personnel who participated in some way in the site review process. Appendix D describes the corrective action plan process the BHO will be required to complete for FY 2013–2014 and the required template for doing so.

Summary of Results

Based on conclusions drawn from the review activities, HSAG assigned each requirement in the compliance monitoring tool a score of *Met*, *Partially Met*, *Not Met*, or *Not Applicable*. HSAG assigned required actions to any requirement within the compliance monitoring tool receiving a score of *Partially Met* or *Not Met*. HSAG also identified opportunities for improvement with associated recommendations for some elements, regardless of the score. Recommendations for requirements scored as *Met* did not represent noncompliance with contract requirements or federal health care regulations.

Table 1-1 presents the scores for **Foothills Behavioral Health Partners, LLC** (**FBHP**) for each of the standards. Findings for requirements receiving a score of *Met* are summarized in this section. Details of the findings for each requirement receiving a score of *Partially Met* or *Not Met* follow in Appendix A—Compliance Monitoring Tool.

Table 1-1—Summary of Scores for the Standards

Standard	# of Elements	# of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
I Coverage and Authorization of Services	31	31	31	0	0	0	100%
II Access and Availability	15	15	15	0	0	0	100%
Totals	**46**	**46**	**46**	**0**	**0**	**0**	**100%**

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

Table 1-2—Summary of Scores for the Record Reviews

Description of Record Review	# of Elements	# of Applicable Elements	# *Met*	# *Not Met*	# *Not Applicable*	Score (% of *Met* Elements)
Denials	150	97	97	0	53	100%
Totals	**150**	**97**	**97**	**0**	**53**	**100%**

Standard I—Coverage and Authorization of Services

Summary of Findings as Evidence of Compliance

FBHP delegated utilization management (UM) functions to ValueOptions (VO). As the delegate, VO performed the daily UM functions such as utilization review (UR) of requests for services, communications with requesting providers, and notifications of authorizations and denials. The **FBHP** program was comprehensive and included all of the required elements to ensure the appropriate utilization of services. **FBHP** submitted numerous utilization data reports. On-site, **FBHP** and VO staff members reported that these reports (e.g., average length of stay, daily census, and readmissions) were reviewed by **FBHP** staff, VO staff, and community mental health center (CMHC) staff to provide information used in daily UM rounds meetings, for detecting over- and underutilization, for trending discussions in the UM and quality committee meetings, and to develop studies and quality initiatives.

VO UM staff members used well-defined level of care (LOC) guidelines to make UR decisions. LOC guidelines were developed at the national VO level with approval and/or modification by the Colorado VO/**FBHP** UM committee. **FBHP** provided documentation of extensive methods for ensuring the consistency of UR decisions. Methods included a robust training package for clinical

care managers (CCMs), periodic case audits, annual interrater reliability testing with corrective action as needed, and a daily rounds process. **FBHP** used periodic medical records audits to evaluate completeness of medical record-keeping and appropriateness of treatment planning. **FBHP** performed audits on the independent provider network (IPN), and the CMHCs performed the CMHC medical record audits.

Denial record reviews demonstrated that authorization requests were consistently processed within required time frames. VO processed all inpatient authorizations as expedited requests. The CCM verbally communicated real-time with the requesting provider to obtain applicable clinical information and communicate the authorization decision. Denial record review results documented the following:

- All cases reviewed were new requests for services, 11 of 15 records reviewed were expedited requests, 4 of 15 records were for standard authorizations, none of the cases included an extension of the decision time frame, and none of the cases were denied due to lack of information.
- All of the denials were compliant with all required criteria, including determination within required time frames, notice of action (NOA) sent to member and provider, determination based on criteria, decision made by qualified clinician, and NOA included required content.

All UM authorization reviews were documented in the Care Connect system, which was demonstrated during the on-site review. The system allowed for documentation of the essential elements of the UM process, including date-stamped receipt of the authorization request and decision, type of authorization, communications with providers, decision outcomes, and detailed clinical and reviewer notes. Staff members described that Provider Connect, a Web-based application, allowed providers to enter authorization requests, look up authorization letters, ask questions about eligibility, and access online customer service.

Policies and member and provider communications defined emergency and post-authorization services as specified in requirements. The Emergency and Poststabilization policy stated that **FBHP** would cover emergency and poststabilization services provided by contracted or non-contracted providers without prior authorization. Claims review procedures supported that emergency services for a covered diagnosis were paid in all cases. If VO determined upon retrospective review that emergency care was for a non-covered diagnosis, the NOA would inform the member that he or she was not financially responsible and inform the member and provider of alternative sources for Medicaid coverage. The NOA template included this information. The policy stated that poststabilization services ended when the member was discharged from the emergency room to another LOC. Policies described the circumstances in which **FBHP** was financially responsible for poststabilization services, as defined in the requirements.

Summary of Strengths

FBHP's NOAs were based on templates to ensure inclusion of all required information; however, they were also customized to included member-specific information. During the on-site interview, **FBHP** and VO staff stated that the clinical manager reviewed all NOAs for accuracy and clarity prior to sending. NOAs also included additional information when needed, which was beyond the requirements, but often provided information to increase clarity or refer the member to where additional information could be obtained. Examples included referring the member to the **FBHP** Web site for LOC guidelines, recommending a more appropriate LOC, and providing an affirmative statement that the member would not be responsible for any payment of the denied services.

VO provides 24-hour availability for authorization decisions when clinically necessary such as emergency inpatient decisions. The rounds meeting process is used (up to daily when necessary) for discussing cases to ensure appropriateness of care. Situations that may trigger discussions in daily rounds are anticipated denials, recidivism, medical management questions, longer-than-expected lengths of stay, and system issues such as lack of hospital engagement.

VO had an effective system of ensuring that a professional with the appropriate level of expertise made the authorization or denial decision. Peer advisors were used to consult with the CCMs, and then the case would be referred to the medical director or designee for a final decision if a denial decision was anticipated. VO's process also included detailed procedures on how to request additional records and how to offer a peer-to-peer reconsideration process, when needed.

Summary of Findings Resulting in Opportunities for Improvement

While it was evident that VO staff took the extra step to customize NOAs and consider readability, two letters were potentially over the sixth-grade reading level because they contained clinical language that was not thoroughly explained. VO may want to review processes to further explain clinical language that must appear in NOA letters.

Summary of Required Actions

There were no required actions for this standard.

Standard II—Access and Availability

Summary of Findings as Evidence of Compliance

FBHP delegated provider network development and provider relations activities to VO. VO provided administrative and delegated services to three BHOs in Colorado and conducted data analysis of network sufficiency. VO developed most network plans across the three combined BHO regions, with analysis and reporting of providers according to county so that outreach and recruitment planning was county-based. The provider handbook required providers to maintain coverage 24 hours a day, 7 days a week, and communicated all appointment response time requirements. The Measurement of Access and Availability policy addressed monitoring of access standards, as well as giving feedback to providers and taking corrective action as necessary. **FBHP** submitted evidence of provider monitoring to ensure compliance with access standards, and evidence of recruitment efforts to ensure network sufficiency.

Single case agreements (SCAs) were used to provide out-of-network services, when needed. **FBHP** submitted numerous reports, including comprehensive quarterly network adequacy reports and the Annual Needs Assessment that demonstrated periodic evaluation of provider network sufficiency. Network adequacy reports stated that providers included mental health centers, independent practitioners, essential community providers, and licensed independent practitioners. The reports included an adequate statewide distribution of providers. In addition, staff reported that VO had added contracts to expand the network, with particular attention to including nurses with prescriptive authority and growing intensive in-home services as an alternative to out-of home care such as hospitalization and residential treatment.

The Network Development Plan (statewide information) identified the following priority provider recruiting criteria: providers practicing in a primary care integrated model; out-of-state psychiatrists; providers with special language or cultural expertise; providers in rural/frontier areas; providers who have a specific clinical specialty; and providers who have 10 or more SCAs. VO tracked increases in the number of BHO members by State benefit categories, increases in the number of members served, and penetration rates. VO staff members stated that psychiatrists, practitioners who have experience working with the child welfare system, and essential community providers are considered statewide recruitment priorities. Staff members also stated that VO and **FBHP** monitor utilization; and when significant changes in utilization are detected, they initiate studies to determine the cause.

Policies and procedures outlined processes for provision of second opinions and out-of-network services at no cost to the member. The Office of Member and Family Affairs (OMFA) processed and tracked these requests, assisting members in obtaining referrals or in understanding the authorization process, if needed. SCAs were used to contract with out-of-network providers or to meet unique treatment or cultural needs of members.

The **FBHP** Cultural Competency Plan described outlined program goals, which described cultural assessment of **FBHP** operations and staff members, and cultural competency training. The plan described community-based activities to gain insight into the cultural needs of the **FBHP** region and

identify training needs of **FBHP** staff to appropriately respond to the needs of the community. Numerous policies and procedures addressed methods of delivering services to meet members' diverse linguistic needs. VO provided cultural competency education for staff and providers via Webinars and PowerPoint presentations available on the Web site. Providers' linguistic expertise was included in the provider directory and used by staff to refer members to appropriate providers. During the on-site interview, **FBHP** staff members explained that the CMHCs use bilingual front desk staff and bilingual treatment staff to provide services in the members' preferred language. Certified translators and the language line are also used when needed.

Summary of Strengths

FBHP integrated provider monitoring and resulting access data into the Quality Improvement work plan with ongoing tracking and interventions. VO had a Web-based authorization system providers could use to independently enter information and receive authorizations immediately, which significantly decreased the amount of time between the request and the member accessing services for routine care. Provider training was robust and frequent (at least quarterly) via in-person presentations, Webinars, and availability on the Web site, VO staff tracked provider participation.

Summary of Findings Resulting in Opportunities for Improvement

Considering the changing demographics and cultural needs of the BHO population resulting from Medicaid expansion, **FBHP** may want to consider updating the cultural competency plan and integrate revisions into provider network development plans.

Summary of Required Actions

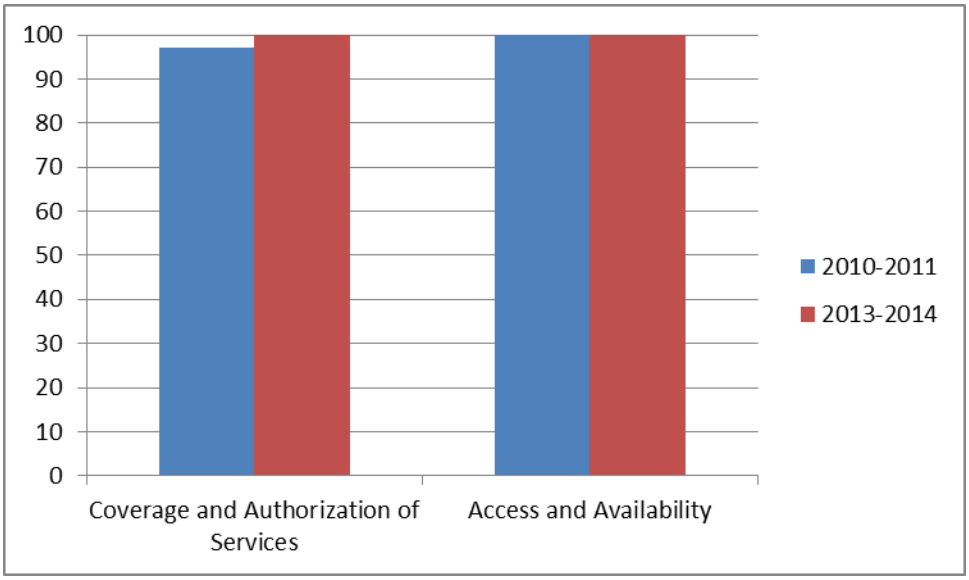
There were no required actions for this standard.

Comparison of Results

Comparison of FY 2010–2011 Results to FY 2013–2014 Results

Figure 2-1 shows the scores from the FY 2010–2011 site review, when Standard I and Standard II were previously reviewed, compared with the results from this year's review. The results show the overall percent of compliance with each standard. Although the federal language did not change with regard to requirements, **FBHP**'s contract with the State may have changed, and may have contributed to performance changes.

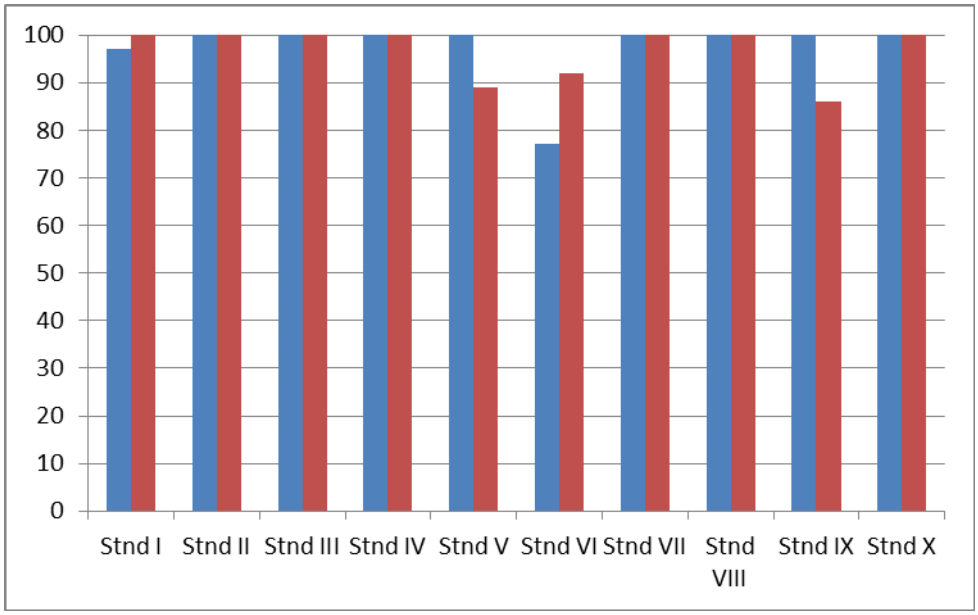
Figure 2-1—Comparison of FY 2010–2011 Results to FY 2013–2014 Results



Review of Compliance Scores for All Standards

Figure 2-2 shows the scores for all standards reviewed over the last two, three-year cycles of compliance monitoring. The figure compares the score for each standard across two review periods and may be an indicator of overall improvement.

Figure 2-2—FBHP's Compliance Scores for All Standards



Note: The older results are shown in blue. The most recent review results are shown in red.

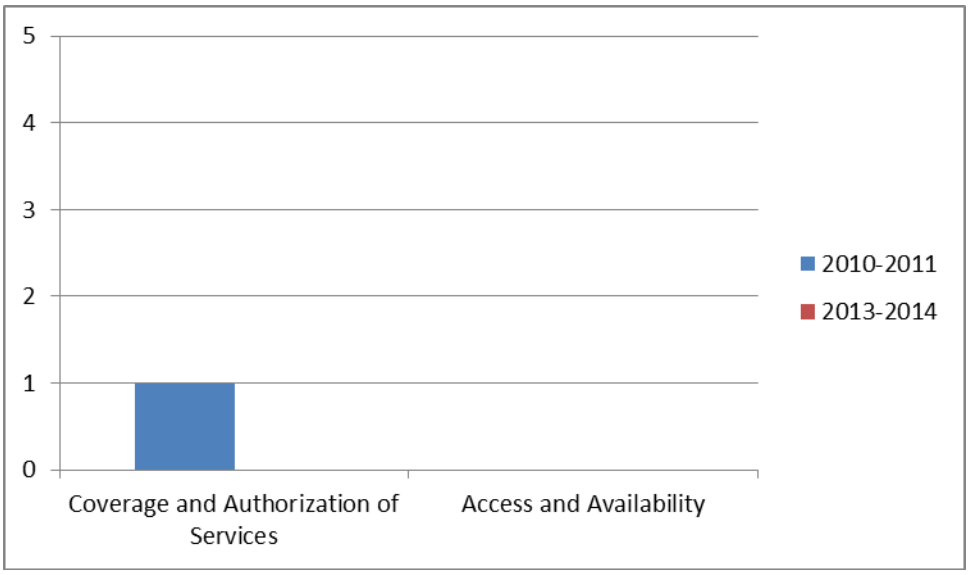
Table 2-1 presents the list of standards by review year.

Table 2-1—List of Standards by Review Year						
Standard	**2008–09**	**2009–10**	**2010–11**	**2011–12**	**2012–13**	**2013–14**
I—Coverage and Authorization of Services			X			X
II—Access and Availability			X			X
III—Coordination and Continuity of Care			X		X	
IV—Member Rights and Protections		X			X	
V—Member Information	X			X		
VI—Grievance System		X		X		
VII—Provider Participation and Program Integrity		X		X		
VIII—Credentialing and Recredentialing		X			X	
IX—Subcontracts and Delegation		X		X		
X—Quality Assessment and Performance Improvement		X			X	

Trending the Number of Required Actions

Figure 2-3 shows the number of requirements with required actions from the FY 2010–2011 site review, when Standard I and Standard II were previously reviewed, compared to the results from this year's review. Although the federal requirements did not change for the standards, **FBHP**'s contract with the State may have changed, and may have contributed to performance changes.

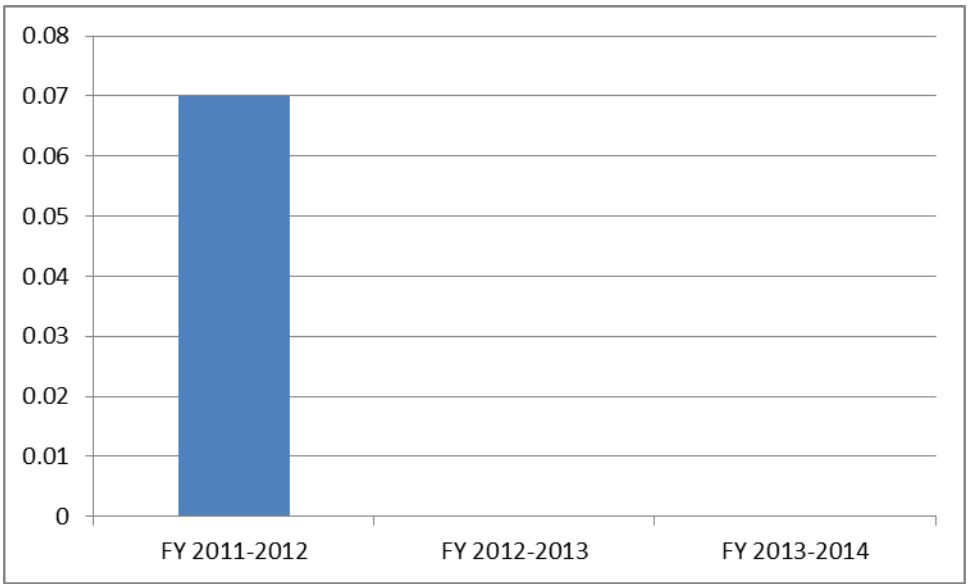
Figure 2-3—Number of FY 2010–2011 and FY 2013–2014 Required Actions per Standard



Note: **FBHP** did not have any required actions for Access and Availability in FY 2010–2011.
FBHP did not have any required actions for either standard in FY 2013–2014.

Figure 2-4 shows the percentage of requirements that resulted in required actions over the past three-year cycle of compliance monitoring. Each year represents the results for review of different standards.

Figure 2-4—Percentage of Required Actions—All Standards Reviewed



Note: **FBHP** did not have any required actions for FY 2012–2013 or FY 2013–2014.

Overview of FY 2013–2014 Compliance Monitoring Activities

For the fiscal year (FY) 2013–2014 site review process, the Department requested a review of two areas of performance. HSAG developed a review strategy and monitoring tools consisting of two standards for reviewing the performance areas chosen. The standards chosen were Standard I—Coverage and Authorization of Services and Standard II—Access and Availability. Compliance with federal managed care regulations and managed care contract requirements was evaluated through review of the two standards.

Compliance Monitoring Site Review Methodology

In developing the data collection tools and in reviewing documentation related to the two 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 records, documents, and materials provided on-site; and on-site interviews of key BHO personnel to determine compliance with federal managed care regulations and contract requirements. Documents submitted for the desk review and on-site review consisted of policies and procedures, staff training materials, reports, minutes of key committee meetings, member and provider informational materials, and administrative records related to BHO service and claims denials. In addition, HSAG conducted a high-level review of the BHO's authorization processes through a demonstration of the BHO's electronic system used to document and process requests for BHO services.

A sample of the BHO's administrative records related to Medicaid service and claims denials was also reviewed to evaluate implementation of Medicaid managed care regulations related to member denials and notices of action. Reviewers used standardized monitoring tools to review records and document findings. HSAG used a sample of 15 records with an oversample of 5 records. Using a random sampling technique, HSAG selected the samples from all applicable BHO Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. For the record review, the BHO received a score of *C* (compliant), *NC* (not compliant), or *NA* (not applicable) for each of the required elements. Results of record reviews were considered in the scoring of applicable requirements in Standard I—Coverage and Authorization of Services. HSAG also separately calculated an overall record review score.

The site review processes were consistent with *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Appendix E contains a detailed description of HSAG's site review activities consistent with those outlined in the CMS final protocol. The two standards chosen for the FY 2013–2014 site reviews represent a portion of the Medicaid managed care requirements. These standards will be reviewed in subsequent years: Standard III—Coordination and Continuity of Care, Standard IV—Member Rights and Protections, Standard V—Member Information, Standard VI—Grievance System, Standard VII—Provider Participation and Program Integrity, Standard VIII—

Credentialing and Recredentialing, Standard IX—Subcontracts and Delegation, and Standard X—Quality Assessment and Performance Improvement.

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 health care regulations and managed care contract requirements in the two 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 recommended to improve the quality of the BHO's services related to the standard areas reviewed.

4. Follow-up on Prior Year's Corrective Action Plan

for **Foothills Behavioral Health Partners, LLC**

FY 2012–2013 Corrective Action Methodology

As a follow-up to the FY 2012–2013 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 it successfully completed each of the required actions. HSAG and the Department continued to work with **FBHP** until it completed each of the required actions from the FY 2012–2013 compliance monitoring site review.

Summary of 2012–2013 Required Actions

For the four standards reviewed by HSAG (Coordination and Continuity of Care, Member Rights and Protections, Credentialing and Recredentialing, and Quality Assessment and Performance Improvement), **FBHP** earned an overall compliance score of 100 percent. **FBHP** had no required actions as a result of the FY 2012–2013 site review.

Summary of Corrective Action/Document Review

FBHP had no required actions as a result of the FY 2012–2013 site review.

Summary of Continued Required Actions

FBHP had no required actions as a result of the FY 2012–2013 site review.

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

The completed compliance monitoring tool follows this cover page.

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
1. The Contractor established and maintains a comprehensive Utilization Management (UM) Program to monitor the access to, use, consumption, levels and intensity of care, outcomes of, and appropriate utilization of covered services. The Contractor evaluates the medical necessity, appropriateness, efficacy, efficiency of health care services, referrals, procedures, and settings. The Contractor's Utilization Management Policies and Procedures include: ◆ Prior authorization for identified intensive levels of care. ◆ Description of activities undertaken to specifically identify and address underutilization. ◆ Routine trending and analysis of data by level of care (including care not prior-authorized). ◆ Routine trending of services by provider. Contract: II.I.1.a., II.I.1.s, Exhibit V, IV.A and IV.B	**Documents Submitted/Location within Documents:** 1. FBHP Delegation Agreement_FY 14_executed—see pg. 2 Article 2.02 & pg. 8 Exhibit A #1 2. FBHP Amendment to Delegation Agmt 2014 (executed) – entire document 3. FBHP Policy D3 Delegation Utilization Management-Entire Document 4. C101 Utilization Management Program Description Policy_3BHO– Entire policy 5. C101A Utilization Management Program Description Outline_3BHO– Entire policy 6. C102 Quality Management_Utilization Management Work Plans_3BHO– Entire policy 7. 202L Medical Necessity_3BHO– – Entire policy 8. IP Benefit Limit_3BHO- entire document 9. IP_Readmit_3BHO-Entire document 10. Weekly Inpatient Census_2014-01-13-03-47-18_FBHP-Entire document 11. DailyCensus_2013-0307_3BHO-Entire document 12. 2013-01Census Summary_FBHP -Entire document 13. Performance Measures FY 2012 2013_3BHO-Entire document 14. HLOC DecisionSummary_Nov2013_FBHP-Entire document 15. FY13 UM PLAN-goals-final_FBHP-Entire Document 16. Annual UM Evaluation FY13 110_FY13 UM PLAN-goals-final_FBHP-Entire Document 17. FBHP UM Program Description_final-entire document 18. 206LDataCollectionContinuedAuthHLOC_ 3BHO-entire document 19. 204LIntakeDataCollectInitialAuthHLOC_3BHO-entire	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	document 20. FBHP MHC Compliance checklist 2013 (see in Standard II folder) 21. AccessToCare_HCPF_FINAL_Report_Q1FY14_2013Oct 30_FBHP-Entire Document (see in Standard II folder) 22. SCA report-3BHO 23. FBHP QI Program Evaluation FY 13 revised (see in Standard II folder) pg 8-12 is the evaluation of the MHSIP, YSS, YSS-F 24. IP ALOS by Provider-3BHO **Description of Process:** ValueOptions® is the FBHP delegate for all utilization management functions (document1, 2, & 3). The program is under the oversight of Dr. Alan Fine, FBHP's Medical Director, and UM activities are reported through the BHO's Quality Improvement and Utilization Management Committee (FBHP UM Program Description_final and FY13 UM PLAN-goals-final_FBHP-Entire Document; documents18 and 16). ValueOptions policies and procedures describing our comprehensive Program can be found : • C101 Utilization Management Program Description Policy_3BHO (Document 4) • C101A UM Program Description Outline_3BHO – Entire policy (Document 5) • C102 Quality Management_Utilization Management Work Plans_3BHOs –(Document 6) Additionally, the UM program operates under the BHO's comprehensive medical necessity policy (Policy 202L; document 7). This keystone document provides the operational definition of	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	medical necessity used by the BHO. It is FBHP's policy to monitor the appropriateness of care for FBHP members by formally reviewing their documentation of care, as well (Medical Record Audit Report FY '13_final, entire document, see Standard II folder) **Prior authorization for identified intensive levels of care:** Through the authorization process, medical necessity and appropriateness of referrals are evaluated during the initial authorization process. During requests for continued authorization, Care Managers take clinical information which helps them make decisions on medical necessity and determine whether the services provided are effective for the member as they review the treatment plan and member's progress towards discharge goals. Preauthorization is required for higher levels of care, including 23 hour observation, inpatient, ATU, partial hospitalization, day treatment and residential services require prior authorization. The authorization process for initial and concurrent reviews are outlined in the following documents: • 204LIntakeDataCollectInitialAuthHLOC_3BHO (Document 19) • 206LDataCollectionContinuedAuthHLOC_ 3BHO (Document 18). • On a more granular level, treatment progress and the efficacy of treatment are monitored through the concurrent review and authorization processes by the ValueOptions care management team .See (FBHP UM Program Description_final (Document 17) **Description of activities undertaken to specifically identify and address underutilization:**	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Under-utilization is monitored on an aggregate basis by looking at the service penetration rate and comparing it to that of the other BHOs in the state. Under-utilization also may be indirectly reflected by performance measures such as inpatient readmission rates or ambulatory follow-up rates (Performance Measures, document 13). An annual evaluation of the UM program is provided to the FBHP's QI-UM Committee (Annual UM Evaluation FY13 110_FY13 UM PLAN-goals-final_FBHP-Document 16). **Routine trending and analysis of data by level of care (including care not prior-authorized).** FBHP routinely reviews the utilization of services through ValueOptions's monthly and quarterly reports and UM dashboard data: • .DailyCensus_2013-0307_3BHO-Entire Document (Document 11) • Weekly Inpatient Census_2014-01-13-03-47-18_FBHP (Document 10) • 2013-01Census Summary_FBHP -Entire document Authorization decisions, including denials and appeals are monitored on a regular basis (HLOC DecisionSummary_Nov_2013_FBHP-Entire Document document 14) A variety of policies and reports as well as satisfaction surveys provide evidence of the monitoring and evaluation of health care services, access to care, procedures and settings Additionally, each facility is required, per NCQA, to have an accreditation or undergo a facility site visit upon credentialing and recredentialing. The on-site reviewer uses the facility site visit tool. (FBHP MHC Compliance checklist 2013 (see in Standard II folder) in order to	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	measure contract compliance. Many other reports are used to evaluate and monitor provision of appropriate services to FBHP members: • **Access:** • AccessToCare_HCPF_FINAL_Report_Q1FY14_2013Oct 30_FBHP (Document 21) • Efficiency of Call Center operations indicate members can easily reach us for referrals and call center performance is monitored through various telephone statistics and the timeliness of authorization decisions Timely authorization decisions also contribute to ease of access for FBHP members as providers are able to proceed with treatment without undue delay (Document 16) • SCA report-3BHO (Document 22) allows for monitoring of services provided out of network by type of service, area and provider. **Procedures and Settings**: (appropriateness of care) • FBHP MHC Compliance checklist 2013 `(Document 20) • FBHP QI Program Evaluation FY 13 revised (Document 23 pg 8-12 is the evaluation of the MHSIP, YSS, YSS-F) • IP ALOS by Provider-3BHO (Document 24) • IP_Readmit_3BHO-(Document 9) These and similar reports are reviewed and evaluated through Quality and Utilization Management Committees. These documents provide trending by levels of care and by provider. They help FBHP monitor use and consumption and levels of care accessed by FBHP members. One indication of outcomes is seen in ValueOptions review of members who	

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	readmit to inpatient levels of care. (Document 9) The quality and appropriateness of services is monitored on an aggregate basis through key performance indicators, including inpatient discharges per 1,000 members, average length of inpatient stay, and ambulatory follow-up after inpatient discharge (see Performance Measures, document 13). Also, service outliers are reported and investigated to identify any common themes that might represent systemic problems in service quality or access (e.g., IP Benefit Limit_3BHO, document 8). **Additional Documents Submitted On-site:** • Jefferson Center for Mental Health—Clinical Peer Review Checklist • Mental Health Partners—General Chart Audit template	
2. The Contractor's Utilization Management Program Description is written so that staff members can understand the program and includes: ◆ Program goals. ◆ Program structure, scope, processes, and information sources, including the identification of all intensive levels of care. ◆ Roles and responsibilities. ◆ Evidence of Medical Director leadership in key aspects of the UM Program to include denial decisions and criteria development. ◆ A description of how oversight of any delegated UM function will occur. ◆ A description of how staff making utilization review decisions are supervised. ◆ A statement regarding staff availability at least eight hours a day during normal business hours for	**Documents Submitted/Location within Documents:** 1. FBHP Policy D2 Monitoring of Delegates 2. FBHP UM Program Description_final 3. FY13 UM PLAN-goals-final_FBHP-Entire document 4. Annual UM Evaluation FY13 110_FY13 UM PLAN-goals-final_FBHP-Entire document 5. 202L Medical Necessity_3BHO-entire policy 6. 223LTreatmentPlanning_Policy_3BHO – Entire policy 7. 236LClinicalLOCGuidelines_Policy_3BHO- entire policy 8. LOC Guideline 3 BHO_23-Hour_Observation- Entire document 9. LOC Guideline 3 BHO_Acute Inpatient Treatment- Entire document 10. LOC Guideline 3BHO_Acute_Treatment_Unit_Services-Entire document 11. LOC Guideline	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
inbound calls regarding UM issues. ◆ The mechanisms used to ensure that members receive equitable access to care and services across the network. ◆ The mechanisms used to ensure that the services authorized are sufficient in amount, duration, or scope to reasonably be expected to achieve the purposes for which the services are furnished. *42CFR438.210(a)(3)(i)* Contract: II.I.1.s, Exhibit V, I.A	3BHO_Adult_Residential_Treatment_Services- Entire document 12. LOC Guideline 3 BHO_Advocacy_Svcs- Entire document 13. LOC Guideline 3 BHO_alternative outpatient services- Entire document 14. LOC Guideline 3 BHO_Alternative_Family_Care- Entire document 15. LOC Guideline 3 BHO_Case_Management_Services- Entire document 16. LOC Guideline 3BHO_Child_Adol_Day_Treatment_Services- Entire document 17. LOC Guideline 3 BHO_Community_Support_Programs- Entire document 18. LOC Guideline 3BHO_Consumer_Operated_Services_Adult- Entire document 19. LOC Guideline 3BHO_Intensive_Outpatient_Programs_Adult- Entire document 20. LOC Guideline 3BHO_IOP_ChildAdol_Sex_Disorder_TX- Entire document 21. LOC Guideline 3BHO_Outpatient_Crisis_Intervention_Services- Entire document 22. LOC Guideline 3 BHO_Outpatient_Services- Entire document 23. LOC Guideline 3BHO_Parameters_for_Treating_Children_Under_5- Entire document 24. LOC Guideline 3 BHO_Partial_Hospitalization- Entire	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	document 25. LOC Guideline 3 BHO_Peer_Support_Services- Entire document 26. LOC Guideline 3 BHO_Psychological-Neuropsychological_Testing- Entire document 27. LOC Guideline 3BHO_Residential_Treatment_Children-Adolescents- Entire document 28. LOC Guideline 3 BHO_Respite_Care_Services- Entire document 29. LOC Guideline 3 BHO_Wrap_Around_Services- Entire document 30. Exhibit D_Covered Mental Health Diagnoses_3BHO-entire document 31. 420LContin24HrCMPhoneCoverage_Policy_3BHO-Entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). The FBHP Program Description, FBHP UM Program Description_final (Document 2) summarizes processes and policies utilized to ensure appropriate services are authorized to help members achieve positive outcomes. The Program Description is made up of 3 trilogy documents - the overall description of the program, FBHP UM Program Description_final, (Document 2) the work plan, FY13 UM PLAN-goals-final_FBHP, (Document 3) and the annual program evaluation (.Annual UM Evaluation FY13 110_FY13 UM PLAN-goals-final_FBHP. (Document 4) The Program goals are referenced in Section XI, p. 32, of the Program Description and detailed in FY13 UM PLAN-goals-final_FBHP – entire document. Multiple policies and avenues exist for ValueOptions® (VO) to ensure that services provided	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	to FBHP's members are reasonably expected to achieve their outcome. These policies are: 202L Medical Necessity_3BHO-entire policy 223L TreatmentPlanning_Policy_3BHO – Entire policy 236LClinicalLOCGuidelines_Policy_3BHO- entire policy In addition to following policy and procedures, VO staff reference the Level of Care Guidelines (Documents 8-29) for all levels of care to determine clear admission, continued stay and discharge criteria for use in case reviews. Matching member clinical details with the admission criteria for each LOC is the first step in insuring that members can achieve their outcomes while in treatment. Continued review focuses on the ongoing criteria for the level of care, which provides regular oversight of the service effectiveness. The guidelines are used to insure that services are appropriate for each member's situation and the services are reasonably expected to achieve the outcome for which the service is furnished. ValueOptions®' clinical staff reviews guidelines, formally, at least annually. FBHP UM Program Description_final provides information about each of the required elements: ◆ Program structure and scope, including roles and responsibilities and oversight of the program can be located in Section III and IV, pp. 6-25 ◆ UM processes are described in detail in SectionIV- B-P, pp. 6-24, information sources can be found in Section III, C, 4 p. 10 and IV, F, pp. 15-16. Identification of all intensive levels of care in can be found in service delivery	

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	descriptions (Section III, 5, p. 10 and IV, G, p. 16). ◆ Staff roles, including supervisory structure, are outlined in Section III, 3, pp. 8-9. ◆ Oversight of delegated functions is described in Section III, A-C, pp. 6-7 ◆ Medical Director leadership in key areas can be found in Section III. A-C, p.6-8; Section IV.E-3rd item; Section IV. G., p. 18, first paragraph. ◆ UM staff and FBHP's Medical Director or designee is available 24 hours per day, 7 days per week through our toll free access to care/clinical referral line (Section IV.A.p. 11) , and management staff (Clinical Peer Advisor, Clinical Director) are available to first level review staff on a 24/7 basis as well (Section VI third paragraph., p. 29) 24/7 availability of staff is also noted in 420LContin24HrCMPhoneCoverage_Policy_3BHO ◆ Member access to care monitoring is described in the executive summary, p. 1, last paragraph and p. 2, first paragraph. The clinical philosophy (pp. 4-5) also highlights a focus on access to care. The QI/UM committee (p. 7) monitors compliance with access to care standards. Section IV.A, pp. 11-12 outlines multiple mechanisms to insure access to care. ◆ VO's Level of Care Guidelines, and insuring that staff apply these consistently is one of the main ways we insure that services are authorized appropriately, and are sufficient to help members achieve their treatment goals. (p.2, 2nd paragraph, clinical philosophy, pp. 4-5, Section	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	IV. E, p. 15, first item and (Documents 8-29) Close involvement and oversight from the Medical Director/Clinical peer advisor of any case that potentially does not meet medical necessity is another safeguard that appropriate services are being authorized for our members (Section IV, K., p. 19) ◆ In addition analysis of the overall program through multiple reports and committees looks at the bigger picture for trends that may show any areas of insufficient services or network status to insure that the program is effective. (SectionV, pp. 25-26) In addition, the program is formally evaluated on all goals each year to insure that services are effective. (Section XII, p. 33 and Annual UM Evaluation FY13 110_FY13 UM PLAN-goals-final_FBHP—Document 4)	
3. The Contractor's UM Program is conducted under the auspices of a qualified clinician and has: ◆ Evidence of formal staff training designed to improve the quality of UR decisions. ◆ Policies and procedures to evaluate and improve the consistency with which UR staff apply criteria (e.g. inter-rater reliability) across multiple levels of care. ◆ Policies, procedures, and job descriptions to specify the qualifications of personnel responsible for each level of UR decision-making (e.g. review, denial). ◆ Policies and procedures to ensure that a practitioner with appropriate clinical expertise in treating the member's condition reviews any potential denial based on medical necessity. *42CFR438.210(b)(3)*	**Documents Submitted/Location within Documents:** 1. Dr Fine Resume –FBHP-Entire Document 2. C405-Orientation and Training of Clinical Staff-3BHO-Entire Document 3. C406 Clinical Rounds_3 BHO_Entire policy 4. ROUNDS_MINUTES_SC_2013OCT03_3BHO-entire document 5. ROUNDS_MINUTES_SC_2013JUL03_3BHO-entire document 6. CCM Training Manual- entire document 7. DSM V Training sheet_Aug2013_CL- 3BHO-Entire Document 8. Sign in Sheet_DSM5Training_2013Aug-3BHO-Entire Document 9. Annual Trainings-National Summary_2013_3BHO-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
Contract: II.I.1.a, II.I.1.h. Exhibit V, VA	10. C409 Interrater Reliability_3BHO-entire policy 11. Clinical Care Manager Job Description_3BHO-entire document 12. Clinical Director Job Description_3BHO-entire document 13. Clinical Supervisor Job Description_3BHO-entire document 14. Peer Advisor PhD Job Description_3BHO-Entire Document 15. FBHP Medical Director job description-entire document 16. 202L Medical Necessity_3BHO-p.5, letter F--entire document 17. 303LPeerAdvisorAdverseDeterm_Policy_page.2-IV-C and V, pp.3-7 18. 408LCareManagementDocAudit_Policy_3BHO-entire document 19. C408 Clinical Operations Audits_3BHO-Entire Document 20. Dementia Training_13OCT09_3BHO-entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partnership s (FBHP). FBHP's Medical Director, Dr. Alan Fine, oversees the UM program by providing leadership and involvement in the day to day functioning of the Clinical Department. Dr. Fine's qualifications are outlined in "Dr. Fine Resume-FBHP (Document 1)." Dr. Fine participates in daily rounds meetings with the team, and also is available daily for case consults and reviews. When he is off site for a meeting, he is available by cell phone to the team. In addition, to Dr. Fine, the team has the management support of our psychologist, Clinical Peer Advisor, Clinical Director and Clinical Services Supervisor who are available to staff for immediate consult on difficult cases for support of administrative workflows and UR decision making	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	on a daily basis. **<u>Formal Staff Training</u>**: Clinical Care Managers (CCM) receive both initial and ongoing training in a variety of venues described in "C405-Orientation and Training of Clinical Staff-3BHO." Clinical Care managers begin their employment with an intensive training process that formally goes through our CCM Training manual, which orients them to important policies and procedures, level of care criteria, and resources for decision making as well as important nuances and systemic information for our Colorado Medicaid contract (CCM Training Manual- entire document_) New CCM receive oversight and 1:1 coaching and training from our Clinical Services Supervisor as they learn our computer system and how to take calls. By the 90 day review point, they are able to apply criteria consistently, and they receive feedback from direct observation of cases as well as audits of recorded calls. Ongoing training is provided throughout the year in a variety of venues. Clinical staff participate in rounds to discuss individual cases and receive formal training. Scheduled rounds time is important to allow applied training on a day to day basis. The C406 Clinical Rounds_3 BHO_Entire policy describes our rounds process. In the fall of 2013, we moved from a weekly rounds time, to a daily rounds time to allow for more training and discussion time for the Medical and Clinical Staff. In this venue, there is both formal training (see Dementia Training_3BHO_ 100713, DSM V Training sheet_Aug2013_CL- 3BHO & Sign in Sheet_DSM5Training_2013Aug-3BHO) , as well as training tailored to trends or questions that come up (ROUNDS_MINUTES_SC_3BHO_2013JUL03_CL and ROUNDS_MINUTES_SC_2013OCT03_3BHO-entire	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	document). In addition to live training, staff complete multiple online trainings each year- including required trainings as well as trainings tailored to interests or areas they need to learn more about. "Annual Trainings-National Summary_2013_3BHO" provides an overview of the variety of trainings completed through our National online resources in 2013. **Policies and Procedures to evaluate and improve consistency of decision making:** Inter-rater reliability is formally tested on an annual basis and compared with VO staff across the country to insure consistent application of guidelines and to identify any needs for improvement by any team or individual not meeting the minimum requirements. C409 Interrater Reliability_3BHO-entire policy describes our IRR testing policy and process. Results are analyzed by geographic region, professional specialty and time with the company to allow for identification of trends and actions to improve the application of criteria. In addition, all phone calls are recorded, and staff making UR decisions receive regular audits of their performance (See C408 Clinical Operations Audits_3BHO). Documentation audits are also done based on a customized list of criteria for initial and concurrent reviews and on timeliness of reviews. (408LCareManagementDocAudit_Policy_3BHO-entire document). Both documentation audits and telephone audits provide formal oversight opportunities to insure that staff are making appropriate application of clinical criteria. **Policies, Procedures and Job Descriptions/Qualifications for UR decision making:** Multiple policies and avenues exist for ValueOptions® (VO) to ensure that staff members are clear on their roles and	

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	responsibilities. VO Colorado 202L Medical Necessity_3BHO-p.5, letter F is one example of this role clarification, noting that Clinical Care Managers only have authority to approve care, and that a Peer Advisor must be consulted to make any denial decisions. The CCM training manual also reiterates that CCM may not ever deny care in our section "Levels of Care to Approve/Deny" (CCM Training Manual, p. 16) Our job descriptions also outline the qualifications for Clinical Care Managers, Clinical Service Supervisor, Clinical Director, and Clinical Peer Advisor and, for FBHP, their Medical Director job description in the corresponding documents: • Clinical Care Manager Job Description_3BHO-entire document • Clinical Director Job Description_3BHO-entire document • Clinical Supervisor Job Description_3BHO-entire document • Peer Advisor PhD Job Description_3BHO • FBHP Medical Director Job Description-entire document **Policies ensuring practitioners with appropriate clinical expertise reviews any potential denial based on medical necessity:** Training materials, job descriptions and policies and procedures make it clear that care can only be denied by the BHO Medical Director or Clinical Peer Advisor. 303LPeerAdvisorAdverseDeterm_Policy_p.2-IV-C, and V, pp.3-7 demonstrates that appropriate clinical staff with expertise in treating the member's condition review any potential denials and make decisions based on medical necessity. In addition, 202L Medical Necessity_3BHO-p.5, letter F--entire document, also reiterates that Clinical Care Managers may not deny care, but potential denials must be reviewed with a Peer Advisor.	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The Contractor does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member. *42CFR438.210(a)(3)(ii)* Contract: II.I.1.e.	**Documents Submitted/Location within Documents:** 1. LOC Guideline 3 BHO_23-Hour_Observation- Entire document 2. LOC Guideline 3 BHO_Acute Inpatient Treatment- Entire document 3. LOC Guideline 3BHO_Acute_Treatment_Unit_Services- Entire document 4. LOC Guideline 3BHO_Adult_Residential_Treatment_Services- Entire document 5. LOC Guideline 3 BHO_Advocacy_Svcs- Entire document 6. LOC Guideline 3 BHO_alternative outpatient services- Entire document 7. LOC Guideline 3 BHO_Alternative_Family_Care- Entire document 8. LOC Guideline 3 BHO_Case_Management_Services- Entire document 9. LOC Guideline 3BHO_Child_Adol_Day_Treatment_Services- Entire document 10. LOC Guideline 3 BHO_Community_Support_Programs- Entire document 11. LOC Guideline 3BHO_Consumer_Operated_Services_Adult- Entire document 12. LOC Guideline 3BHO_Intensive_Outpatient_Programs_Adult- Entire document 13. LOC Guideline 3BHO_IOP_ChildAdol_Sex_Disorder_TX- Entire document 14. LOC Guideline	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	3BHO_Outpatient_Crisis_Intervention_Services- Entire document 15. LOC Guideline 3 BHO_Outpatient_Services- Entire document 16. LOC Guideline 3BHO_Parameters_for_Treating_Children_Under_5- Entire document 17. LOC Guideline 3 BHO_Partial_Hospitalization- Entire document 18. LOC Guideline 3 BHO_Peer_Support_Services- Entire document 19. LOC Guideline 3 BHO_Psychological-Neuropsychological_Testing- Entire document 20. LOC Guideline 3BHO_Residential_Treatment_Children-Adolescents- Entire document 21. LOC Guideline 3 BHO_Respite_Care_Services- Entire document 22. LOC Guideline 3 BHO_Wrap_Around_Services- Entire document 23. 202L Medical Necessity_3BHO– Pages 4-5, Section V.A-F 24. 303L Peer Advisor Adverse Determinations – Entire policy 25. Exhibit D_Covered Mental Health Diagnoses_3BHO-Entire Document 26. ROUNDS_MINUTES_SC_2013SEP25_3BHO-entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' staff refers to the medical necessity policy (202L; document 23), the list of	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	covered diagnoses (Exhibit D, document 25) and clinical level of care criteria (documents 1-22) to authorize care, based on individual case review to ensure that care is not arbitrarily reduced or denied based on diagnostic categories or conditions. Care can be denied only by the BHO's Medical Director or the Clinical Peer Advisor (policy 303L; document 24). Variables such as the member's situation and other care available are also taken into account in each individual situation as demonstrated by the Clinical Rounds process (document 26). Staff work with providers to review the context of the member's care, and give input into best discharge plans to help members stabilize in the long run, with the member's best interest in mind. ValueOptions®' staff refers cases for possible adverse clinical decisions to the Medical Director/Peer Advisor for review.	
5. If the Contractor places limits on services, it is: ◆ On the basis of criteria applied under the State plan (medical necessity). ◆ For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. *42CFR438.210(a)(3)(iii)* Contract: II.I.1.f.1. and II.I.1.f.2.	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_3BHO – Page 3, Section IV. A-B 2. 272LTrackingCaidBenefitLimits_Policy_3BHO_entire policy 3. IP Benefit Limit_3BHO-Entire Document 4. LOC Guideline 3 BHO_23-Hour_Observation- Entire document 5. LOC Guideline 3 BHO_Acute Inpatient Treatment- Entire document 6. LOC Guideline 3BHO_Acute_Treatment_Unit_Services-Entire document 7. LOC Guideline 3BHO_Adult_Residential_Treatment_Services- Entire document 8. LOC Guideline 3 BHO_Advocacy_Svcs- Entire document 9. LOC Guideline 3 BHO_alternative outpatient services-	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	Entire document 10. LOC Guideline 3 BHO_Alternative_Family_Care- Entire document 11. LOC Guideline 3 BHO_Case_Management_Services- Entire document 12. LOC Guideline 3BHO_Child_Adol_Day_Treatment_Services- Entire document 13. LOC Guideline 3 BHO_Community_Support_Programs- Entire document 14. LOC Guideline 3BHO_Consumer_Operated_Services_Adult- Entire document 15. LOC Guideline 3BHO_Intensive_Outpatient_Programs_Adult- Entire document 16. LOC Guideline 3BHO_IOP_ChildAdol_Sex_Disorder_TX- Entire document 17. LOC Guideline 3BHO_Outpatient_Crisis_Intervention_Services- Entire document 18. LOC Guideline 3 BHO_Outpatient_Services- Entire document 19. LOC Guideline 3BHO_Parameters_for_Treating_Children_Under_5- Entire document 20. LOC Guideline 3 BHO_Partial_Hospitalization- Entire document 21. LOC Guideline 3 BHO_Peer_Support_Services- Entire document 22. LOC Guideline 3 BHO_Psychological-	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	Neuropsychological_Testing- Entire document 23. LOC Guideline 3BHO_Residential_Treatment_Children-Adolescents- Entire document 24. LOC Guideline 3 BHO_Respite_Care_Services- Entire document 25. LOC Guideline 3 BHO_Wrap_Around_Services- Entire document. 26. Exhibit D_Covered Mental Health Diagnoses_3BHO **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). The Medical Necessity policy uses the State definition (202L Medical Necessity – Page 3, Section IV. A-B). Covered Diagnoses lists are stipulated by contract (Exhibit D_Covered Mental Health Diagnoses_3BHO). Care is limited based on the State benefit limits, (272LTrackingCaidBenefitLimits_Policy_3BHO_entire policy and IP Benefit Limit_3BHO-Entire Document). Level of Care Guidelines provide the basis for any other limits placed on services authorized to control utilization and focus it on the members who will benefit from services and achieve their goals. (Documents 4-25). Each Level of Care guideline starts with a clear description of the service, and continues with inclusion and exclusion criteria designed to authorize care for the members who would reasonably be expected to benefit from the service. Criteria are clearly outlined to continue authorization for members who are progressing in treatment or who have treatment plans adjusted by providers to address any lack of progress. Care managers actively work with providers during reviews, based on the LOC criteria to shape treatment so that it will achieve the purposes needed by members.	

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6. The Contractor specifies what constitutes "medically necessary services" in a manner that: ◆ Is no more restrictive than that used in the State Medicaid program. ◆ Addresses the extent to which the Contractor is responsible for covering services related to the following: • The prevention, diagnosis, and treatment of health impairments. • The ability to achieve age-appropriate growth and development. • The ability to attain, maintain, or regain functional capacity. *42CFR438.210(a)(4)* Contract: I.A.25.	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_3BHO –Entire policy, especially Section IV.A 2. 223LTreatmentPlanning_Policy_3BHO-entire policy 3. Exhibit D_Covered Mental Health Diagnoses_3BHO-entire document 4. LOC Guideline 3 BHO_23-Hour_Observation- Entire document 5. LOC Guideline 3 BHO_Acute Inpatient Treatment- Entire document 6. LOC Guideline 3BHO_Acute_Treatment_Unit_Services-Entire document 7. LOC Guideline 3BHO_Adult_Residential_Treatment_Services- Entire document 8. LOC Guideline 3 BHO_Advocacy_Svcs- Entire document 9. LOC Guideline 3 BHO_alternative outpatient services-Entire document 10. LOC Guideline 3 BHO_Alternative_Family_Care- Entire document 11. LOC Guideline 3 BHO_Case_Management_Services-Entire document 12. LOC Guideline 3BHO_Child_Adol_Day_Treatment_Services- Entire document 13. LOC Guideline 3 BHO_Community_Support_Programs-Entire document 14. LOC Guideline 3BHO_Consumer_Operated_Services_Adult- Entire document 15. LOC Guideline 3BHO_Intensive_Outpatient_Programs_Adult- Entire	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	document 16. LOC Guideline 3BHO_IOP_ChildAdol_Sex_Disorder_TX- Entire document 17. LOC Guideline 3BHO_Outpatient_Crisis_Intervention_Services- Entire document 18. LOC Guideline 3 BHO_Outpatient_Services- Entire document 19. LOC Guideline 3BHO_Parameters_for_Treating_Children_Under_5- Entire document 20. LOC Guideline 3 BHO_Partial_Hospitalization- Entire document 21. LOC Guideline 3 BHO_Peer_Support_Services- Entire document 22. LOC Guideline 3 BHO_Psychological-Neuropsychological_Testing- Entire document 23. LOC Guideline 3BHO_Residential_Treatment_Children-Adolescents- Entire document 24. LOC Guideline 3 BHO_Respite_Care_Services- Entire document 25. LOC Guideline 3 BHO_Wrap_Around_Services- Entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). Medically necessary services are needed for the diagnosis or treatment of a health impairment and also to prevent deterioration in functioning as a result of a covered mental health disorder (policy 202L, document 1). VO's treatment planning policy	

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	(223LTreatmentPlanning_Policy_3BHO_) outlines the focus of treatment by starting with an individualized assessment of the member, including the DSM diagnosis. This diagnosis includes the 5 axis assessment that includes not only a behavioral health diagnosis, but developmental and personality factors, physical health factors, social and developmental stressors as well as the member's functioning level. The policy notes that treatment goals need to be focused and measurable to address these identified problems. The Level of Care guidelines (documents 4-25) apply these principles to specific types of treatment and levels of care. Each LOC guideline is designed to take into account the needs of the member to help them in the recovery process from their behavioral health disorder. For example, for children, academic success is a core focus of age appropriate development and success. Helping children and adolescents in the school setting contributes to their ability to maintain or regain a functional capacity and appropriate participation in the school environment is an age appropriate milestone for our youngest members. Therefore, the LOC guideline for Child and Adolescent Day Treatment Services (Document 12) focuses on the current academic impairment in the admission and discharge criteria. Similarly, the LOC guideline for Adult Residential Services (document 12) provides in the definition, a focus on the attainment of life skills to help members with activities of daily living. These are life tasks that a member needs to accomplish in order to be able to transition to a less restrictive level of care, once they go back to the community. Services are rehabilitative in nature and as such, designed to help members return to or attain a higher level of functioning. (Definition of service I, page 1, Document 12) All of our LOC guidelines are written with these principles in mind.	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	ValueOptions®' policies are based on the State Medicaid Program's definition for medical necessity and the covered diagnoses (Exhibit D, document 3) provides the scope of covered diagnoses that FBHP is responsible to treat.	
7. The Contractor has written policies and procedures that address the processing of requests for initial and continuing authorization of services. *42CFR438.210(b)* Contract: II.I.1.g.	**Documents Submitted/Location within Documents:** 1. 203L Medical Necessity Determination_3BHO – Section IV, definitions and Section V Pages 4-17 2. 204LIntakeDataCollectInitialAuthHLOC_3BHO- entire policy 3. 206LDataCollectionContinuedAuthHLOC_ 3BHO- entire policy **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partnerships (FBHP). ValueOptions®' policies clearly define and outline the procedures and information needed for each type of authorization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
8. The Contractor has in place and follows written policies and procedures that include effective mechanisms to ensure that each staff member is applying criteria consistently, such as inter-rater reliability testing. The contractor takes action to improve consistency where possible. *42CFR438.210(b)(2)(i)* Contract: II.I.1.q	**Documents Submitted/Location within Documents:** 1. C409 Interrater Reliability_3BHO-entire policy 2. 236LClinicalLOCGuidelines_Policy_3BHO- section V, A, 2 pages 2-3 3. 408LCareManagementDocAudit_Policy_3BHO- entire policy 4. VO IRR CAP-individual-3BHO-entire document 5. IRR results_3BHO-entiredocument **Description of Process:** The submitted documents demonstrate our written policies/procedures for ensuring consistent application of criteria: C409 Interrater Reliability_3BHO-entire policy and 236LClinicalLOCGuidelines_Policy_3BHO- section V, A, 2	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
	pages 2-3 outlines our policies, procedures and mechanisms to ensure and oversee that staff are consistently applying criteria for decision making. IRR results_3BHO is the result of our annual Inter Rater Reliability testing. We analyze results by discipline, and length of time with the company to see if there are any general trends or problems in application that need to be followed up for additional training. In addition, VO IRR CAP-individual-3BHO is an example of some of the follow up and re-training that is done with individuals who don't pass the test. VO also does quarterly documentation audits to make sure that all required elements are being documented- as elements must be present to be included into decision making appropriately. 408LCareManagementDocAudit_Policy_3BHO- entire policy outlines this audit process. Care managers perform these audits on their peers, which allows them to see how others are documenting and also provides a natural reinforcement of items that need to be in each record. These are formal processes to make sure that criteria is applied consistently. VO also has informal mechanisms in place such as daily rounds meeting where cases are discussed with the Medical Director, and reviews of cases that are denied when the Notice of Action is being sent, to make sure that the letter accurately reflects what took place. During this review process, the work of the individual case managers receives oversight and any issues where criteria was not applied correctly can be identified and followed up.	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
9. The Contractor has in place and follows written policies and procedures that include a mechanism to consult with the requesting provider when appropriate. *42CFR438.210(b)(2)(ii)* Contract: II.I.1.j.	**Documents Submitted/Location within Documents:** 1. 202L Medical Necessity_3BHO– Page 4, Section V.D 2. 203L Medical Necessity Determination_Policy_3BHO – Section V., pages 4-24 3. 303L Peer Advisor Adverse Determ_3BHO – Page 1, Section III.C **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' policies direct staff to contact the provider, when necessary, for a review determination (policy 303L, entire policy, document 3). In addition, VO policies outline a formal process which includes consultation with a requesting provider, upon request, for reconsideration when initial or continued authorization is denied (303L Peer Advisor Adverse Determ_3BHO – Page 1, Section III.C). Authorizations or denials of services involve immediate telephonic notification of providers. (203L Medical Necessity Determination_Policy_3BHO – Section V., pages 4-24). If providers fail to request additional services, VO staff reach out to coordinate with the provider to determine whether the member has discharged from care. If there is not enough information available to make a determination, the provider is notified along with details about the information needed. (202L Medical Necessity_3BHO– Page 4, Section V.D) Finally, appropriate attempts are made to contact the requesting provider for reconsideration/peer to peer review before finalizing any adverse clinical decisions.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
10. The Contractor has in place and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (notice to the provider need not be in writing). *42CFR438.210(c)* Contract: II.I.1.j	**Documents Submitted/Location within Documents:** 1. 203L Medical Necessity Determination_Policy_3BHO – Page 8-17, sections V.D-V.G **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' policy outlines the processes for notifying the requesting provider and involved member of any decision to deny or authorize less care than requested, for all types of requests and levels of care. Specifically, • **Section V.D.5** outlines that for denials/limited authorization or urgent prospective requests, the requesting provider is notified telephonically at the time of determination, and that the member, facility and provider all receive written notice of the determination; • **Section V.E.5** outlines the same notification guidelines indicated above for urgent concurrent reviews; • **Section V.F.5** outlines the same notification guidelines indicated above for routine initial reviews; and • **Section V.G.5** outlines the same notification guidelines indicated above for routine concurrent reviews.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
11. The Contractor has in place and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions as expeditiously as the member's health condition requires not to exceed: ◆ For standard authorization decisions—10 calendar days. ◆ For expedited authorization decisions—3 business days.	**Documents Submitted/Location within Documents:** 1. 203L Medical Necessity Determination_Policy_3BHO – Pages 6 – 16, Section V.C-H **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' policy specifies the timeframes for each type of authorization and level of care. Specifically,	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
42CFR438.210(d) Contract: II.F.10, 10CCR2505—10, Sec 8.209.4.A.3.c	• **Section V.C** outlines all authorization timeframes for decisions. Standard (non-urgent) decisions are made within 10 calendar days and expedited decisions (urgent) are made within 72 hours; • **Section V.D.1** notes 72 hours as timeframe for expedited initial authorizations; • **Section V.E.1** notes 72 hours as the maximum timeframe for concurrent urgent authorizations (expedited); • **Section V.F.1** notes the timeframe for routine initial authorizations is 10 calendar days; • **Section V.G.1** notes the timeframe for routine concurrent authorization is 10 calendar days; and,	
12. The notices of action must be mailed within the following time frames: ◆ For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the time frames specified in 431.211: • The notice of action must be mailed at least 10 days before the date of the intended action unless exceptions exist (see 42CFR431.213 and 214). ◆ For denial of payment, at the time of any action affecting the claim. ◆ For standard service authorization decisions that deny or limit services, as expeditiously as the member's health condition requires but within 10 calendar days following receipt of the request for services. ◆ For service authorization decisions not reached within the required time frames on the date time frames expire.	**Documents Submitted/Location within Documents:** 1. 203LMedicalNecessityDetermination_Policy_3BHO – ***see narrative for page numbers **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). Policy 203L outlines the timeframes for mailing of Notices of Action: • For termination, suspension or reduction of previously authorized services, notices must be mailed at least 10 days before the date of the intended action (Section I. pages 19-20) • For denial of payment (such as for retro reviews), at the time of the action affecting the claim (Section H.4, pages 18-19) • All authorization decisions are made as expeditiously as the member's health condition requires (Section V.A.2, pages 4-5) • For standard service authorization decisions that deny or	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
◆ For expedited service authorization decisions, as expeditiously as the member's health condition requires but within 3 business days after receipt of the request for services. *42CFR438.404(c)* *42CFR438.400(b)(5)* Contract: II.F.10, 10CCR2505—10, Sec 8.209.4.A.3.a	limit services- within 10 calendar days of the receipt of request for service (Sections V.F.5, page 14 and V.G.5, page 17) • For service authorization decisions not reached within the required timeframes, on the date timeframes expire (Section A.5, page 5) • For expedited decisions, letters are mailed no later than 3 calendar days from the receipt of request for services (Section V.D.5, page 9 and V.E.5, page 11)	
13. Notices of action must meet the language and format requirements of 42CFR438.10 to ensure ease of understanding (6th-grade reading level wherever possible and available in the prevalent non-English language for the service area). *42CFR438.404(a)* Contract: II.F.4.e, II.F.10 10CCR2505—10, Sec 8.209.4.A.1	**Documents Submitted/Location within Documents:** 1. FBHP Policy M4 Member Information 2. 306LMemberMaterials_Development_3BHO-III.A-E; IV.B 3. NoticeofActionEnglish_FBHP-Entire Document 4. NoticeofActionSpanish_FBHP-Entire Document **Description of Process:** ValueOptions follows FBHP's and VO's policy on member materials development for any member materials. All member materials are translated into Spanish, which has been deemed as a prevalent language by the state. VO recognizes that a large proportion of Medicaid enrollees have low health literacy, so we follow guidelines developed by CMS in developing the ValueOptions' member materials policy for low literacy readers. For example, when VO presents a concept that may be unknown to a low literacy reader, we offer a definition in simple language. The Notice of Action letter is translated into Spanish, and VO/FBHP is prepared to translate it into other languages should a member request this. VO tests materials to ensure they are at or below the 6th grade reading level.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
14. Notices of action must contain: ◆ The action the Contractor (or its delegate) has taken or intends to take. ◆ The reasons for the action. ◆ The member's, the member's authorized representative's, or provider's (on behalf of the member) right to file an appeal and procedures for filing. ◆ The date the appeal is due. ◆ The member's right to a State fair hearing. ◆ The procedures for exercising the right to a State fair hearing. ◆ The circumstances under which expedited resolution is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal and how to request that the benefits be continued. ◆ The circumstances under which the member may have to pay for the costs of services (if continued benefits are requested). ◆ Language clarifying that oral interpretation is available for all languages and how to access it. *42CFR438.404(b)* Contract: II.F.4.e, II.F.10, 10CCR2505—10, Sec 8.209.4.A.2	**Documents Submitted/Location within Documents:** 1. Notice of Action Standard Non Covered Diagnosis_ FBHP-Entire Document 2. Notice of Action Standard- Not Mtg Med Nec_ FBHP-Entire Document 3. Notice of Action Standard Service Not Covered_ FBHP-Entire Document 4. Grievance Appeal Guide_2013_ FBHP-Entire Document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions ensures that members receive Notices of Action which contain all of the required elements. VO staff meet on a regular basis to continue refinement of the Notice of Action letters, in a continuous quality improvement process. Staff look for opportunities to refine the letters to make them easier for FBHP's members to read. This year VO changed from one main letter with multiple check boxes, for the denial reasons, to three separate letters which only contain information relevant to the situation of the member receiving the letter. The goal was to remove information that could confuse FBHP members when it is not relevant to their situation. In our effort to only include elements in the letter, which pertain specifically to the member. VO staff had moved some information related to the circumstances under which benefits could continue and under which they may have to pay for the cost of benefits into the Grievance and Appeal Guide (**Grievance Appeal Guide_2013_FBHP) ,** which is mailed with every Notice of Action. Upon review of the NOA requirements, VO put this information back into the letter and have been using the revised letter since January 2013. The included letter templates (FBHP-Notice of Action Standard Non Covered Diagnosis, FBHP-Notice	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	of Action Standard- Not Mtg Med Nec, and FBHP-Notice of Action Standard Service Not Covered) include all of the covered elements.	
15. The Contactor may extend the authorization decision time frame if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. The Contractor's written policies and procedures include the following time frames for possible extension of time frames for authorization decisions: ◆ Standard authorization decisions—up to 14 calendar days. ◆ Expedited authorization decisions—up to 14 calendar days. *42CFR438.210(d)* Contract: II.F.10, 10CCR2505—10, Sec 8.209.4.A.3	**Documents Submitted/Location within Documents:** 1. 203L Medical Necessity Determination_Policy_3BHO – Pages 7-10, Sections V.D2 and V.D 3 and V.E2 and pages 13-15 Sections V.F.3 and V.E.3 **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). Value Options rarely extends decision timeframes, however when extensions are made, policy 203L provides the guidelines that are followed. For expedited authorizations, due to the urgent nature of the care and to meet URAC requirements, authorization decisions must be made within 72 hours, so extensions are only give due to lack of information to make **any** decision or if the member requests an extension. • **Section V.D.2** outlines the timeframe for possible extension, when requested by the member, is up to 14 calendar days for an urgent (expedited) case for an initial authorization decision. • **Section V.D.3** outlines the timeframe for possible extension when there is a lack of information to make **any** authorization decision is up to 14 calendar days. • **Section V.E.2** outlines the timeframe for possible extension is up to 14 calendar days for an urgent (expedited case) for a concurrent authorization decision. For standard (routine) authorizations: • **Section V.F.3 and V.G.3** notes a 14 calendar day extension is available if there is a lack of information to	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	make an authorization decision, or if the member requests an extension for initial or concurrent authorization decisions. • **Section V.F.3** notes a 14 day extension is available if there are circumstances beyond the control of ValueOptions®.	
16. If the Contractor extends the time frame for making a service authorization decision, it: ◆ Provides the member written notice of the reason for the decision to extend the time frame. ◆ Informs the member of the right to file a grievance if the member disagrees with the decision to extend the time frame. ◆ Carries out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires. *42CFR438.404(c)(4) and 438.210(d)(2)(ii)* Contract: II.F.10, 10CCR2505—10, Section 8.209.4.A.3.c	**Documents Submitted/Location within Documents:** **1.** 203L Medical Necessity Determination_Policy_3BHO – Pages 8-15- Sections V.D.3.a , V.E.3.a, V.F.2-3 and V.G.2-3 **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' policy details the requirements to send written notification to the member and to carry out the determination as expeditiously as the member's health condition requires. Written notification requirements can be found in VO Colorado 203L Medical Necessity Determination in the following locations: • V.D.3.a, page 8 • V.E.3.a, pag3 10 • V.F.2, page 12 • V.F.3, page 13 • V.G.2, pages 14-15 • V.G.3, page 15 The policy also outlines the fact that authorization decisions are made as required by the member's health condition, and no later than the date the extension expires: • V.D.1, page 7 • V.E.1, pages 9-10 • V.F.1, page 12	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	• V.G.1, pages 14-15 **Additional Documents Submitted On-site:** • Extension notice template	
17. The Contractor has in place and follows written policies and procedures that provide that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42CFR438.210(e)* Contract: II.I.1.c.	**Documents Submitted/Location within Documents:** 1. C421 Objectivity in Clinical Decision-Making-3BHO-Entire Policy 2. VOCO Annual Attestation- 3BHO-Entire Document 3. Code of Conduct Annual Training_3BHO-Entire Document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions® has policies in place that define conflict of interest and specifically state that employees are not provided incentives, nor permitted to accept gifts in relation to any UM activities. ValueOptions®' staff annually receives training regarding conflict of interest and employee code of conduct, including signing an annual attestation agreeing with policies that they are not given incentives to deny or limit care for members.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
18. The Contractor defines Emergency Medical Condition as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: ◆ Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. ◆ Serious impairment to bodily functions. ◆ Serious dysfunction of any bodily organ or part. *42CFR438.114(a)* Contract: I.A.12	**Documents Submitted/Location within Documents:** 1. 270L EmergencyPost-Stabilization Services_Policy_3BHO – Page 4, Section IV.A defines Emergency Medical Condition. 2. C214-Member Life Threatening-Non Life Threatening Emergency- FBHP-Entire Document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' 270L Emergency and Poststabilization Services policy defines emergency medical conditions. Members receive information in the member handbook about what defines an emergency or crisis and how to obtain emergency services. ValueOptions®' staff assists members and directs them to the nearest facility/ER when there is any question of an emergency medical condition. The provider handbook defines emergency medical condition for providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
19. The Contractor defines Emergency Services as inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title, and are needed to evaluate or stabilize an emergency medical condition. *42CFR438.114(a)* Contract: II.A.13	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO – Page 4, Section IV.C. 2. FBHP Member Handbook-pg 4-5 (in Miscellaneous folder) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' 270L Emergency and Poststabilization Services policy provides this exact definition of Emergency Services. This definition is also given to providers in the Provider Handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
20. The Contractor covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the Contractor. *42CFR438.114(c)(1)(i)* Contract: II.D.6.a.1	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO – Page 1, Section III.A. 2. Colorado Reference Guide _3BHO_112613, #22, page 12 **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' Colorado ER claims procedures indicates members can access these services without prior authorization. This procedure document states that claims for emergency services are accepted and paid for any provider, regardless of network status. Claims processors are instructed to consider claims from In or Out of network providers.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
21. The Contractor does not require prior authorization for emergency services. *42CFR438.10(f)(6)(viii)(B)* Contract: II.I.1.p.1.	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO – Page 1, Section III.A. and Section III, F. 2. 203L Medical Necessity Determination_Policy-3BHO-page 6, Section B 3. Colorado Reference Guide _3BHO_112613, #22, page 12 **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). The above policies and guide state that prior authorization is not required for emergency services	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
22. The Contractor may not deny payment for treatment obtained under the following circumstances: ◆ A member had an emergency medical condition, and the absence of immediate medical attention would ***have*** had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. ◆ Situations which a reasonable person outside the medical community would perceive as an emergency medical condition but the absence of immediate medical attention would ***not*** have had the following outcomes: • Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy. • Serious impairment to bodily functions. • Serious dysfunction of any bodily organ or part. ◆ A representative of the Contractor's organization instructed the member to seek emergency services. *42CFR438.114(c)(1)(ii)* Contract: II.D.6.a.2.	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO – Pages 1-2, Section III.B.1-3 2. Colorado Reference Guide _3BHO-entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' 270L Emergency and Poststabilization Services policy clearly outlines that payment may not be denied under either of these circumstances. There is no authorization requirement at all for emergency services. These services are not denied when billed as emergency services, regardless of the actual outcome. Providers are also informed of this requirement through the provider handbook.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
23. The Contractor does not: ◆ Limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms. ◆ Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the Contractor or State agency of the member's screening and treatment within 10 days of presentation for emergency services. *42CFR438.114(d)(1)* Contract: II.D.6.b.	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO – Page 2, Section III.C.1-2 2. Colorado Reference Guide _3BHO-entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' 270L Emergency and Poststabilization Services policy does not limit what constitutes an emergency medical condition based on diagnoses, symptoms or refuse to cover emergency services based on the provider, hospital or fiscal agent not notifying the primary care providers within 10 days of presentation for services. During claims processing, ValueOptions®' staff pays these claims without the need for an authorization. Providers are not required to notify Value Options of ER services or request authorizations to obtain reimbursement.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
24. The Contractor will be responsible for Emergency Services when the primary diagnosis is psychiatric in nature even when the psychiatric diagnosis includes some procedures to treat a secondary medical diagnosis. Contract: II.D.6.i.2.	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO – Page 1, Section III.A.3 2. Colorado Reference Guide _3BHO_112613, #22, page 12 **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' 270L Emergency and Poststabilization Services policy indicates that the ValueOptions, as FBHP's delegate for claims adjudication, is responsible to pay for ER services when the primary diagnosis is psychiatric in nature, even if the ER services also included some procedures to treat a secondary medical diagnosis. During claims processing, ValueOptions®' staff pays these claims , without the need for an authorization.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
25. The Contractor does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42CFR438.114(d)(2)* Contract: II.D.6.c.	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO – Page 3, Section III.D. 2. FBHP Member Handbook-pg 13 (see in Miscellaneous folder) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' 270L Emergency and Poststabilization Services policy releases the member from liability for payment for any subsequent screening and treatment needed to stabilize an emergency medical condition. Members are informed via the member handbook that the member is not responsible to pay for services covered by the Medicaid plan. Members are instructed to call the Behavioral Health Organization if the member receives a bill for services.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
26. The Contractor allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor who is responsible for coverage and payment. *42CFR438.114(d)(3)* Contract: II.D.6.d.	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO – Page 3, Section III.E **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' 270L Emergency and Poststabilization Services policy states the attending physician/facility makes decisions independent of any contact with the Behavioral Health Organization regarding stabilization, as there is no preauthorization required for emergency services, and no authorization needs to be on file for the claim to be paid. The provider makes treatment decisions and submits the bill after services have been rendered.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
27. The Contractor defines Poststabilization Care as covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or provided to improve or resolve the member's condition. *42CFR438.114(a)* Contract: II.A.32.	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO – Page 5, Section IV.D. **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions®' 270L Emergency and Poststabilization Services policy clearly defines post stabilization care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
28. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have been*** pre-approved by a plan provider or other organization representative. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.e.	**Documents Submitted/Location within Documents:** 1. 270L EmergencyPost-Stabilization Services_Policy-3BHO-page 3, Section III.G. 1 **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). FBHP understands that the BHO is responsible for poststabilization care services obtained within or outside the network that have been pre-approved by a plan provider or organization representative and ValueOptions®, as FBHPs delegate, for claims adjudication, carries out this BHO responsibility by paying on behalf of FBHP. Policy 270 L Section III. G.1. clearly states this delegated responsibility.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
29. The Contractor is financially responsible for poststabilization care services obtained within or outside the network that ***have not been*** pre-approved by a plan provider or other organization representative, but are administered to maintain the member's stabilized condition under the following circumstances: ◆ Within 1 hour of a request to the organization for pre-approval of further poststabilization care services. ◆ The Contractor does not respond to a request for	**Documents Submitted/Location within Documents:** 1. 270L EmergencyPost-Stabilization Services_Policy-3BHO page 3-4, Section III.G2-3 **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). FBHP understands that the BHO is responsible for poststabilization care services obtained within or outside the network that have not been pre-approved by a plan provider or organization representative under specified	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
pre-approval within 1 hour. ◆ The Contractor cannot be contacted. ◆ The Contractor's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with a plan physician, and the treating physician may continue with care of the patient until a plan physician is reached, or the Contractor's financial responsibility for poststabilization care services it *has not* pre-approved ends. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.f.1–3.	circumstances and ValueOptions®, as FBHPs delegate, for claims adjudication, carries out this BHO responsibility by paying on behalf of FBHP. Policy 270 L Section III, G.2-3. clearly states this delegated responsibility.	
30. The Contractor's financial responsibility for poststabilization care services it ***has not*** pre-approved ends when: ◆ A plan physician with privileges at the treating hospital assumes responsibility for the member's care. ◆ A plan physician assumes responsibility for the member's care through transfer. ◆ A plan representative and the treating physician reach an agreement concerning the member's care. ◆ The member is discharged. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.g.	**Documents Submitted/Location within Documents:** 1. 270L EmergencyPost-Stabilization Services_Policy-3BHO pages 3-4, Section III.-3-c:1-4 **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). FBHP understands that the BHO responsibility for poststabilization care services that have not been pre-approved ends under specific circumstances and ValueOptions®, as FBHPs delegate, for claims adjudication, carries out this BHO responsibility of setting policy and procedures on payment on behalf of FBHP. Policy 270 L, Section III.G.3.c1-4 outline when this delegated responsibility for VO ends.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard I—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the BHO**	**Score**
31. The Contractor must limit charges to members for poststabilization care services to an amount no greater than what the Contractor would charge the member if he or she had obtained the services through the Contractor. *42CFR438.114(e)* *42CFR422.113(c)* Contract: II.D.6.f.4.	**Documents Submitted/Location within Documents:** 1. 270L Emergency and Post-Stabilization Services_Policy-3BHO page 3, Section III. D. **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partnerships (FBHP). ValueOptions®' policy details the additional circumstances by which ValueOptions®, as FBHPs delegate, maintains responsibility for provided services. Policy 270 L states that members are not charged for these services regardless of whether the services are obtained through Value Options or not.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard I—Coverage and Authorization of Services							
Total	Met	=	31	X	1.00	=	31
	Partially Met	=	0	X	.00	=	0
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	NA	=	NA
Total Applicable		=	31	**Total Score**		=	31

Total Score ÷ Total Applicable	=	100%

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
The Contractor ensures that all covered services are available and accessible to members through compliance with the following requirements:		
1. The Contractor maintains a comprehensive provider network capable of serving the behavioral health needs of all members in the Medicaid Program, including any new populations. *42CFR438.206(b)(1)* Contract: II.E.1.c.1.	**Documents Submitted/Location within Documents:** 1. FBHP Delegation Agreement_FY 14_executed (in Standard I folder)—see pg. 2 Article 2.02 (e) & pg. 11-12 Exhibit A #5 2. FBHP Amendment to Delegation Agmt 2014 (executed) – (in Standard I folder) entire document 3. FBHP Policy D6 Delegation Provider Network (entire document) 4. NetDevPlan_FY2014_3BHO (entire document) 5. FBHP Policy Q3 Access to Services (see page 3-4 Sec IV on monitoring of member access) 6. FBHP Policy Q5 Provider Monitoring (entire document) 7. PR302 NetworkDesignAndAccessStandards_3BHO - entire document 8. AccessToCare_HCPF_FINAL_report_Q1FY14_2013Oct30_FBHP -entire document 9. AccessToCare_HCPF_FINAL_report_Q4FY13_2013JULY 30_FBHP -entire document 10. IPNAuditTool _3BHO -entire document 11. FacilitySiteReviewTool_3 BHO-entire document 12. NetworkAdequacyReport Q4FY13_3BHO -entire document 13. ProviderDirectory_3BHO-entire document 14. FBHP MHC compliance checklist 2013-entire document 15. NetworkAdeq_Policy_3BHO- entire document 16. Medical Record Audit Report FY 13_Final -entire document 17. FBHP Q6 Member Medical Record -entire document 18. 403ProviderTreatmentRecordReviewanalysis	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	andReportingAttachmentA_Policy_3BHO (entire document) **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners), although FBHPartners' QI Department staff work closely with VO and maintain BHO policies regarding member access and provider monitoring (see documents (Documents #1-3 and #5-6, #17). ValueOptions® has policies outlining the monitoring process of provider availability (Documents #7&15). These policies describe the activities involved to assess and maintain a comprehensive provider network to serve the needs of eligible Medicaid members. In addition to policies, ValueOptions®, in partnership with FBHPartners conducts a variety of provider monitoring activities to assure providers are meeting the needs of BHO Medicaid members (Documents #8-11 and #14, 16) and ValueOptions conducts quarterly an assessment of the Network (Document #12). In addition, ValueOptions maintains the Provider Directory, which provides information on individual and facility providers throughout the state and works with FBHP to develop an annual Network Plan (Document #4 &13). For the IPN the 3 BHOs collaborated on a policy for addressing medical record documentation compliance (Document #18)	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
2. In establishing and maintaining the network, the Contractor considers: ◆ The anticipated Medicaid enrollment. ◆ The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the Contractor's service area. *42CFR438.206(b)(1)(i) through (v)* Contract: II.E.1.c.1.	**Documents Submitted/Location within Documents:** 1. PR302 NetworkDesignAndAccessStandards_3BHO entire document 2. NetDevPlan_FY2014_3BHO (entire document) 3. 2013AnnualNeedsAssessment_3BHO -entire document 4. Provider Directory_3BHO -entire document 5. NetworkAdequacyReport_Q4FY13_3BHO-entire document 6. Provider Handbook_3BHO (see Miscellaneous folder) -page 20, section V, Member Choice of Providers, Page 85, Section XVI, Transportation. 7. NetworkAdeq_Policy_3BHO- entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). ValueOptions® reviews the network adequacy for FBHP regularly as per local and national policies and annual planning to ensure Medicaid members have a range of providers that are able to serve their needs (Documents #1-2 & #7). The review includes the number of providers, specialties, languages, locations, and accessibility. ValueOptions monitors the availability of providers quarterly and annually (Documents #3 & 5). The monitoring completed by ValueOptions includes an assessment of member needs and expected utilization. Members are provided choice in providers across the FBHP BHO region as described in the Provider Handbook_3BHO and Provider Directory (Document #4 & 6). The network includes an array of providers who can serve member needs based on specialty, licensure level, or level of care that is found to be medically necessary.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
3. The Contractor has a network plan and it, at a minimum, addresses the following: ◆ The numbers, types, and specialties of providers required to furnish the contracted Medicaid services, including care coordination. ◆ The number of network providers accepting/not accepting new Medicaid members. ◆ The geographic location of providers in relationship to where Medicaid members live. ◆ The potential physical barriers to accessing providers' locations. ◆ The cultural and language expertise of providers. ◆ Provider-to-member ratios for behavioral health care services. *42CFR438.206(b)(1)(i) through (v)* Contract: II.E.1.c.1.i–vi.	**Documents Submitted/Location within Documents:** 1. PR302 NetworkDesignAndAccessStandards_3BHO - entire document 2. 2013AnnualNeedsAssessment_3BHO-entire document 3. Provider Directory_3BHO-entire document 4. FacilitySiteReviewTool_3 BHO-entire document 5. NetworkAdequacyReport Q4FY 13_3BHO –entire document 6. Provider Handbook_3BHO (see in Miscellaneous folder) -page 20, section V, Member Choice of Providers, Page 85, Section XVI, Transportation. 7. NetDevPlan_FY2014 _3BHO-entire document 8. NetworkAdeq_Policy_3BHO- entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners FBHP. ValueOptions® reviews the network adequacy for FBHP as per ValueOptions local and policies regularly to ensure Medicaid members have a range of providers that are able to serve their needs (Documents #1 &8). The review includes, but is not limited to, the number of providers, specialties, languages, locations, and accessibility. ValueOptions maintains a Network Development Plan to address all needs of the BHO network and fill any disparity found (Document #7). Monitoring of the network is completed through reviews quarterly and annually (Document #2 &5) and updating of the provider directory (Document #3). Providers are given information through the provider manual on how members can access transportation (Document #6) for members who may experience barriers with access to care.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
4. The Contractor ensures that its members have access to a provider within 30 miles or 30 minutes travel time, whichever is larger, to the extent such services are available. Contract: II.E.1.a.8.	**Documents Submitted/Location within Documents:** 1. NetworkAdequacyReport_Q1FY14_3BHO-entire document 2. 2013AnnualNeedsAssessment_3BHO-entire document 3. NetworkAdeq_Policy_3BHO- entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). ValueOptions® reviews network adequacy for FBHP regularly as per our local policy (Document #3) to ensure Medicaid members have access to providers within 30 minutes or 30 miles whenever possible. This review is completed quarterly through our network adequacy reports (Document #1) and then annually with the BHO annual needs assessment (Document #2).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
5. The contractor offers to contract with essential community providers located in the Contractor's geographic service area, as defined in Section 25.5-5-404(2) C.R.S. The Contractor's network shall include both essential community providers and other private/non-profit providers, thus allowing members choice and facilitating continuity of care. Contract: II.E.1.c.2.	**Documents Submitted/Location within Documents:** 1. ProviderDirectory_3BHO-(in Miscellaneous folder) entire document 2. ECP_ContractRequests1_3BHO-Entire Document 3. Essential_Community_Providers_Application_Log -entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHP). All essential community providers are offered contracts in the FBHP area including school based providers, FQHCs, RHC, and other community based providers as noted on the state essential community provider listing and example of letter (Document #3 & 4). Those accepting contracts are	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	listed in the provider directory (Document #1). In addition to essential community providers, the BHO also includes a number of private providers in the BHO network.	
6. The Contractor has a mechanism to allow members to obtain a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member. *42CFR438.206(b)(3)* Contract: II.E.1.a.12.	**Documents Submitted/Location within Documents:** 1. FBHP Policy M6 Second Opinion (entire document) 2. FBHP Member Handbook_FBHP-in Miscellaneous folder (pg 13) 3. Provider Handbook_3BHO- in Miscellaneous folder (pg 24) **Description of Process:** The FBHP Office of Member and Family Affairs (OMFA) assists members with the second opinion process according to policy and as described in the Provider Handbook and the Member Manual (Document #1-3). Providers may refer members to the OMFA or to ValueOptions, FBHP's UM and Provider Network delegate, for a second opinion when the member disagrees with a provider diagnosis or recommended course of treatment. In addition, the OMFA may recommend that a member see a second opinion in the course of assisting the member with a grievance. The OMFA gives the member the number for ValueOptions, who then provides the member with a choice of three providers, if available, to contact for the face-to-face second opinion.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
7. If the Contractor is unable to provide covered services to a particular member within its network, the Contractor adequately and timely provides the covered services out of network at no cost to the member for as long as the Contractor is unable to provide them. *42CFR438.206(b)(4)* Contract: II.E.1.c.3. and II.E.1.d.1.	**Documents Submitted/Location within Documents:** 1. FBHP Policy D3 Delegation Utilization Management (see in Standard I folder) – entire document 2. FBHP Policy D6 Delegation Provider Network – entire document 3. 274LProvisionSvcsOutOfNetworkProvider_Policy_3BHO -entire document 4. SCALetter_Practitioner_ with cover_3BHO (2) -entire document 5. SCALetter_ Facilities_ with cover_3BHO (2) -entire document 6. Provider Handbook_3BHO- (see in Miscellaneous folder) page 20, section V, Member Choice of Providers. 7. FBHP Member Handbook–(see in Miscellaneous folder) page 6 and 16 **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners) (Document 1& 2). ValueOptions®'policies and SCA letters describe that when services are not available through an in-network provider that Members can access a covered service through an out-of-network provider at no cost to the member and that all timeframes for authorization decisions must be upheld (Document #3-5). Policies outline the approval process and situations in which Single Case Agreements are approved for member services outside of the provider network. In the member handbook, members are informed that they can ask to see a provider who may not be listed in the provider directory (Document #7). The provider handbook outlines the member's rights regarding choice of providers (Document #6).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
8. The Contractor coordinates with out-of-network providers with respect to payment and ensures that the cost to the member is no greater than it would be if the services were furnished within the network. *42CFR438.206(b)(5)* Contract: II.E.1.d.2.	**Documents Submitted/Location within Documents:** 1. SCALetter_ Facilities_ with cover_3BHO (2)-entire document 2. SCALetter_Practitioner_ with cover_3BHO (2) -entire document **Description of Process:** This element is delegated to ValueOptions® by Foothills Behavioral Health Partners (FBHPartners). Single Case Agreements require that out-of-network providers coordinate with ValueOptions® with respect to payment (Documents #1-2).	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A
9. The Contractor ensures that covered services are available 24 hours a day, 7 days a week when medically necessary. *42CFR438.206(c)(1)(iii)* Contract: II.E.1.a.5.	**Documents Submitted/Location within Documents:** 1. FBHP Policy Q3 Access to Service – entire document 2. FBHP Policy Q11 Mental Health Services NCF_ACF-entire document 3. FBHP Policy Q4 Access for Members with a Developmental Disorder-entire document 4. FBHP Policy Q12 Access for Members with a Traumatic Brain Injury-entire document 5. QI Plan 3rd Qtr report FY ’14 (pg 3-5) 6. FBHP 2013_ACF_NCF_Report (entire document) 7. QI Work Plan FBHP FY ’14 Final (pg 2, 1st bullet under “Plan Structure;” pg 3-4 Access Measures; access projects #7-9 pg 18-19, 21-22) 8. FBHP QI Program Evaluation FY ’13 revised (see pg 4 under “Access to Care;” Access to care measures, pg 6-8; Access projects pg 20, pg 22-24) 9. ProviderTrainingPlanFY13_3BH O-training schedule tab row 38 and curriculum tab rows 15-17 10. Provider Handbook_3 BHO (in Miscellaneous folder)-pg 8-11	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	11. FBHP MHC compliance checklist 2013 (section under "Access to Care"). 12. Access to Care_HCPF_Final_Reports_Q4FY '13_2013July 30_FBHP-entire document 13. Access to Care_HCPF_Final_Report Q1FY14_2013 Oct 30_FBHP-entire document 14. Narrative_IPNEmergencyAccesstoCare_Q4FY13_FBHP-Entire Document **Description of Process:** FBHP Access Policies and Provider Handbook describes FBHP access requirements and methods for monitoring (see documents #1-4 & #10). Methods of monitoring Member access include quarterly Access to Care reports, monitoring through the annual QI Plan/Program, annual MHC compliance assessment, and spot checking providers through surveys and audits (see #6-8; #11-14). In addition training is available on Access in the provider network (see document #9)	
10. The Contractor must require its providers to offer hours of operation that are no less than the hours of operation offered to commercial members. *42CFR438.206(c)(1)(ii)* Contract: II.E.1.a.4.	**Documents Submitted/Location within Documents:** 1. FBHP Policy Q3 Access to Service (pg 3 Sec II) 2. Provider Handbook_3BHO (in Miscellaneous folder)–(pg 8, #1; pg 9-10 #6-8) 3. FBHP MHC compliance checklist 2013 (section under "Access to Care") 4. FBHP MHC compliance checklist 2013_JE results rev 1_20_14 (item 11) 5. FBHP MHC compliance Checklist 2013_MHP results rev 1_20_14 (item 11) 6. Facility Site Review Tool – 3BHO (item #8) 7. JCMH Extended Office Hours (entire document) 8. MHP Hours of Operation 2013 (entire document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: FBHP requires by policy and in the Provider Manual that providers offer hours of operation that are no less than that offered to commercial members and indicates the need to provide extended evening or morning times at key clinic sites (see document #1-2). FBHP monitors this through an annual MHC compliance audit and, by VO, through the facility site review tool (see documents #3-8).	
11. The Contractor must meet, and require its providers to meet, the following standards for timely access to care and services taking into account the urgency of the need for services: ◆ Emergency services are available: • By phone, including TTY accessibility, within 15 minutes of initial contact. • In person within one hour of contact in urban and suburban areas. • In person within two hours of contact in rural and frontier areas. ◆ Urgently needed services are provided within 24 hours from the initial identification of need. ◆ Routine services are available upon initial request within 7 business days. (Routine services include but are not limited to an initial individual intake and assessment appointment. Placing members on waiting lists for initial routine service requests is not acceptable.) ◆ Outpatient follow-up appointments within 7 business days of an inpatient psychiatric hospitalization or residential facility. *42CFR438.206(c)(1)(i)*	**Documents Submitted/Location within Documents:** 1. FBHP Policy Q3 Access to Service (Sec I; pg 1-2) 2. Provider Handbook_3BHO (in Miscellaneous folder)–(pg 8-9) 3. QI Plan 3rd Qtr report FY ’14 (pg 2; pg 8) 4. QI Work Plan FBHP FY ’14 Final (pg 2, 1st bullet under “Plan Structure;” pg 3-4 Access Measures; access projects #7-9 pg 18-19, 21-22) 5. FBHP QI Program Evaluation FY ’13 revised (pg 4; pg 12) 6. ProviderTrainingPlanFY13_3BHO-training schedule tab row 38 and curriculum tab rows 15-17 7. AccessToCare_HCPF_FINAL_Report_Q1FY14_2013Oct 30_FBHP-Entire Document 8. Narrative_IPNEmergencyAccesstoCare_Q4FY13_FBHP-Entire Document 9. FBHP MHC compliance checklist 2013 (see items 10 and 21) 10. FBHP MHC compliance checklist 2013_JE results rev 1_20_14 (item 10 & 21) 11. FBHP MHC compliance Checklist 2013_MHP results rev 1_20_14 (item 10 & 21) 12. FBHP 2013_ACF_NCF_REPORT (see responses to survey item #4)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
Contract: II.E.1.a.6 and 7	13. FY14 Q2 CMHC_EmergAccess to Care_FBHP (entire document) 14. FBHP Member Handbook -(in Miscellaneous folder)-pg 5 **Description of Process:** FBHP requires by policy and in the Provider Manual that Network Providers meet specific emergency, urgent, and routine services, as well as outpatient follow-up standards (see documents #1-2). FBHP monitors providers regarding these standards through the QI Plan measures, access to care reports, surveys and audits (see documents #3-5; 7-13). In addition, provider training on these standards is provided (Document #6). Last, the FBHP Member Handbook describes access standards to Members (Document #14)	
12. The Contractor has mechanisms to ensure compliance by providers with standards for timely access, monitors providers regularly to determine compliance with standards for timely access, and takes corrective action if there is a failure to comply with standards for timely access. *42CFR438.206(c)(1)(iv) through (vi)* Contract: II.E.1.a.9–11	**Documents Submitted/Location within Documents:** 1. FBHP Policy Q3 Access to Service (Sec I; pg 1-2) 2. Provider Handbook_3BHO (in Miscellaneous folder)–(pg 8-9) 3. QI Work Plan FBHP FY ’14 Final (pg 2, pg 3-4 Access Measures - Plan) 4. FBHP QI Program Evaluation FY ’13 revised (pg 4; pg 12) 5. AccessToCare_HCPF_FINAL_Report_Q1FY14_2013Oct 30_FBHP -Entire Document 6. Narrative_IPNEmergencyAccesstoCare_Q4FY13_FBHP-Entire Document 7. FBHP 2013_ACF_NCF_REPORT (see responses and/or recommendations to survey item #4) 8. FY14 Q2 CMHC_EmergAccess to Care_FBHP (entire document)	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	Description of Process: FBHP requires by policy and in the Provider Manual that Network Providers meet specific emergency, urgent, and routine services, as well as outpatient follow-up standards (see documents #1-2). FBHP monitors providers regarding these standards through the QI Plan measures, access to care reports, surveys and audits and implements improvement projects and/or corrective action if providers fail to meet the standards (see documents #3-8)	
13. The Contractor has developed policies and procedures for monitoring the performance of providers on an ongoing basis related to the timeliness of services, and has monitored providers annually to determine compliance. Contract: II.G.10.a.3, II.G.10.a.4, Exhibit S, IV.A	**Documents Submitted/Location within Documents:** 1. FBHP Policy Q3 Access to Service (Sec IV pg. 3-4) 2. FBHP Policy Q5 Provider Monitoring (Sec II pg 1-2) 3. FBHP Policy Q11 Mental Health Services NCF_ACF (sec IV pg. 2) 4. FBHP Policy Q4 Access for Members with a Developmental Disability (Sec III) 5. FBHP Policy Q12 Access for Members with a Traumatic Brain Injury (Section III) 6. QI Plan 3rd Qtr report FY '14 (pg 3-5) 7. QI Work Plan FBHP FY '14 Final (pg 2, 1st bullet under "Plan Structure;" pg 3-4 Access Measures; access projects #7-9 pg 18-19, 21-22) 8. FBHP QI Program Evaluation FY '13 revised (see pg 4 under "Access to Care;" Access to Care measures, pg 6-8; Access Projects pg 20, pg 22-24) 9. FBHP MHC compliance checklist 2013 (see items 10 and 21) 10. FBHP MHC compliance checklist 2013_JE results rev 1_20_14 (item 10 & 21) 11. FBHP MHC compliance Checklist 2013_MHP results rev 1_20_14 (item 10 & 21) 12. FY14Q2CMHC_EmergencyAccessToCare_FBHP-Entire Document	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	13. Narrative_IPNEmergencyAccesstoCare_Q4FY13_FBHP-Entire Document 14. FBHP Policy M3 Grievance System: Grievances and Appeals (Purpose, pg 1; Procedures, 1.C. pg 2; Procedures III. A3&4, pg 4) **Description of Process:** FBHP has in place specified provider monitoring procedures in its Access policies and through FBHP's Grievance System policy, that ensures members can complain about access issues and that trends are reported by the OMFA to the QAPI QI Director for further action and to HCPF quarterly (see documents #1-5; #14) FBHP monitors providers at least annually for compliance (see documents #6-13).	
14. The Contractor participates in the State's efforts to promote the delivery of services in a culturally competent manner, to all members including those with limited English proficiency or reading skills including those with diverse cultural and ethnic backgrounds by: ◆ Developing, implementing, and promoting a written strategic Cultural Competency Plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services. ◆ Maintaining policies that support the provision of health care services that respect individual health care attitudes, beliefs, customs and practices of members related to cultural affiliation. ◆ Having sufficient cultural competency staff to implement and oversee compliance with the Contractor's Cultural Competency Plan, policies,	**Documents Submitted/Location within Documents:** **Monitoring** 1. ProviderDirectory_3BHO-Entire Document (bullet 6, 15) 2. FBHP Policy Q6 Members Medical Record (entire document) (bullet 2, 4,16) 3. QI Work Plan FBHP FY '14 Final (pg 6-7 2d; pg 18 #4) (bullet #7, 8,10,14) 4. FBHP QI Program Evaluation FY '13 revised (pg 10-11 D.1& 2; pg 22 F) (bullet #7,8,10,14) 5. Medical Record Audit Report FY 13_final (pg 1 under Assessment first bullet; under Treatment Plan 2nd bullet) (bullet #4,16) 6. StRpt_FBHP Griev State Report FINAL_Q4 FY 13_OMFA (under Access – item "Language/Cultural Barriers (bullet #14) 7. FBHP MHC compliance checklist 2013 (items 2,4,18) (bullet 7-12, 16) 8. FBHP MHC compliance checklist 2013_JE results rev	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

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Requirement	**Evidence as Submitted by the BHO**	**Score**
and contract requirements and to oversee compliance with all cultural competency requirements and limited English proficiency needs. ◆ Making a reasonable effort to identify members whose cultural norms and practices may affect their access to health care. Such efforts may include: • Inquiries conducted by the Contractor of the language proficiency of members during the Contractor's orientation calls. • Being served by participating providers. • Improving access to health care through community outreach and Contractor publications. ◆ Developing and/or providing cultural competency training programs, as needed, to the network providers and Contractor staff regarding: • Health care attitudes, values, customs, and beliefs that affect access to and benefit from health care services. • The medical risks associated with the client population's racial, ethnic, and socioeconomic conditions. ◆ Making a reasonable effort, when appropriate, to develop and implement a strategy to recruit and retain qualified, diverse, and culturally competent clinical providers that represent the racial and ethnic communities being served. ◆ Providing access to interpretive services by a qualified interpreter for deaf or hard of hearing members in such a way that it promotes accessibility and availability of covered services. ◆ Providing to members in their preferred language	1_20_14 (items 2,4,18) (bullet 7-12, 16) 9. FBHP MHC compliance Checklist 2013_MHP results rev 1_20_14 (items 2,4,18) (bullet 7-12, 16) 10. NetDevPlan_FY_2014_3BHO (pg 6 #6; under monitoring #2) (bullet #6) 11. Provider Handbook_3BHO (in Miscellaneous folder) (pg 84-85; 90) **Plans and Policies** 12. FBHP Policy M7 Non Discrimination (entire policy) 13. 2013 AnnualNeeds Assessment_3BHO (tab specialty information) -Addresses language and cultural expertise of providers (bullet #15) 14. FBHP Policy M4 Member Information (in Standard I folder) (procedures IA; IH1-4; Describes how member information is written for low literacy and mailings are sorted by Spanish speaking households) (bullet 8 & 9) 15. FBHP Member Handbook (in Miscellaneous folder) (pg 4 second paragraph form bottom; pg 5 second and last paragraph; pg.6 fourth bullet from top; pg 10 under "What if I have a…."; pg 16; The Handbook includes several statements to help members understand their rights to culturally and linguistically appropriate services) (bullets 4,5, and 6.) 16. FBHP Policy M2 Cultural Competency (entire policy) 17. FBHP Cultural Competency Plan 2009 (entire document but especially "Purpose", pg 1; and Goals 1-X pgs 5-9). Following is a list of Goals in the Plan and which bullets they address: Goal I bullets 1,2 &5 Goal II bullets 4 & 5 Goal III bullets 6,14 & 15	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
verbal offers and written notices, upon request, informing them of their rights to receive language assistance services. ◆ Materials, including member handbook, correspondence, and newsletters. Written member information and correspondence shall be made available in languages spoken by prevalent non-English-speaking member populations within the Contractor's service area. ◆ Providing language assistance services, including bilingual staff and interpreter services, at no cost to any member with limited English proficiency at all points of contact, in a timely manner during all hours of operation. ◆ Ensuring the competence of language assistance provided to limited English proficient members by interpreters and bilingual staff. Family and friend should not be used to provide interpretation services (except on request by the member). ◆ Making available easily understood member-related materials and posting signage in the languages of the commonly encountered groups and/or groups represented in the service area. ◆ Developing policies and procedures, as needed, on how the contractor responds to requests from participating providers for interpreter services by a qualified interpreter. ◆ Ensuring that when providing or arranging for the provision of all medically necessary covered behavioral health services that they are linguistically and culturally accessible to all members, including racially and ethnically diverse communities, the	Goal IV bullets 10,11,12 & 13 Goal V bullets 7 & 8 Goal VI bullets 7-15 Goal VII bullets 8-10 Goal VIII bullets 9 & 12 Goal IX bullets 1-3 18. FBHP Intro to Info Different Cultures (entire document; The Introduction to a series of descriptions of characteristics of different cultures and how these characteristics may influence the cultures' access to health care). 19. FBHP African American Cultural Information (entire document; example of the cultural descriptions) 20. Jefferson Center for Mental health Language Policy Procedure July 20132 (entire document; Details the Center's procedures regarding culturally and linguistically appropriate services) (bullets 1-15). 21. MHP Procedure for Interpreter Services (entire document; Details the Center's procedures regarding culturally and linguistically appropriate services) (bullets 1-15). 22. JCMH Cultural Competency Plan 12-15-10 (entire plan but especially Goal I, Organizational Structure, third paragraph; Goal IV, first paragraph; Goal VIII Written Materials) (bullets 2-7) 23. MHCBBC Cultural Responsiveness Plan 12-9-10 (Entire plan but especially Goals I, II, IV, V, VI & VIII, which mirror the Goals in the FBHP Plan) 24. FBHP Policy M5 Member Rights (entire document) (bullets 2,5,7-10, & 14) 25. FBHP Policy M8 Language Assistance (entire document – Describes FBHP's commitment to language assistance for non-English speakers and people who are deaf and hard of	

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Requirement	**Evidence as Submitted by the BHO**	**Score**
disability community, and deaf and hard of hearing members. ◆ Addressing the language and cultural expertise of providers in the network plan. ◆ Evaluating members' cultural and linguistic needs in the individual needs assessment and using information gathered (regarding cultural and linguistic needs) in the service plan. *42CFR438.206(c)(2)* Contract: II.E.1.c.1.v; II.F.4.j.3.iv; II.F.7.d.1; II.F.7.d.8; and II.F.9.a; II.I.9; Exhibit N, I.A.4	hearing and low literacy (bullets 1,4, 7-16) **Training** 26. FBHP Annual Cultural Comp Training agenda12-13-13 (entire document; example of FBHP annual employee training) 27. FBHP Language Line Instructions (entire page; Training and handout for FBHP staff on using Language Line) 28. JCMH NEO Training rev 10-24-13 (slides 5& 9) (bullets7,8,9 & 10) 29. JCMH Rights Annual Trng Clinical (slides 6 & 12) (bullets 7-10). 30. MHP Client Rights 2013 Annual EmployeeTraining (Slides 2, 10, and 14) (bullets 5, 7-14) 31. MHP Client Rights New Employee Orientation (Slides 3,6,and 7) (bullets 7-12 & 14) 32. VO Cultural Competency training (entire document; Excellent training resource available to FBHP and all of our providers). **Description of Process:** FBHP's Cultural Competency Plan establishes goals, timelines and responsibilities for ensuring that all members receive culturally sensitive and linguistically appropriate service. In addition the Plan describes FBHP's commitment to services, regardless of the member's culture or proficiency in English. FBHP's Director of the Office of Member and Family Affairs is the Cultural Competency Coordinator and is supported by other OMFA staff as well as Coordinators from the Partner Mental Health Centers, the Chair of the VO Cultural Competency Committee and a Network of Subject Matter Experts (Document 17).	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
	FBHPs Cultural Competency and Language Assistance Policies describe FBHP's commitment to culturally and linguistically relevant services. Policy procedures include an FBHP task force and Cultural Competency Plan as well as required Cultural Competency Plans of Partner Mental Health Centers that mirror the FBHP Plan (Document #16, #22-23, #25) ValueOptions , our Provider Network Delegate, offers cultural competency information, through the Provider Manual and through trainings for the Provider Network and ensures the adequacy of our network in terms of linguistic and cultural competence. In addition, the PMHCs provide training within each MHC (Documents #11 and 28-32) Through our QI process, FBHP monitors provider cultural competency through medical record reviews, to ensure that cultural issues are assessed in the assessment and in treatment planning and through Member surveys and grievances, obtaining member feedback on provider attention to cultural issues. In addition, through an annual compliance assessment FBHP ensures PMHCs have clear processes to provide appropriate interpreter services and written materials in other languages (Documents #2-9; #20-21). ValueOptions, as FBHPs delegate for the Provider Network, works closely with FBHP, to ensure adequacy of the provider network in regard to cultural competency (Documents #1&10) . Finally, through the Member Rights Policy, the OMFA staff ensure Members are aware of their rights, including cultural competent Provider services (Document 24)	

Standard II—Access and Availability		
Requirement	**Evidence as Submitted by the BHO**	**Score**
15. The Contractor monitors member perceptions of accessibility and adequacy of services provided by the Contractor. The Contractor uses tools including member surveys, anecdotal information, and grievance and appeals data. Contract: II.H.2.m.1	**Documents Submitted/Location within Documents:** 1. FBHP Policy Q1 QAPI Program (pg 2 IV B) 2. QI Work Plan FBHP FY '14 Final (pg 5-7, member survey measures; pg 18 monitoring grievances) 3. FBHP QI Program Evaluation FY '13 revised (pg 4; pg8-12 under Quality Dimension #2; pg 22 F. Grievances) 4. FBHP Internal Survey Report FY 13 (entire report) 5. CAP request MHP 11_19_13 (entire document) **Description of Process:** FBHP's QAPI Program policy and QI Work Plan describes procedures for monitoring member perceptions of access, including surveys, anecdotal information, and grievance/appeal data. The QI Program Evaluation and FBHP Internal Survey Report provide data on the monitoring of member information, including anecdotal comments. A recent CAP request is included, providing an example of how closely FBHP attends to member perception.	☒ Met ☐ Partially Met ☐ Not Met ☐ N/A

Results for Standard II—Access and Availability							
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%

Appendix B. Record Review Tool

for Foothills Behavioral Health Partners, LLC

The completed record review tool follows this cover page.

Appendix B. Colorado Department of Health Care Policy and Financing
FY 2013–2014 Denials Record Review Tool
for Foothills Behavioral Health Partners, LLC

Review Period:	January 1, 2013–December 31, 2013
Date of Review:	March 6, 2014
Reviewer:	Barbara McConnell and Rachel Henrichs
Participating Plan Staff Member:	Amie Adams

Requirement	File 1	File 2	File 3	File 4	File 5
1. Member ID	******	******	******	******	******
2. Date of initial request	5/16/13	9/28/13	10/29/13	3/11/13	12/2/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR	NR	NR	NR
4. Standard (S) or Expedited (E)	E	E	E	S	E
5. Date notice of action sent	5/16/13	9/30/13	10/30/13	3/19/13	12/2/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	0	2	1	7	0
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	C	C	C	C	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	C	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	C	NA	NA	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	6	7	6	6	6
Total Compliant Elements	6	7	6	6	6
Score (Number Compliant / Number Applicable) = %	100%	100%	100%	100%	100%
Comments:					

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

Requirement	File 6	File 7	File 8	File 9	File 10
1. Member ID	******	******	******	******	******
2. Date of initial request	3/4/13	5/13/13	6/2/13	7/1/13	10/9/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR	NR	NR	NR
4. Standard (S) or Expedited (E)	S	S	E	E	E
5. Date notice of action sent	3/5/13	5/20/13	6/3/13	7/1/13	10/9/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	1	7	1	1	1
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	C	C	C	C	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	C	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	NA	C	C	NA
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	6	6	7	7	6
Total Compliant Elements	6	6	7	7	6
Score (Number Compliant / Number Applicable = %)	100%	100%	100%	100%	100%
Comments:					

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)
NA = Not Applicable
Cal = Calendar; Bus = Business

Requirement	File 11	File 12	File 13	File 14	File 15
1. Member ID	******	******	******	******	******
2. Date of initial request	6/24/13	5/21/13	1/29/13	11/11/13	11/11/13
3. What type of denial? (termination [T], new request [NR], or claim [CL])	NR	NR	NR	NR	NR
4. Standard (S) or Expedited (E)	S	E	E	E	E
5. Date notice of action sent	5/25/13	5/22/13	1/30/13	11/11/13	11/11/13
6. Notice sent to provider and member? (C or NC)	C	C	C	C	C
7. Number of days for decision/notice	1	1	1	1	1
8. Notice sent within required time frame? (C or NC) (S = 10 Cal days after/E = 3 Bus days after/ T = 10 Cal days before)	C	C	C	C	C
9. Was authorization decision timeline extended? (Y or N)	N	N	N	N	N
a. If extended, extension notification sent to member? (C or NC, or NA)	NA	NA	NA	NA	NA
b. If extended, extension notification includes required content? (C or NC, or NA)	NA	NA	NA	NA	NA
10. Notice of Action includes required content? (C or NC)	C	C	C	C	C
11. Authorization decision made by qualified clinician? (C or NC, or NA)	C	C	C	C	C
12. If denied for lack of information, was the requesting provider contacted for additional information, or consulted (if applicable)? (C or NC, or NA)	NA	NA	NA	NA	NA
13. If denied due to not a covered service but covered by Medicaid Fee-for-Service/Wraparound service, did the notice of action include clear information about how to obtain the service? (C or NC, or NA)	NA	C	C	C	C
14. Was the decision based on established authorization criteria (i.e., not arbitrary)? (C or NC)	C	C	C	C	C
15. Was correspondence with the member easy to understand? (C or NC)	C	C	C	C	C
Total Applicable Elements	6	7	7	7	7
Total Compliant Elements	6	7	7	7	7
Score (Number Compliant / Number Applicable = %)	100%	100%	100%	100%	100%
Comments:					

Total Record Review Score	**Total Applicable Elements: 97**	**Total Compliant Elements: 97**	**Total Score: 100%**

C = Compliant; NC = Not Compliant (scored items)
Y= Yes; N = No (Not a scored item—informational only)

NA = Not Applicable
Cal = Calendar; Bus = Business

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

Table C-1 lists the participants in the FY 2013–2014 site review of **FBHP**.

Table C-1—HSAG Reviewers and BHO Participants	
HSAG Review Team	**Title**
Barbara McConnell, MBA, OTR	Director, State & Corporate Services
Rachel Henrichs	Project Coordinator
FBHP Participants	**Title**
Amie Adams	Clinical Director
Hazel Bond	Office of Member and Family Affairs
Tom Clay	Chief Executive Officer
Michelle Denman	Director of Provider Relations
Alan Fine	Medical Director
Kiara Marienau	Quality Improvement Coordinator
Scott Marmolstein	Quality Analyst
Linda Runyon	Consumer Advocate
Barbara Smith	Chief Quality Officer
Deborah Trout	Corporate Compliance Officer
Patty Vines	Client and Family Advocate, Jefferson Center for Mental Health
Department Observers	**Title**
Russell Kennedy	Quality and Health Improvement Unit

Appendix D. Corrective Action Plan Template for FY 2013–2014

for **Foothills Behavioral Health Partners, LLC**

If applicable, the BHO 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 compliance site review report via e-mail or through the file transfer protocol (FTP) site, with an e-mail notification to HSAG and the Department. The BHO must submit the CAP using the template provided. For each element 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 health care regulations and managed care contract requirements.

The template for the CAP follows.

Table D-2—FY 2013–2014 Corrective Action Plan *for* FBHP		
Standard I—Coverage and Authorization of Services		
Requirement	**Findings**	**Required Action**

FBHP did not have any required actions.

Appendix E. Compliance Monitoring Review Protocol 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' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

Table E-1—Compliance Monitoring Review Activities Performed

For this step,	HSAG completed the following activities:
Activity 1:	**Establish Compliance Thresholds**
	Before the site review to assess compliance with federal Medicaid managed care regulations and contract requirements: ◆ HSAG and the Department participated in meetings and held teleconferences to determine the timing and scope of the reviews, as well as scoring strategies. ◆ HSAG collaborated with the Department to develop monitoring tools, record review tools, report templates, on-site agendas; and set review dates. ◆ HSAG submitted all materials to the Department for review and approval. ◆ HSAG conducted training for all site reviewers to ensure consistency in scoring across plans.
Activity 2:	**Perform Preliminary Review**
	◆ HSAG attended the Department's Behavioral Health Quality Improvement Committee (BQuIC) meetings and provided group technical assistance and training, as needed. ◆ Sixty days prior to the scheduled date of the on-site portion of the review, HSAG notified the BHO in writing of the request for desk review documents 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 two standards and on-site activities. Thirty days prior to the review, the BHO provided documentation for the desk review, as requested. ◆ Documents submitted for the desk review and on-site review consisted of the completed desk review form, the compliance monitoring tool with the BHO's section completed, policies and procedures, staff training materials, administrative records, reports, minutes of key committee meetings, and member and provider informational materials. The BHOs also submitted a list of all Medicaid service and claims denials that occurred between January 1, 2013, and December 31, 2013. HSAG used a random sampling technique to select records for review during the site visit. ◆ 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 3:	**Conduct Site Visit**
	◆ 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. ◆ HSAG reviewed a sample of administrative records to evaluate implementation of Medicaid managed care regulations related to BHO service and claims denials and notices of action.

Table E-1—Compliance Monitoring Review Activities Performed	
For this step,	**HSAG completed the following activities:**
	◆ Also while on-site, 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 confidential or proprietary, or were requested as a result of the pre-on-site document review.) ◆ At the close of the on-site portion of the site review, HSAG met with BHO staff and Department personnel to provide an overview of preliminary findings.
Activity 4:	**Compile and Analyze Findings**
	◆ HSAG used the FY 2013–2014 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. ◆ HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to the State**
	◆ HSAG populated the report template. ◆ 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.